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Senate

The Senate met at 9:30 a.m. and was called to order by the Honorable HILLARY RODHAM CLINTON, a Senator from the State of New York.

PRAYER

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

Gracious Father, You give us inner eyes to see You and Your truth. Today we celebrate the birthday of Helen Keller, born on this day in 1880. Thank You for her courageous life. With Your help she overcame tremendous obstacles of being born blind and deaf. We are grateful for people like Anne Sullivan who taught her to read braille so that later she could attend Radcliffe College and eventually become a prolific author.

Our spirits are lifted today as we ponder Helen Keller's words, ''I thank God for my handicaps, for, through them, I have found myself, my work, my God.'' We intentionally adopt for our lives four things Helen Keller urged us to learn in life: ''To think clearly without hurry or confusion; To love everyone sincerely; To act in everything with the highest motives; To trust God unhesitantly.'' And for our work, Keller's words ring true: ''Alone we can do so little; together we can do so much.'' Thank You, Father, for the memory of this great woman. Help us today to use all that we have to do as much good as we can in as many circumstances and to as many people as we can. You are our Lord and Saviour. Amen.

PLEDGE OF ALLEGIANCE

The Honorable HILLARY RODHAM CLINTON 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.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, June 27, 2001.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable HILLARY RODHAM CLINTON, a Senator from the State of New York, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mrs. CLINTON thereupon assumed the chair as Acting President pro tempore.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order the leadership time is reserved.

RECOGNITION OF THE ACTING MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The acting majority leader is recognized.

BIPARTISAN PATIENT PROTECTION ACT

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will now resume consideration of S. 1052, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1052) to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage.

Pending:

Kyl amendment No. 818, to clarify that independent medical reviewers may not require coverage for excluded benefits and to clarify provisions relating to the independent determinations of the reviewer.

Allard amendment No. 817, to exempt small employers from certain causes of action.

THE ACTING PRESIDENT pro tempore. Under the previous order, there will now be 60 minutes of debate in relation to the Allard amendment, No. 817, prior to a vote on or in relation to the amendment.

The Senator from Nevada.

SCHEDULE

Mr. REID. On behalf of Senator DASCHLE, the Senate is advised that the Senate will resume consideration of the Patients' Bill of Rights that has been called by the Chair. There is going to be an hour of debate on the Allard amendment and thereafter on the Kyl amendment. There will be votes on those two matters this morning.

Madam President, I have been advised by the managers of this bill that there has been progress made during the night. If things go as expected, we should be able to meet the deadline that has been set by the leadership; that is, we are going to finish this bill by the Fourth of July break and we can also do the supplemental bill and organizing resolution.

Mr. ALLARD. Will the Senator yield?

Mr. REID. I will be happy to yield.

Mr. ALLARD. My understanding is we have an hour for the Allard amendment equally divided between both sides; is that correct?

Mr. REID. That is true.

I would just say, Madam President, the managers of this legislation, the Senator from Arizona, Mr. MCCAIN, and the Senator from North Carolina, Mr. EDWARDS, and the Senator from Massachusetts, Mr. KENNEDY, have done outstanding work. Senator GREGG and the people he has been working with have been very cooperative. I think this is a good sign for this legislation and movement of this legislation generally.

The ACTING PRESIDENT pro tempore. Who yields time?

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

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Mr. ALLARD. Madam President, I would like to yield 2 minutes to the senior Senator from Arizona.

The ACTING PRESIDENT pro tempore. The Senator from Arizona.

Mr. MCCAIN. I thank the Senator from Colorado. I will be very brief. I would just like to say to all my colleagues, on this issue I think we have made significant progress. Overnight we have the outlines of an agreement, thanks to Senators SNOWE and DEWINE, NELSON, LINCOLN, and others, on the issue of employer liability. We hope we can get the final details of that ironed out soon. I thank those four Senators and others on this issue.

On the issue of scope, I think we are close to an agreement on that major issue.

I thank all involved, including Senator FRIST and many others, for the serious negotiations that have been ongoing.

We may end up with a couple of issues that simply require votes on the floor to resolve them and the majority of the Senate will prevail. But I am very hopeful, and frankly very pleased at the progress we have made. All parties are seriously negotiating. That is the only way you can resolve an issue that has this much detail and this much complexity associated with it.

Again, I echo the sentiments of the Senator from Nevada. I think we could easily complete this in the next couple of days with the kind of willingness that has been displayed so far.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Nevada.

Mr. REID. One thing I forgot to mention, Senator KENNEDY and I, late last night, spoke to Senator JUDD GREGG—well, it wasn't late; it was in the evening. He indicated he would try today to get a list of amendments so we would have a finite list of amendments so we could work through those. If we can do that, it will be very easy to schedule what we will be doing in the next couple of days. If that doesn't happen, there is no question we will have to work late tonight and tomorrow night. Everyone should be advised Senator GREGG said he would try to get a finite list of amendments to us this morning.

The ACTING PRESIDENT pro tempore. The Senator from Massachusetts.

Mr. KENNEDY. If I could just proceed for a moment, I just thank all our Members for their cooperation. We have made some progress. There is a lot of work to do on this. We are encouraged by the cooperation of all our Members. But having been around here a long time, we have a lot of work to do. We have to keep at this job. There are very important matters before us.

We ought to just recognize we have a lot of work to do and we will have a chance to see where we are as we take this step by step. We have important debates this morning, and we have some additional issues on employer liability that we will address, on medical necessity, and hopefully on the areas of scope.

Those are being worked out; I hope are being drafted. As we all know, the key is in the details. I don't want to have any false sense of anticipation. We have still some very important policy issues that have to be resolved. But we are making progress. We are very grateful to all the Members for their help and cooperation, and we look forward to this morning's debate.

The ACTING PRESIDENT pro tempore. The Senator from North Carolina.

Mr. EDWARDS. Madam President, I want to echo the words of my colleagues, the Senator from Arizona and the Senator from Massachusetts.

There is certainly significant work to be done. Important issues need to be resolved. But we spent a good part of the day yesterday working on the issue of scope, making sure that every American is covered by this bill. I think we have, in fact, made great progress on that issue.

On the issue of medical necessity, which is one of the pending amendments—the Kyl-Nelson amendment—we expect to offer our own compromise amendment on that issue later today, something that was worked out yesterday through the process of discussions. As I think everyone knows, Senators SNOWE, DEWINE, and NELSON have worked very hard, along with the three of us, to work out an agreement on employer liability—all of us believing that employers all over this country need to be protected. That is not what this legislation is about. It is about giving patients rights and putting health care decisions back in the hands of doctors and patients and not in the hands of big HMOs. All of us are in agreement that in that process it is important to protect employers so they continue to provide coverage for employees all over this country.

So I echo the words of my colleagues. I do think it is true that we have made great progress. I think it is also true there is work left to be done. We will continue to work diligently with our colleagues. We have had colleagues on both sides of the aisle working on all these issues. We will continue to work on them as we go forward with these votes and this debate. But we are optimistic that we will be able to conclude this bill this week.

I yield the floor.

The ACTING PRESIDENT pro tempore. Who yields time?

The Senator from Colorado.

Mr. ALLARD. How much time does this side have?

The ACTING PRESIDENT pro tempore. Twenty-eight and a half minutes.

Mr. ALLARD. Madam President, I yield 18 minutes to the junior Senator from Arizona. And I would like to reserve the last 10 minutes for myself.

The ACTING PRESIDENT pro tempore. The Senator from Arizona.

AMENDMENT NO. 818

Mr. KYL. Madam President, I do not intend to take the full time right now. There may be others who wish to speak.

Senator ALLARD has been kind enough to allow those who support the Nelson-Kyl-Nickles amendment to take some of the time right now. I would like to change the subject back to that amendment which we brought before this body last night and debated for about an hour, and then we will also have an opportunity to conclude the debate on it after the vote on the Allard amendment. But now that we have a few moments, I would like to discuss that.

For those who were not in this Chamber last night to hear the debate, let me make it clear that there were two essential problems that we saw that needed resolution. We had worked with Senator KENNEDY, Senator EDWARDS, and others—and Senator NELSON had extensive conversations—about how to resolve these issues. One of the issues has apparently been resolved by agreement, although no amendment has yet been proposed to deal with it; and that all has to do with reviewing a case by the external reviewer. In other words, the insurance company has an internal review of an issue, and then if that isn't resolved, it goes to an external reviewer.

I think everybody agrees that if we can resolve the case at that stage and not have to go to litigation, it is better for everybody. So the question is, what exactly can be considered by that independent reviewer? The first problem that we saw was that the independent reviewer actually had the authority, under the bill, to order that benefits be provided to a patient that were excluded by the contract—legally excluded. The insured bought a certain set of benefits, and there were certain benefits excluded, but the independent reviewer would theoretically have the right to order excluded benefits to be provided for a patient.

I think everybody realized that was not what was intended, and it is at least the representation of those on the other side—and specifically Senator EDWARDS has made the point—that there is a way to fix that, and a very specific way, which we all understand. If that amendment is offered, then I think it will be a satisfactory conclusion to that particular matter.

The other matter that remains has to do with the other kind of issue that can come up. There is a benefit which is covered but the question is, what exactly is the appropriate medical service in this case? Here is a very simplistic example. The plan says: We are not sure exactly what is wrong with this person. We will take an x-ray to find out. But the doctor and the patient say: Look, we already had an x-ray, and the x-ray was not definitive enough. We think we need a CAT scan or an MRI.

Those are pretty expensive. The plan says: Look, we just don't think we need the MRI.

That is the dispute. There is no question that the diagnostic service is covered. The question is, which diagnostic service is appropriate or medically necessary in this particular case? So it goes to the internal reviewer. Let's say the internal reviewer says that an x-ray is good enough, but that is not what the doctor or the patient wants to hear. So they go to the independent or external review and make their case.

What is the standard for the external reviewer to decide whether or not an x-ray is good enough or whether or not there should be a CAT scan or an MRI, for example? There should be some kind of standard that is relatively uniform, unless the States have adopted a specific standard for review of plans within their particular State.

I will read the language in the bill that causes us concern because this is the deficiency as we see it. It is on page 37 of the bill. Under ''Independent Determination.—'':

In making determinations under this subtitle, a qualified external review entity and an independent medical reviewer shall—

Let me read the two subparagraphs here.

(i) consider the claim under view without deference to the determinations made by the plan or issuer or the recommendation of the treating health care professional . . .; and

(ii) consider, but not be bound by the definition used by the plan or insurer of ''medically necessary and appropriate'' or ''experimental or investigational''. . . .

''Consider, but not be bound by the definition used by the plan''—of course, that could raise a question of abrogation of contract. When the insurer says: Look, this is the insurance that you bought, and here is the definition under the plan, who has the right to go in and change the definition? So we think that language is inappropriate. The independent reviewer should not be able to just ignore the definition in the plan. But that then raises the question of whether or not a plan's definition could be overly restrictive.

What we basically agreed to, at least some of us believe is an appropriate compromise, is to say: You have to use the definition of the plan, but the plan has to have a reasonable definition. What would that definition be?

First of all, if a State mandates certain language, then obviously we need to use that language. So for the 13 or so States that actually mandate language, that would have to be applied. But for the rest of the States, there would be a definition, and the definition that we use is the definition that the Federal Employees Health Benefits Plan has used, approved by the Office of Personnel Management for fee-for-service plans.

So, Madam President, you and I, and the other Members of this body have an opportunity to acquire health insurance through the Federal Employees Health Benefit Plan just as all other Federal employees do. And there are basically two standards that they use for these contracts. One is for managed care. We consider that to be insufficiently protective of the patients. The other is for the fee-for-service. It is a more strict standard. That is the standard that we use.

For 49 percent of the people who are covered by a Blue Cross-Blue Shield contract—and that language, we believe, is also used by another 23 percent. So almost three-fourths of the people are covered by very specific language. That is exactly the language we have included in the bill.

There are five specific elements of it. The one that matters the most is the second one, which is: ''Consistent with standards of good medical practice in the United States.''

So the reviewer—if you are in a State that does not have a mandatory definition—would then apply this definition. You might say: ''Consistent with standards of good medical practice.'' That is pretty broad. That could be almost anything. It is not almost anything. What it is is good medical practice. And good medical practice can be determined by experts in the field, based upon the standards of the community, what literature suggests should be done in a particular case, and at least affords an opportunity for the independent reviewer to decide whether or not the patient needs the MRI or the CAT scan, in this case, whether good medical practice would ordinarily call for that, or whether, based on the circumstances of this case, it is just not that difficult and an x-ray ought to be good enough.

There are four other elements to it as well, but that is the key one.

There is a third opportunity here. If people do not like that definition, even though it covers three-fourths of us under a Federal plan, then we provide for a negotiated rulemaking procedure whereby all the stakeholders can get together and figure out a definition. I do not know what that would be. If they can all agree on a definition, we provide a mechanism for them to do so. And if they do, then that supplants this other definition. One year after that is agreed to, then this other definition is gone.

So there is an opportunity to come up with something that all of the parties agree is better if, in fact, they can do that. In the meantime, this is the definition that would apply. We think that is reasonable. We think it is an improvement on the legislation. Certainly something has to be done with this particular section.

Senator KENNEDY last night talked to both Senator NELSON and me about some possible changes in that. We are very open to that. I am hoping that in the remaining hour of debate on the Allard amendment—and then we will have the vote on the Allard amendment—and then we have an hour of debate on the Nelson-Kyl amendment—I am hoping in that 120 minutes or so we can come to an agreement as to what exactly this language should be. If we can, we are very willing to change the amendment and adopt whatever we can agree to. Senator KENNEDY had one particular idea last night that both Senator NELSON and my staff are exploring right now.

If we can do this, then we will announce it to the body. We will explain what it is, and hopefully we will have an agreement that everyone can support. If not, then obviously we will need to proceed with this language. In any event, we have identified a problem. We have a reasonable solution to the problem. If somebody has a better idea, we are open to consider what that might be.

I urge my colleagues who are interested to come to the floor and speak to it. We not only have a few remaining minutes under Senator ALLARD's time, but we have additional time when the amendment is debated after the vote on the Allard amendment.

I reserve the remainder of the time. Again, I invite anyone who is interested in speaking to this matter to come to the Chamber and address it.

The ACTING PRESIDENT pro tempore. Who yields time?

Mr. KENNEDY. Madam President, how much time do we have on our side?

The ACTING PRESIDENT pro tempore. Twenty-six minutes.

Mr. KENNEDY. I yield myself 10 minutes.

The PRESIDING OFFICER. The Senator from Massachusetts.

AMENDMENT NO. 817

Mr. KENNEDY. At the start of this discussion, we ought to understand the significance of the sort of carve-out that is offered by the Senator from Colorado. This effectively would eliminate 45 percent of all the workers in this country from the kind of coverage and protections we are trying to ensure through the Patients' Bill of Rights.

It seems to me if you work for a company that employs 48 employees and you happen to have a child who needs a specialist, you should not be denied that protection by an HMO making bottom line decisions more in the interest of profits rather than in the interest of the child and the medical decision.

That is what this issue is all about. Are we going to say if you work in a company with 49 employees, you are not covered, but if you work in a company with 51 employees, you are covered? What kind of fairness is that for the families of America?

We recognize that small business—although employing 50 is probably somewhat larger than most of the small businesses we have in our State—needs help. They pay 30 or 40 percent more in terms of their premiums. They don't deal, in most instances, with the largest of the HMOs, many of which act responsibly. They are dealing with the marginal HMOs that are more driven by profits and the bottom line rather than services to patients.

We know at the present time small businesses have additional burdens in terms of affording health insurance. We

ought to address that. I am all for addressing it. But excluding them from this coverage is not addressing that particular problem. It is not going to change the premiums for this kind of coverage. That is the bottom line. If the Senator wants to give help to those small businesses in terms of additional kinds of financial incentives, or helping them get into various groups so they could purchase their health insurance at more reasonable levels, we are all for it. But first, this is not the way to go.

As the Senator from Colorado pointed out last night, the HMO's premiums have gone up 13 percent last year, 12 percent this year, with the best cost of our proposal being less than 1 percent a year. It is a gross misrepresentation and a distortion to think that this is going to solve their particular problems; it will not.

What we will be doing, if we accept the Allard amendment, is exposing working families all over the country. Families who are working should get the kind of protections we want through this legislation, the kind of protections they thought they were getting when they bought their health insurance. This amendment effectively puts these families on the sidelines and frees them from any of the protections of this legislation.

Mr. EDWARDS. Madam President, will the Senator yield?

Mr. KENNEDY. I am glad to yield to the Senator from North Carolina.

The ACTING PRESIDENT pro tempore. The Senator from North Carolina.

Mr. EDWARDS. Madam President, as the Senator is aware, we are continuing to work very aggressively with Members on both sides of the aisle, led by Senators SNOWE, NELSON, and DEWINE on this issue, specifically to provide protection for employers, including small employers. As somebody who has been involved with this issue for many years, I wonder if the Senator believes we can have a real patient protection act, real Patients' Bill of Rights, if, in fact, we exempt almost half of the employees in the country from the legislation?

Mr. KENNEDY. The Senator is quite right. Of course, we cannot. That is effectively what we are doing to about 43 or 44 percent. In addition, many of those who have looked at the amendment think there will be larger companies that will break down into units of 50 or fewer in order to escape the protections of this legislation. That can go on ad infinitum. We are talking about 40, 45 employees per employer. It may be a lot more.

The Senator is quite correct: This is a position that I do not think even the President supports. In the President's list of particulars and principles, he is for holding the employers accountable that are going to be involved in making medical decisions that ultimately work to the disadvantage and the harm of the various patients. That isn't what this is all about. More likely than not, and I will let others comment on this—if you are a hardware store owner who has four employees and you are paying your premium, you are not involved in making medical judgments and decisions. That defies any kind of ordinary understanding of what is happening with small businesses. They are not the ones doing it.

The concern we have is that employers who provide HMO coverage to several hundred employees could say to the HMO: Let me know anytime there is going to be an expense over $50,000 or $75,000 because I want to know about it. When the HMO calls them up, they say: Don't provide the service. That is the real world, not the smaller business men and women.

This is an amendment which undermines a basic concept. If the good Senator can explain to me, the proponents, why should families in small companies be put at more risk? Why shouldn't the family members of a company that has less than 50 employees be able to get the specialists they need? Why shouldn't a woman worker in a smaller company be able to get to the OB/GYN as a primary care physician? Why should the wife in a smaller company not be able to get the clinical trial that will save her life from cancer?

What is the answer from the other side? What is possibly the answer from the other side? Well, the premiums have gone up.

We have talked about the issue of premiums. The President understands that. It seems to me, with the Allard amendment, we are putting the workers in these plants and factories at enormous risk. Whatever the problems are today, once we give them carte blanche, the problems are just going to increase a thousandfold. These employers are going to be immune, effectively, from any kind of action.

We are opening the barn door and inviting any employer to go with any HMO. It won't make any difference because there will not be a remedy for the workers. Is that what this whole debate and discussion is about? I don't think so.

I hope this amendment will not be accepted. It is a carve-out. As the Senator from North Carolina has stated, there are Members on both sides of the aisle who are working—Senator SNOWE and others—to tighten the language included in the basic document. We have talked about and debated the language during this time, in terms of the role of the employer and to ensure that there won't be unwarranted additional burdens on the employer. That is in the process. That is what we are dealing with as the way to go. We are going to have the opportunity to consider that later in the day.

Now we have an amendment that is going to effectively eliminate responsibility for almost half of the employees in this country. The protection for those employees is not warranted and justified with the legislation.

How much time do we have remaining, Madam President?

The ACTING PRESIDENT pro tempore. Seventeen minutes.

Mr. KENNEDY. I yield to the Senator from North Carolina.

Mr. EDWARDS. Thank you, Madam President.

I would like to speak briefly to the Allard amendment. Let me say first to my colleague, the sponsor of the amendment, who is in the Chamber, I have no doubt that his intentions in this amendment are nothing but good and he is trying to accomplish something he believes is important. The problem is this approach is extreme. It is extreme, it is outside the mainstream of all the work, essentially, that has been done on this issue.

The McCain-Edwards-Kennedy bill deals specifically with protecting small employers. The competing legislation, the Frist-Breaux bill, also deals with that issue, without this kind of extreme carve-out. The Norwood-Dingell bill that passed the House of Representatives by a wide margin did not have this kind of language in it. The American Medical Association, the medical groups from all over the country would not support this kind of carve-out. The reason is, it is impossible to have a real Patients' Bill of Rights so all patients and families across this country are protected if in fact you exclude almost half the employees in this country.

The more sensible approach, the more mainstream approach, which is the one we are taking in our legislation and as we speak, is to make sure you provide the maximum protection you can, keeping the interests of the patient in mind, for these small employers. That is the reason we are continuing, as we speak, working across party lines, to craft language that we believe is appropriate to the purpose of protecting employers in general and specifically to protecting small employers. But to exclude almost half of the employees in this country from this legislation means we have essentially left half the country out of patient protection, which I do not think anyone thinks is a sensible solution to the issue.

So I understand the concern. It is a concern we believe we have addressed in our legislation, which is to protect small employers. But we are working to go further with colleagues on both sides of the aisle, Republican and Democrat, to make sure small businesses all over the country are protected. But the solution is not to penalize almost half the families in this country and not provide them with the same rights that all other Americans would have.

It just makes no sense to have no patient protection for employees who work at a firm of 48, 49 employees and for a firm with 60 employees, in fact, the protections are there. That is just illogical; it doesn't make any sense. Most important, it is an extreme response to a legitimate issue. The legitimate issue that is raised we believe we

have adequately responded to in our legislation by specifically protecting employers. But in addition to that, we are taking further steps to make sure all employers, and specifically small employers, are protected.

So I say to my colleagues, if you are concerned about employers, if you are concerned about small employers, we have protections for that group in our legislation. We are going further on that issue as we work across party lines on another amendment that will be offered, we expect, later this afternoon.

But this measure is totally outside the mainstream. It is outside what we have done. It is outside the Frist-Breaux bill. It is outside the Norwood-Dingell bill. It is outside anything the American Medical Association or medical groups across this country would ever support.

So while I understand the issue being raised by my colleague, this measure is extreme and it penalizes almost half of the families in this country and leaves them out of patient protection. Those families will still be in the same place they are today, which is HMOs can deny them coverage and they cannot do anything about it; they are simply stuck. Women will not have the right to go to their OB/GYNs; children will not have access to specialists; there will be no emergency room protection if they need to go to the nearest emergency room; and there will be no way to challenge any decision that an HMO has. That 45 percent of American families, almost half of American families, under this amendment would be totally left out. They would continue to be in the place where the HMO held complete control over their health care.

That is what we are trying to do something about. It is not the right thing to do, to exempt almost half of America from this patient protection. Not that the concern is not legitimate, because it is, but this response is extreme and totally outside the mainstream of the work and thinking that has been done by everyone in this area.

The PRESIDING OFFICER (Mr. NELSON of Nebraska). The Senator from Massachusetts.

Mr. KENNEDY. Will the Senator be good enough to yield for a question?

Mr. EDWARDS. Yes.

Mr. KENNEDY. Can the Senator conceive of a situation where the employer got hold of the HMO and said: Look, I have a worker who has been hurt. I know it is going to be a costly process to bring that worker back to good health, and I don't want you to spend more than $25,000 on this. I want to put a limit on this. We are not going to spend more. I don't want you to spend more.

The HMO is going to say, if I am going to keep this as a client, I am going to follow that client.

Let me ask you this. If the Allard amendment is accepted, and the worker was seriously injured because of the failure to give the kind of medical treatment that the doctors have recommended and suggested, would that patient be able to hold that employer accountable under the Allard amendment?

Mr. EDWARDS. In answer to the Senator's question, not only under this amendment the employer couldn't be held accountable, in fact the HMO couldn't be held accountable because they would both be exempted from the legislation. So the family and the patient would be completely left out. That was my point earlier in responding to the Senator, in my comment that this is an extreme response. We have a response, both in our legislation and legislation on which the Senator has been very actively involved, that provides adequate protection, will make sure small employers are protected, but does not punish almost half the families in the country.

Mr. KENNEDY. If the Senator will yield further, this is almost an invitation, is it not, to employers, such as the mom-and-pop stores that have half a dozen employees, that basically are just paying the premium and are not making the decisions? Someone will say to them: Look, not only do you get your health insurance but you can just tell your HMO not to spend more than $10,000 or $15,000. You can do that and be completely immune and save yourself in terms of the additional premiums, although in that way you put at risk your workers. Could they not do that?

Mr. EDWARDS. Not only that, but I say to the Senator, having worked for and with small businesspeople for many years, I know they care about their employees. They care deeply about their employees, the vast majority of small businesses around this country. They do not want their employees to be in a position that they have no rights against the HMO.

To small businesspeople all over this country, their lifeblood is their employees. They need those people to come to work every day, enjoy the work, and be productive. One of the critical components of that, as the Senator well knows after all his years of work on this issue, is that they have quality health care. The small employers in this country who care about their employees—in my judgment, the vast majority—will want to make sure their employees have the best product they could possibly have. They will want them to have the same protections.

Those small employers will want to be protected from liability. That is a reasonable concern, and that is the concern, as the Senator knows, that we have addressed in our legislation and we are continuing to address with even stronger language with colleagues from across the aisle.

Mr. KENNEDY. Finally, if I may yield myself 30 seconds—under the proposal that we anticipate and support, I will make the assertion that under this proposal and Senator SNOWE's proposal later in the afternoon, which will be introduced with the good support of the now Presiding Officer, we will ensure those employees are going to be protected. That is the way to go. That is what we want to achieve, to give real protection to those employers. That is the way to proceed.

I think it is a much more effective way, efficient way for the employers, a more fair way for them, and certainly a great deal more fair for their employees.

The PRESIDING OFFICER. The Senator from Colorado.

Mr. ALLARD. Mr. President, I yield myself 5 minutes and then, following my 5 minutes, yield 5 minutes to the Senator from Missouri.

The PRESIDING OFFICER. The Senator is recognized.

Mr. ALLARD. I think we ought to just take a little time out here and summarize where we are in this debate on whether or not we exempt businesses of 50 employees or fewer. And this is the way I want to lay it out. The Democrats are arguing that 41 percent of small business employees will lack protection from HMOs. That argument is wrong. Forty-one percent of small business employees will be subject to increased health care premiums or even losing their health maintenance insurance altogether. They will not be insured.

So this argument that there is a line being drawn between 48 and 51 employees, the fact is, when you expose small employers and small businesses to increased lawsuits when they take on a program, they are not going to take on the program. So employees will not be insured.

Moreover, an employee does not get protection from HMOs from suing their employer. If they need to sue, they should sue their HMO, not the employer, who happens to be, by the way, kind enough to offer the health insurance.

Under S. 1052, employee health costs will increase $1.19 per month. Again, I believe this argument is irrelevant, and because of S. 1052 we will see, in my view, more than 1 million Americans will lose their health insurance. At least the Senate can do something to help out small employers by exempting them from these unnecessary lawsuits. I am talking about businesses with less than 50 employees.

S. 1052 will allow a small business of five employees, for example, to be sued for unlimited economic, unlimited noneconomic damages, and up to $5 million in punitive damages. Now, that is not protecting the small businessman. That is not protecting those businesses that have 50 or fewer employees.

According to a recent survey of 600 national employers, 46 percent of the employers would be likely to drop health insurance coverage for their workers if they are exposed to new health care lawsuits, plain and simple.

I will ask to print in the RECORD a Denver Post editorial from June 21,

2001. I will quote a small section of it. It says:

The competing Democrat bill, in our view, goes too far and includes a provision that will allow employees to sue their employers for denial of a medical request if the employer helped make the decision.

We think this type of language would have the effect of encouraging more lawsuits and driving up costs instead of encouraging quick, early resolution of disputes.

It went on to say:

We also find fault with the provisions that would authorize individual lawsuits to produce punitive damage awards in the multimillion-dollar range. Compensatory damages are one thing; punitive damage awards are quite another.

I ask unanimous consent that this editorial be printed in the RECORD.

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

[From the Denver Post, June 21, 2001]

WEIGHING PATIENTS' RIGHTS

As we are so often reminded, the demands for medical care are infinite while supply is not. HMOs arrived on the scene some years ago and quickly became the primary form of medical insurance precisely because they were designed to hold down medical costs. Employers, who provide the lion's share of insurance, liked them for that reason.

Now, but a few short years later, public opinion polls suggest the general public believes HMOs provide an inferior form of insurance.

Enter Congress.

The U.S. Senate is considering bills that would establish a Patients' Bill of Rights and specifically authorize a patient to sue the HMO for damages incurred when medical care is denied.

The issue for the Senate and for the nation is how wide to open the doors to the courts.

President Bush has offered what seems to be a sensible compromise. He supports a bill sponsored by Sens. John Breaux, D-La., Bill Frist, R-Tenn., and James Jeffords, former Republican turned independent from Vermont. The bill would establish an independent review process to resolve disputes before a lawsuit could be filed. Thus, a person who wants a particular medical service and is denied would be required first to submit his complaint to a review panel, which, in turn, would consider the facts and make a timely decision.

This approach recognizes the legitimate interest of the medical provider in controlling costs by delivering only necessary medical treatments. At the same time, it provides for a second set of eyes to review the quality of the decision.

The competing Democratic bill, in our view, goes too far and includes a provision that would allow employees to sue their employers for a denial of a medical request if the employer helped make the decision.

We think this type of language would have the effect of encouraging more lawsuits and driving up costs instead of encouraging quick, early resolution of disputes. We also find fault with the provisions that would authorize individual lawsuits to produce punitive damage awards in the multimillion-dollar range. Compensatory damages are one thing; punitive damage awards are quite another.

It would be nice if we could all have medical care provided on our terms alone. Somewhere a balance must be struck.

We favor something closer to the president's position than to that endorsed by the Democratic leadership, but remain optimistic that—given the high political stakes—the nation will see a bill signed this year.

Mr. ALLARD. Mr. President, the employer is not protected. In fact, he is exposed to more lawsuits—multimillion-dollar lawsuits. In order to protect himself, he is not going to provide health insurance. That means the employees will not be covered. The argument was made, why don't you provide coverage for small employers? Why don't you provide coverage for emergency service? Why don't they provide coverage for medical needs that occur in families and what not? The employer isn't going to provide that coverage if he has to face lawsuits. It is optional. He will decide not to offer health insurance.

I was a small businessman and I had to face the challenge of medical costs. We had between 10 and 15 employees. The health care costs were eating us alive. So finally we went to the employees and said what we would like to do is this: We can't afford this, so we will pay you more in a salary and then, hopefully, that will be enough of an increase that you can buy your own health insurance. We could not afford to do that. That was in times that weren't as challenging as they are today.

We are seeing horrendous increases in premiums to small business employers. Now we are going to tack on top of that these mandates and increased costs and the increased threat of a lawsuit. It is not hard for me to believe that we are going to have at least a million more workers out there who are not going to be insured if this bill passes.

Now, it is 41 percent of the workforce that we are talking about with this amendment. But I look at it a different way. I think we are helping assure that they will have health care coverage with this amendment because we are exempting them from the lawsuits.

I think this amendment is a very responsible one. It is needed. If it is not adopted, the small business community of 50 employees or less will suffer.

I yield 5 minutes to the Senator from Missouri.

Mr. BOND. Mr. President, I thank my friend from Colorado and I commend him for this amendment, which I think is very important because it goes to one of the real key areas in this Patients' Bill of Rights.

We want to make sure that people have good health care coverage and that they get what they deserve from their HMO, their insurance company. That is what this debate is all about. How do we get there? One of the most important parts of that question is how we deal with the small businesses that provide health care coverage now for their employees and who may not in the future.

My colleagues on the other side of the aisle insist that employers will not drop coverage due to the McCain-Kennedy bill. For some employers, that is probably true. Virtually all large companies offer health care, and even if we pass this legislation and dramatically increase costs, they will probably have to do so. They will have to pay more and their employees will have to pay more. But they are likely to have coverage. But from everything I am hearing from the small business community, it is much less likely that small businesses—even those who now provide health care coverage—will be able to do so.

I heard a colleague on the other side of the aisle say that the McCain-Kennedy bill has taken care of small employers—the small employers health care provision. Right. Just like a herbicide takes care of a bed of flowers, it is going to kill small business health care at the roots. I know what ''taken care of'' means in that context. I have sprayed herbicide; I know what they do to a flower bed or a lawn. That is how McCain-Kennedy takes care of the health care coverage of small business. They drive them out.

Small businesses are the ones that are struggling to survive. Small businesses are the ones that struggle to provide health care. They are at the heart of the problem that the McCain-Kennedy bill totally ignores—the 43 million Americans who have no health insurance. Of that 43 million Americans who have no health care insurance, approximately 60 percent are small businessowners, employees and their dependents, the family members. That is 25.8 million Americans, either small businessowners, employees, or family members, who are not covered by health insurance. They can't be a patient under the Patients' Bill of Rights. In Missouri, we have 570,000 uninsured, and 342,000 are in families headed by a small businessperson, man or woman.

If we drive more of the small businesses out of health care coverage, those numbers are going to go up. That is a disaster. That is the wrong way to go. Many small businesses do not offer coverage. Why is that? Well, there are still many barriers to small businesses providing health care coverage.

First, they have higher premium costs.

Second, they have higher annual premium increases.

Third, there are more difficult administrative hurdles. In mom and pop operations, neither mom nor pop usually has the administrative skills to set up health care and other benefit plans.

Limited deductions for the self-employed, we voted on that last week. Unfortunately, my colleagues chose to turn a blind eye to the needs of the self-employed and their families and said we are going to skip them in this bill. That is one more mistake in this bill. Here are the problems. Under McCain-Kennedy, there would be a 4.2 percent cost increase—slightly more. That is going to make health care coverage more expensive for the small

business and the small business employee. That means fewer patients, because 300,000 lose coverage for every 1 percent increase.

Exposure to liability is the big one. Employers throughout Missouri are writing: we cannot afford the continuing cost increases in health care and we will not tolerate those plus exposure to liability.

The PRESIDING OFFICER. The Senator has used 5 minutes.

Mr. ALLARD. I yield the Senator an additional 3 minutes.

Mr. BOND. I ask for 1 minute.

Most small businesses in America are only one lawsuit away from going out of business. This lawsuit, under the multitude of causes of action provided in the McCain-Kennedy bill, could drive any single small business out of business. They are one lawsuit away from going out of business. Small businesses are smart enough to know if they are one lawsuit away from going out of business because they provide health care, they are one McCain-Kennedy bill away from getting out of the health care coverage business.

The 43 million Americans who are now uninsured—watch those numbers increase. Yesterday I noted 1,895 Missouri employees of small businesses would lose health care coverage because their small business employer could not take the risk. That number is going to be higher. It is much higher nationally.

I commend the amendment offered by my colleague from Colorado. I offer this as a suggestion: If Members care about small businesses and the health care coverage they provide their employees, vote for the Allard amendment. This is the only way to save small businesses from a knife in their back, making health care coverage for their employees unaffordable.

Mr. ALLARD. I yield 2 minutes to the Senator from Texas.

Mr. GRAMM. Mr. President, I congratulate Senator ALLARD. Yesterday we had an amendment on exempting employers from being sued. That amendment was important. This amendment is important, as well.

Our basic point yesterday was, when an employer, because they care about their employees and because they want to attract and hold good employees, puts up their own money to help people buy health insurance, we should not reward that voluntary activity by making them liable to being dragged into court and sued.

The bill before the Senate is a classic bait and switch bill, make no doubt. It says you cannot sue employers, and then it says you can sue employers, and it has 7½ pages of conditions under which employers can be sued, including conditions where they exercise control, which is a little trick phrase because ERISA, the program that governs employer benefits to employees, guarantees that the employers are always deemed to be in control. So the bill before the Senate is written to guarantee every employer in America can be sued. If anybody doesn't understand that, it is because they don't want to understand it.

This amendment does not fix the problem. This amendment simply makes a plea that if you are going to force companies such as Wal-Mart to cancel their insurance—at least they have smart lawyers and they have lots of money and can figure out a way to get around this provision by changing their plans. Some of them won't. They will cancel their health insurance. And the proponents of this bill will be back a year from now, 2 years from now, saying, well, the number of uninsured has gone up and we need to have the Government take over and run the health care system.

This amendment is simply a last gasp effort to introduce some reason into this bill which says while clearly this bill is aimed at allowing employers to be sued, and clearly large employers are going to be hit with this liability and they are going to be forced either to drop their plan or change it, they have some ability to make a change. It is not smart. It is counterproductive. It is hurtful to America. But that is the way it is. That is the majority position.

The point is, this amendment says, if the company has 50 or fewer employees. We are talking about small business; we are not talking about companies that can go out and hire a legion of lawyers; we are not talking about companies that have the ability to junk their health care plan and to figure out a clever way to try to get around the devastating provisions in this bill. If you vote against this amendment, you are saying to every small business in America, we don't care if you are sued; we don't care if you provide health insurance.

It is unimaginable we would not adopt this amendment and say that while we are willing in the name of bringing lawsuits to the doorstep of every employer in America, we are not willing to destroy the ability of small business to provide health insurance, and therefore we are going to adopt this amendment. This does not fix the problem. This is an amendment that should bring out some degree of shame as to what we are willing to do. I urge my colleagues to vote for this amendment.

I yield the floor.

Mr. ALLARD. How much time remains?

The PRESIDING OFFICER. Two minutes, and the other side has 7 minutes 16 seconds.

Mr. KENNEDY. I yield myself 4½ minutes.

Mr. President, the issue is the protection of these workers. We have had 22 days of hearings; we have had this legislation for 5 years, trying to get it before the Senate; and now we have the opportunity to provide real protections to families in this country.

Now this amendment wants to say, we will provide protections for some but we will eliminate 45 percent of the protections for families in this country. What possible sense does that make?

There is a representation that somehow employers will be at risk. They will not be at risk unless they are making medical decisions that will result in harm or injury to the patient. If they are not, they are free, in spite of all the agitation we have heard from those supporting this amendment.

I have been around here long enough to realize that when we take on the special interests—and that is the HMO in this case—we hear dire consequences. When we worked on the Family and Medical Leave we heard the estimates that it would cost American business $25 to $30 billion a year. That was all malarkey. We worked on the Kassebaum-Kennedy bill regarding portability of health insurance, particularly for the disabled. They said it would increase the premiums 30 percent, it would be the end of small business and the end of the American economy. That was a lot of baloney. We worked on increasing the minimum wage. We heard it would put small business out of business, and that there would be hundreds of thousands out of work all over this country. That was baloney.

The burden we hear that would be put on small business is baloney. They have nothing to fear. They have nothing to fear in this. But the HMOs have something to fear if they are not going to permit doctors and nurses and trained personnel to provide for their patients.

The facts belie these representations that have been made. If you look at the States that have tough HMO legislation, as we have gone through repeatedly, the message should become clear. For instance, in Texas with their tough HMO law, there have been 17 cases in 5 years.

California has a tough law that has been in effect now 9 months, and no cases. No cases. Do you hear me? No cases. No small businessmen, nobody with 50 or less, none, no cases on it. And what has happened? The employees are getting the protections they need.

Now we hear, well, what about the premiums? I read into the RECORD yesterday that the total cost of this amounts to 1 percent a year over the period of the future—4.2 percent over 5 years. That amounts to about $1.19 a month. Let me tell every premium payer in this country about what is happening in terms of their premiums, why they are going up.

We have Mr. McGuire, United Health Group, who got $54 million in compensation last year and $357 million in stock options for a total compensation of $411 million. That is $4.25 a month for every premium. We are talking about $1.19 a month.

You want to do something about the increase in terms of your premiums, tell Mr. McGuire he does not need $411

million a year in annual compensation and stock options. We know what is happening. They had $3.5 billion—$3.5 billion—in profits last year. Fine. Well and good. But when you see the millions of dollars that they are spending out there on the airwaves every single day, don't cry crocodile tears in this Chamber about what is going to happen to the HMOs.

We are going to ensure that small businesses will be protected. I will join with the Senators from Colorado and Texas if they want to try to assist small business with help through the Tax Code to offset the 25 to 30 percent increase in premiums. The reason they are getting that 25 or 30 percent increase is because they are getting gouged by the major HMOs. That is the real reason. That is what we ought to be about, the real business of that, not taking it out on the injured patients in this country who are not getting the health care they need. How much time do I have?

The PRESIDING OFFICER. Two minutes forty seconds.

Mr. KENNEDY. I yield that time to the Senator from North Carolina.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Let me just conclude from our side by saying a couple things about what the Senator from Colorado is trying to accomplish. We understand his concern about this issue. We do not believe this is the appropriate response or the appropriate measure. This is an extreme response to a legitimate issue. The legitimate issue is making sure small business people all over this country are in fact protected. We have provided in our legislation that unless they make an individual medical decision, which small businesspeople do not, then they are immune from responsibility.

No. 2, in addition to that, we are continuing to negotiate with our colleagues—Senator SNOWE, the presiding Senator, and others—on this issue, and we expect to have an amendment to offer later today that also will provide further protection for small businessmen.

I know that the Presiding Officer and many others on both sides of the aisle care deeply about this issue. This is an extreme response. It will have an extraordinarily bad effect on almost half of the employees in this country. It is outside the mainstream, outside our legislation, outside the Frist-Breaux bill, outside the Norwood-Dingell bill, not supported by the American Medical Association, not supported by any of the health care groups in this country. This is not what needs to be done. So I urge my colleagues to defeat this amendment, to vote against it, to vote with the patients, and we will continue to address the issue of ensuring that small businesses all over America are protected.

I thank the Chair.

Mr. ALLARD. Mr. President, has time expired on the other side?

The PRESIDING OFFICER. The majority has 42 seconds. The Senator from Colorado has 1 minute 50 seconds.

Mr. ALLARD. I reserve my time until the majority has used their time on the amendment.

The PRESIDING OFFICER. Who yields time?

The Senator from North Carolina.

Mr. EDWARDS. Very quickly, with the remaining 40 seconds that we have, we urge our colleagues to vote against this amendment. We are doing the things necessary to protect small businesspeople all over this country, but that can be done without leaving almost half of the families of America uncovered by the necessary patient protections that are in our legislation. For that reason we urge our colleagues to vote against the Allard amendment.

We yield back the remainder of our time.

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

The Senator from Colorado.

Mr. ALLARD. Mr. President, I yield myself the remainder of the time.

First of all, I would like to thank my colleagues from Texas and from Missouri for their very cogent comments on small business and the adverse impact of this particular bill on small business. My particular amendment exempts businesses of 50 employees or less. This is important because what we do in this bill is we expose businesses to more lawsuits. The consequences are that businesses will not insure their employees. They will not provide health coverage. The other side is trying to make the point that somehow or the other this amendment will hurt health care coverage for employees. Just the opposite will happen. If this amendment is not adopted and the bill is passed, small employers all over America will cancel their health care coverage and turn to the employee and ask them to provide for their own health care coverage. That is not more health care coverage; that is less health care coverage.

I am a small businessman. I have had to face those tough decisions, and it is not hard for me to believe that a million employees will lose health care coverage if this particular bill is passed. I am going to ask my colleagues in this Chamber to vote for this Allard amendment because we want to make sure that we have a viable small business community in America. We want to assure that coverage for employees now covered by health plans of their small business employers continues.

If this bill passes, there is a good chance they are going to lose that coverage and that is going to mean less health care coverage for employees, not more.

This is a key amendment. It is a key vote for the small business community.

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

Mr. ALLARD. I ask Senators to join me in supporting the Allard amendment. It is important to the small business community. It is important to health care in this country.

The PRESIDING OFFICER. All time has expired.

Mr. ALLARD. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The question is on agreeing to the amendment No. 817. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. REID. I announce that the Senator from Delaware (Mr. CARPER) and the Senator from New York (Mr. SCHUMER) are necessarily absent.

The PRESIDING OFFICER (Ms. CANTWELL). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 45, nays 53, as follows:

[Rollcall Vote No. 199 Leg.]

YEAS—45

Allard	Frist	Murkowski
Allen	Gramm	Nickles
Bennett	Grassley	Roberts
Bond	Gregg	Santorum
Brownback	Hagel	Sessions
Bunning	Hatch	Shelby
Burns	Helms	Smith (NH)
Campbell	Hutchinson	Smith (OR)
Cochran	Hutchison	Specter
Collins	Inhofe	Stevens
Craig	Kyl	Thomas
Crapo	Lincoln	Thompson
Domenici	Lott	Thurmond
Ensign	Lugar	Voinovich
Enzi	McConnell	Warner

NAYS—53

Akaka	Dodd	Levin
Baucus	Dorgan	Lieberman
Bayh	Durbin	McCain
Biden	Edwards	Mikulski
Bingaman	Feingold	Miller
Boxer	Feinstein	Murray
Breaux	Fitzgerald	Nelson (FL)
Byrd	Graham	Nelson (NE)
Cantwell	Harkin	Reed
Carnahan	Hollings	Reid
Chafee	Inouye	Rockefeller
Cleland	Jeffords	Sarbanes
Clinton	Johnson	Snowe
Conrad	Kennedy	Stabenow
Corzine	Kerry	Torricelli
Daschle	Kohl	Wellstone
Dayton	Landrieu	Wyden
DeWine	Leahy	

NOT VOTING—2

Carper	Schumer

The amendment (No. 817) was rejected.

Mr. REID. I move to reconsider the vote.

Mr. DORGAN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. BYRD. Madam President, could we have order in the Senate.

Mr. STEVENS. Madam President, it is a very serious matter we would like to discuss with the Senate. I do hope the Senate will come to order.

The PRESIDING OFFICER. The Senate will be in order. Members will take their conversations off the floor.

The Senator from West Virginia.

SUPPLEMENTAL APPROPRIATIONS

Mr. BYRD. Madam President, I have asked for recognition at this time so

that I might inquire of the joint leadership as to when we might expect to take up the supplemental appropriations bill. That bill was reported from the Appropriations Committee several days ago. It is on the calendar. We only have a little time left this week.

The administration has asked for this bill. The amount in the bill is within the request of the President of the United States—not one cent, not one thin dime over the President's request.

The bill has had the joint support of the distinguished Senator from Alaska, Mr. STEVENS, and myself, and our respective sides.

I will be able, at a later time, to compliment the members of the committee. Right now I want to inquire. This is a very serious matter. The administration says it wants this bill before we go out because of the need in the military for moneys for services, for training, and so forth. I do not want us to be out through this recess and have this bill hanging out there, and have it there when we get back.

Now we are ready to go. I would suggest we try to get a time agreement that would be amenable to the feelings of the two leaders and our respective sides. I think we can do that. I have every confidence we can do that. I just take the floor now to inquire as to what the chances are for us to move this supplemental appropriations bill before we go home for the Independence Day recess.

Mr. STEVENS. Will the Senator yield for one moment?

Mr. BYRD. I gladly yield.

Mr. STEVENS. Madam President, I just received word from the House of Representatives that they are scheduling two appropriations bills on the floor, and they have bipartisan agreement to finish by Thursday night. That is why this dialog right now is very important. We do have to go to conference with the House before they leave.

I join the Senator in making the inquiry.

Mr. BYRD. Madam President, I thank the distinguished Senator.

Mr. DASCHLE addressed the Chair.

Mr. BYRD. Madam President, I yield to the distinguished majority leader.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. DASCHLE. Madam President, I thank the distinguished chairman for yielding.

I reply that it would be my intention to complete the supplemental prior to the time we leave. I do not think we ought to leave Washington prior to the time the supplemental has been satisfactorily disposed of. I do not think we ought to take vacation until this legislation has been completed.

I have indicated, just now, to Senator LOTT that if we could reach some agreement—a finite list of amendments remaining on this bill, with an understanding of how long these amendments would require for debate—that I may be willing to enter into something I was not prepared to do earlier, which is to move to the supplemental prior to the time we complete our work on the Patients' Bill of Rights. We will complete our work on the Patients' Bill of Rights this week, and we will finish the supplemental this week, and the organizing resolution this week —or before we leave, whatever time it takes.

I hope our House colleagues will choose not to leave town until the conference has been completed and until we have been able to deal with the conference as well. It should not take long in conference. But clearly that work must be done. As I say, if we could reach that agreement with regard to a finite list, I would be prepared then to find a way with which to schedule and then perhaps take up a unanimous consent agreement that would allow us to consider the supplemental over a designated period of time.

Mr. STEVENS. Will the Senator yield?

Mr. BYRD. I yield to the Senator.

Mr. STEVENS. Madam President, the leader is correct about the timing. We should all stay until we finish this matter. But if we don't finish it by Thursday, and the House is already scheduled, I can tell you, you are not from as far west as I am, but you can't get reservations out of this place over the Fourth of July now. It is going to be very difficult for all of us and our staffs to get out of town for the Fourth of July unless we know now what we are going to be able to do. I am confident they will stay if they know we are sincere about finishing.

I am prepared to stay tonight. We have a Republican dinner tonight, but I think we can stay tonight. That would be a time when we normally would not have votes, but we can have our debates on whatever amendments might be offered and get an agreement to vote tomorrow at the leader's discretion. We have to get this bill to the House by tomorrow noon or it is not fair to ask them to stay to complete it. We should not expect them to just stay here, cancel all their reservations, not knowing whether we are going to finish by Thursday.

Mr. DASCHLE. Madam President, will the chairman yield?

Mr. BYRD. I yield to the distinguished majority leader, with the understanding I not lose my rights to the floor.

Mr. DASCHLE. I thank the chairman for yielding.

Let me just say, the whole purpose in my announcement early last week that we would have to finish the supplemental, the organizing resolution, and the Patients' Bill of Rights was to accommodate Senators who had reservations. It is not my desire to inconvenience Senators or Members of the House with regard to this schedule. I do believe that the President believes, and many of us believe, that vacations are important, reservations are important, but not as important as finishing the supplemental, not as important as the Patient Protection Act, certainly not as important as the organizing resolution. We will stay here. I hope our House colleagues will share the same view we have with regard to the importance of getting our work done on the supplemental.

I announced that last week. I don't know if people believed I was serious about it, but we are serious. We are resolute. That will be the order for whatever length of time it takes to complete our work.

I thank the chairman for yielding.

Mr. STEVENS. Will the Senator yield?

Mr. BYRD. I thank the distinguished majority leader.

I yield to my counterpart.

Mr. STEVENS. I know the Senator from Oregon wishes to have a conversation. I am prepared—I think the Senator should be prepared—to present to the Senate now our wishes with regard to the agreement.

From my own point of view, we have a very limited managers' amendment which Senator BYRD and I are working on, and I think we disclosed it with most people. But other than that, I know of only one amendment that is certain to be offered. That is an amendment of the Senator from Arizona.

I am prepared to enter into an agreement of no more than an hour on an amendment, and amendments be disclosed here by noon. We will debate them tonight and vote tomorrow.

Mr. BYRD. Madam President, may I first yield to the distinguished Senator from Oregon who has been waiting. Then I want to respond to the distinguished Senator from Alaska.

Mr. SMITH of Oregon. I thank the chairman of the Appropriations Committee. Senator BYRD does not have a bigger fan in this Chamber than I when it comes to the way he defends the people of West Virginia.

I am one of those who would like not to be holding up this bill, but I am looking at a situation in the Klamath Basin of Oregon and California that is in a drought condition. Drought is typical in the western United States. It is regular. You can count on it. Unlike past droughts, the people of Klamath Basin have had the Government magnify their drought by cutting off every drop of water. There are probably 1,500 farm families who have no income because of a Government policy which has exalted a bottom-feeding sucker fish above their welfare.

That is the Government's choice, if it wants to save the sucker fish, but my plea is that in this bill, as the President has asked, that at least the $20 million he has asked for be included or else I can't get out of the way.

I do this in the spirit of ROBERT BYRD and the way I have seen him operate. I admire it so much because I can't go home and look into the faces of these desperate people who are without now because of the Federal Government. The truth is, they need $200 million, if

we want to be right by them. But the President only asked for 20. I am asking that we do at least that much.

I thank the Senator for his consideration.

Mr. BYRD. Madam President, I know about the Klamath problem. I would be happy to discuss that. I also know that the administration wants this bill. I hope the Senator will not stand in the way of final action on it. There are many things I have wanted over the years, and the Senator has every right to stand on the floor as long as his feet will hold him and speak as long as he wants. I will be here listening when he speaks. I have a sick wife. She has been in the hospital now for 10 days—9 days, but she is on the mend. I will be here as long as the Senator wants to talk. If he wants to stay in the way of the bill, I will be here listening. But we will talk about this.

I am not saying no, but I am saying that when anyone wants to stand in the way, they are going to have the administration to compete with there. The President wants this bill. And my friend TED STEVENS and I have busted a gut to get this bill to the floor and to keep it within the President's limits.

If any Senator is contemplating calling up an amendment, if it is a money amendment, that Senator ought to be ready to find an offset in the bill. That Senator ought to be ready to have the administration call that amendment an emergency on this bill. Now, if the administration wants to call it an emergency or if there is an offset, I am sure the Senator probably won't have a great deal of trouble. But I want to do what the President has asked for in this instance. This money is needed now.

That is a long story, but I say to the distinguished Senator from Oregon that he won't be by himself if he wants to hold up the bill.

Mr. LOTT. Madam President, will the distinguished Senator from West Virginia yield?

Mr. BYRD. Yes, I will.

Mr. LOTT. I apologize to my colleagues for not being here to hear the discussion earlier. I have been briefed on basically what has been said.

I commend the chairman of the Appropriations Committee and the ranking member for the work they have done on this very important defense, and other issues, supplemental appropriations bill. They have worked hard. They did bust a gut to get it out, and they held it within the area of the President's request. They have done a credible and formidable job.

I would like to get a time agreement, a tight time agreement, and a limit on amendment or amendments, and would, in spite of the fact that there is a very important conflict tonight, be willing to work with the managers of the legislation to see if we could get an agreement to do it tonight so that a conference would be possible with the House and this very important matter could be completed in the conference and the money be available for the needs of our defense and the health care of our military men and women.

I will be glad to work with the Senator from West Virginia and with his leader, the majority leader, and to work with Senators who do have concerns to make sure we address those, that they are heard.

The important thing is that we push to try to get this done. I appreciate that effort. I know the President wants it. I have spoken to him, and Senator DASCHLE has spoken to him. Clearly, we need to get this business done. I make my commitment to the Senator that I will work with him and others to see if we can't work out an agreement to handle the bill tonight and then we can do the conference tomorrow. I will be working on that and will confer with Senators as we go forward.

Mr. BYRD. Madam President, I thank the Republican leader. Let me close by urging that our respective staffs—I thank both leaders for the assurances they have given of cooperation and of desire to get the bill finished. I would like to suggest that the proposal by Senator STEVENS go forward, that our respective staffs get together, work out a time agreement, and any Senators who want to offer amendments under the constrictions that have been stated here, by which we are bound, let's have those Senators come forward by noon today and tell us about their amendments.

Mr. REID. Madam President, if the Senator has finished——

Mr. BYRD. I thank all Senators.

Mr. STEVENS. If the Senator will yield for a moment, because of my negotiations with the House, I urge that we set a time limit on when we are coming back, if that is agreeable to the leadership, and that we announce that amendments must be presented to us at the desk by noon.

Mr. BYRD. Madam President, I make that request.

Mr. REID. Reserving the right to object and I will object, I haven't had an opportunity to confer with the majority leader. He should be in on this. We will be happy to try to work something out. I object until Senator DASCHLE is apprised of this.

The PRESIDING OFFICER. Objection is heard.

Mr. BYRD. Madam President, I still have the floor. I don't lose it on an objection to a unanimous consent request. Let me simply say that I will just express the hope that we can know by noon. I have discussed this with our leader during the break. I certainly want to work with our distinguished whip between now and then. There hasn't been any Democratic whip in my time here that is any better, and few have been as good as Mr. REID. I am not one of those who is any better. I am one of those who hasn't been as good a whip as Mr. REID. So I thank him. I am sure that we will work together.

Mr. STEVENS. Will the Senator yield for one more inquiry?

Mr. BYRD. Yes.

Mr. STEVENS. Is there some way to set a time limit so we can go to the House and let them know? They have schedules to meet, too. I urge that we have some way to get an agreement that we have this bill called up tonight and we debate any amendments tonight and all amendments must be debated tonight and that we vote tomorrow. That seems to be agreeable with the majority leader. I hope it is. But the main thing is to get us some way that we know how many amendments are out there, I say to my good friend. I spent 8 years as a whip. I know your task is difficult. I think we have a right to ask for disclosure of the amendments that would be offered to the supplemental and have it done by a specific time today.

Mr. REID. If the Senator from West Virginia will yield.

Mr. BYRD. Yes, but I retain my right to the floor.

Mr. REID. I say to the two chairmen, I am also a member of that committee, and I would like to finish the business at hand. Senator DASCHLE has been very clear. He has stated for more than a week now that we must move forward with the Patients' Bill of Rights. We are doing that. He said this morning—and I have been in conference with Senator KENNEDY and Senator EDWARDS. I have spoken to JUDD GREGG, manager of the Patients' Bill of Rights bill. I indicated to him we need a finite list of amendments on the Patients' Bill of Rights. That seems simple. We are very interested in doing that, and that should be able to be accomplished quickly. Everybody knows the contested issues on this matter. We need a finite list of amendments.

When that is done, Senator DASCHLE said he would be happy to work with the two Senators and work out something that is fair. We can do that as quickly as possible. I think there could be a finite list given to us in the next hour. It should not be very hard to do at all.

Mr. BYRD. Madam President, I want to make sure the distinguished whip understood my request. My request was not that we take up the bill by noon. My request is only that Senators who have amendments make it known by 12 noon, that we close out after they have made it known as to what amendments they want to call up, and that we close out the amendments at that point. The leader would still retain, of course, his right to call up the bill whenever he wishes.

Having said that, might I make the request again?

Mr. REID. Madam President, as the Senator knows, I have come to him on many occasions on various bills saying we need to enter into an agreement when the amendments can be filed. We want to do this. I am saying that we will do this as quickly as possible. You need not be on the floor. I will try to get the agreement as soon as possible. We have time limited to the supplemental, but there are certain people I

have to check with, and we will do that as quickly as possible.

Mr. BYRD. I yield to the Senator from Alaska.

Mr. STEVENS. My question to the distinguished whip is plain and simple. Is the Senator from Nevada saying that the finite list of amendments to the Patients' Bill of Rights must be reached before we can get the finite list for the supplemental?

Mr. REID. No. If the Senator allow me to respond.

Mr. BYRD. I yield for that purpose.

Mr. REID. We need a finite list on the Patients' Bill of Rights so a time can be arranged to do the supplemental.

Mr. STEVENS. Respectfully, that is not how I understood my discussion with the majority leader. We discussed doing this bill tonight. There will be a window. This is the night of the Republican dinner. Some of us have agreed to stay and debate the amendments on the supplemental so that it might be voted on in a very short window tomorrow and get it to the House tomorrow so they can finish it so we can get it back by Thursday or Friday. Unless we do that today, I for one am going to give up on the supplemental.

Mr. REID. If the Senator from West Virginia would allow me to answer.

Mr. BYRD. Yes.

Mr. REID. First of all, probably if you are something like me, that would be a good excuse so you would not have to go to the dinner if you had to be here.

Mr. STEVENS. Better not said, but you are right.

Mr. REID. But there is no reason that we cannot have a finite list of amendments on the Patients' Bill of Rights within the next hour or so. I am sure Senator DASCHLE would be happy to work with Senator LOTT and arrange a time. Give us a little time on this.

I repeat to my friends again, the question on the list of amendments should be filed and we will work on that very quickly.

Mr. BYRD. Madam President, I hope we have reached an understanding. I have been at this work for many years. I have learned a long time ago that when you are within reach and you have both leaders having expressed their desire for a unanimous consent request, and with the work that the Senator from Alaska and I have already done with respect to arriving at such a request, that other amendments, other Senators, and other requests can come out of the woodwork. I would like to get this nailed down by noon, or earlier, because the longer we wait, the more Senators there will be that will say, ''This is my chance.''

In closing, I hope we can go forward with this request soon. I yield the floor.

AMENDMENT NO. 818

The PRESIDING OFFICER. Under the previous order, there will now be 15 minutes for debate on the Kyl-Nelson amendment No. 818.

The Senator from Arizona is recognized.

Mr. KYL. Madam President, I will speak and then yield time to Senator NELSON of Nebraska, my colleague on this amendment. In discussing this proposed amendment with some of the stakeholders involved, a couple questions have been raised. I want to clarify my intention and turn the time over to Senator NELSON.

One question asked was, With respect to the external review, is this a de novo hearing? That is to say, does the external reviewer begin with whatever record is before it, but can bring in other witnesses, or consider other material or other factors or records in addition to that which may have been considered by the internal reviewer. The answer to that question is yes. I believe that is what the underlying bill provides. Our amendment intends the same. To the extent that would need to be clarified, we are willing to do that.

Secondly, there is concern that with respect to the negotiated rulemaking procedure that is provided for in the amendment, that the composition of the stakeholders be fair.

Obviously, we believe that should be fair. We believe that the providers need to have adequate representation in such rulemaking procedure, that all stakeholders should be represented.

I do not know what we can do to make our commitment any more firm, but to the extent anyone has a suggestion about how we ensure that fairness, it would certainly be our intention to do so.

In summary, we have identified a specific problem with the bill, a need to add a standard that is uniform and to ensure that the two extremes do not represent what occurs here. One extreme is that the external reviewer has no guidance and can just ignore the contract. The other extreme is that an HMO can draft a contract that is so strict that the reviewer has no ability to provide medically necessary care for the patient.

We are proposing a standard of care that can be utilized by the external reviewer to ensure that the patient receives the necessary care and that neither ignores the terms of the contract nor is so pinched that it would not be able to provide the care. That is why we have chosen the terms that apply to over 73 percent of Federal employees under the FEHBP that serves all the Members of Congress, our families, as well as other Federal employees. That is the language we have.

I ask my colleague, Senator NELSON, to speak to this. Senator NELSON has probably as much experience as anybody in this body with insurance contracts at the State level from his previous positions in Nebraska, as well as being Governor of the State of Nebraska.

It has been a pleasure for me to work with Senator NELSON who had the idea for this and brought a group together and expressed his idea. It made sense to me at the time. The more I work with him, the more sense it makes to me, and what he is proposing is desirable for us to do.

I urge my colleagues to respect the experience he brings to this issue from his perspective from the State of Nebraska which, I might add, is my State of birth. I am very pleased to have worked with Senator NELSON on this. Again, I just hope my colleagues respect the experience he brings to this particular issue.

I yield to the Senator from Nebraska.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. NELSON of Nebraska. Madam President, I appreciate the opportunity to join with my colleague, Senator KYL from Arizona, to support and pursue the opportunity for making certain there is a definition and a standard in the Patients' Bill of Rights legislation that will give certainty and clarity to the standard by which medical claims can be submitted and the providing of medical care can be made.

There is some concern about whether or not the Federal Employees Health Benefits Plan definition of ''medical necessity''—which is essentially the definition, the standard, if you will, that is being proposed in our amendment—is something where the Office of Personnel Management would be bound by the plan's determination.

We have never said that the plan, in this case the medical reviewer, would have to be bound by the plan, but they would have to be bound by the definition. That is what this is about. It is making certain there is certainty, clarity, and an understanding, a meeting of the minds, about what will be covered and to what extent, always subject to outside standards, outside review.

I support having a Patients' Bill of Rights that provides the kind of patient protections that are included within this bill. I support the opportunity for a patient to have a review from the internal side and from the external side, and I support the opportunity and the right of the patient to sue the HMO to ensure the medical decisionmaker in conjunction with any questions that are provided for in the level of support that is provided within the current bill.

It is important as the decisions are made about the claims that there is at least certainty and clarity as to a standard. I do not think even the proponents of the legislation would deny it is important to have a standard. As a matter of fact, I understand the history of this bill to some degree, and I know that in the past there was an effort to arrive at a standard. There were two groups with two different pieces of legislation, and they could not quite achieve an understanding as to what the standard should be or the definition. Perhaps out of frustration, and certainly out of not coming together, the decision was made to leave this open.

The problem with leaving it open is there is no basis of a standard; there is

no way to know what the definition of ''medical necessity'' can be. It can be about anything. When you have a contract and when you have two parties to it, an insurer and insured, you need some degree of certainty. That is what we are asking for, so you can know of what medical necessity truly consists.

As to the question about whether or not this language, which is taken right out of OPM's definition that is included in the Federal Employees Health Benefits Plan—as to whether or not that is adequate language, it seems to me there should be no question about it. This is to what the Federal employees are subject. You and I, those who are insured, are subject to the language, the standard, and the definition that is included within this amendment.

I find that it would be unusual if somebody objected to this standard, but our plan provides, even if there is a concern about this standard, that under the rulemaking and the negotiations of regulations another standard could be arrived at with the stakeholders to this legislation. The stakeholders, about 19 of them, would all be assembled, and if they did not like this particular standard, then they could achieve, upon agreement, another standard.

This is about having a standard, and there seems to be very little concern about whether or not the current standard that is included within this amendment is an adequate standard, certainly from the standpoint of Federal employees. In other words, if it is good enough for me, it ought to be good enough for other people. If it is good enough for the thousands of Federal employees, then it ought to be good enough to be included.

What does it provide? It provides that the determination of services, drugs, supplies, be provided by hospital or other covered provider appropriate to prevent, diagnose, treat, a condition, illness, or injury, and that they must be consistent with standards of good medical practice in the United States. That is a standard we can all live by because we cannot ask for more than having care that is consistent with standards of good medical practice in the United States.

There are some other requirements as well, but they are essentially the same as what I just read.

I cannot imagine anyone would want to argue for not having a standard or having a contract that is open-ended and not know that would, in effect, leave uncertainty, a lack of clarity, and an openness that nobody wants to propose or support.

I hope my colleagues will take a look at this as we fight to keep down the high cost of health care, the availability of health care, and that we work toward making this standard the kind of standard that can be included as part of the Patients' Bill of Rights.

Anything that establishes clarity and certainty is desirable in the context of this legislation, and certainly that is included within this amendment.

There are some who thought the standard might consist of something such as a cost benefit. This does not involve any kind of cost-benefit analysis regarding medical care. There are some who were concerned about that. I would be concerned about that. This does not do that. There is some concern that somehow the plan might not be bound by the decisionmaking. It is not, but it ought to be bound by the definition.

I realize this is a very complex area that the average person is not going to deal with every day, so I apologize for the complexity, but I do not apologize for having something that will simplify it, that will give us the certainty and the clarity of having a definition and a standard that we can all understand and one with which we can agree and against which good medical care, under good medical practice in the United States, might be compared. That is what we are looking for.

There is a proposal that I understand will be coming forth for consideration this afternoon that will solve part of this problem, but it does not solve the problem of the standard of care and the definition.

The PRESIDING OFFICER. Who yields time?

Mr. NELSON of Nebraska. I yield time to the Senator from Oklahoma.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. NICKLES. Madam President, I compliment my friend and colleague from Nebraska, Senator NELSON, for his expertise in this field. He and Senator COLLINS are probably more qualified in this field because they both worked in their respective States in their insurance departments, I think, as commissioners of insurance and they also have expertise in the field from years of experience. When Senator NELSON or Senator COLLINS talk about medical necessity, or being bound or exempt from contracts, they have a certain degree of expertise that the rest of us do not have.

I remember visiting with Senator NELSON and he brought up the medical necessity and the fact this bill before the Senate unfortunately voids contracts. It goes so far as to even say you have to cover things that are excluded.

Page 35 of the bill says: No coverage for excluded benefits.

That sounds fine.

But page 36 says: Except to the extent . . .

In other words, you don't have to cover items excluded in contracts. Except to the extent somebody considers it medically necessary—and so on, even if specifically excluded in contracts. Part of the Nelson-Kyl amendment clears that up.

On contract sanctity, I concur 100 percent. I mentioned a few things excluded under the CHAMPUS program for VA, specifically excluded in contracts under this bill someone might have to pay. They might even be sued if they do not provide a benefit specifically excluded in their contract. That sounds absurd but in reading the language, that could happen. The Nelson-Kyl amendment fixes this. Things excluded under CHAMPUS include: Acupuncture, exercise equipment, eyeglasses, contact lenses, hearing aids, hypnosis, massage therapy, physical therapy consisting of exercise programs, sexual dysfunction, smoking cessation, weight control or weight reduction programs.

The point is, almost every medical health care plan says we will pay for this list of benefits; we will not pay for these benefits. Those benefits would be excluded. This bill says they will be excluded, but maybe they should be paid for anyway and they will be subject to review. And if the reviewer says it is needed, it should be paid.

Part of Nelson-Kyl says no, we will strike the language that deals with ''except to the extent,'' allowing contracts to be contracts that would not cover excluded benefits.

That is exactly what the Federal Government does. Many people want to model private health care after the Federal employees health care benefits. We have many different plans. They work. Employees are happy.

Federal employees cannot sue their employer, and Federal employees have to be bound by the contract. If you look at the consumer bill of rights and responsibilities, in OPM's guidelines dealing with the Federal Employees Health Benefit Program, it says if someone wants to appeal, OPM seeks to determine whether the enrollee or family member is entitled to the services under the terms of the contract. It is bound by the contract.

Blue Cross/Blue Shield, 2001, it says OPM will review your disputed claim requests and use the information it collects from you to decide whether our decision is correct. OPM will determine whether we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send a final decision within 60 days. There are no other administrative appeals.

Interesting to note, the Federal Employees Health Benefits Plan, they appeal to OPM, appeal through their employer. This is not an independent review entity. Again, OPM will make their determination based on the contract.

The Senator from Nebraska and the Senator from Arizona say a contract should be a contract. We should adhere to the contract and have contract sanctity. We should have some definition, some certainty in the definition, and we even use the definition for Federal employees' fee-for-service plans as one option, as well as the rulemaking process that the Senator from Nebraska spoke about.

I think there are too many people voting ''remote control,'' thinking, I will vote with Senator KENNEDY or

with Senator MCCAIN on this issue. I hope they look at this amendment. Should you have contract sanctity? Should you look at the guidelines we use in the Federal Employees Health Benefits Plan to have some contract sanctity? It is obliterated by the underlying bill. I think so.

This is an excellent amendment, an important amendment. If you want a bill that preserves some sanctity of contract, I think it is most important we pass this amendment. I urge my colleagues to vote in favor of the Nelson-Kyl amendment.

Mr. ENZI. Will the Senator yield 4 minutes?

Mr. NELSON of Nebraska. I yield.

Mr. ENZI. Madam President, I thank the Senator from Nebraska for the care and concern that has gone into this amendment. I support it along with him. I know how important it is for businesses to be able to nail down the prices so they can provide this voluntary insurance to people. If they don't know how much it will cost, if it is going to rise astronomically, I guarantee the small businesses will bail out. That is what the discussion has been about this week and last week—how to continue to have insurance for people.

I am an accountant, the only accountant in the Senate. I like dealing with numbers. The people who really deal with numbers are the actuaries. They are the ones who have to figure out what the odds are that something is going to happen to people. The smaller the plan, the tougher it is to figure the odds. But those odds have to be calculated in order to figure out the price. If the actuary said figure the whole universe of things that could happen, normally we exclude the ones that are difficult to calculate, but you don't get to exclude those anymore. You have to figure it as though those could happen to the person, and some reviewer will charge your plan with that. So we cannot tell you what you are going to have to pay. We guarantee it will have to be a higher number because of the uncertainty.

It is extremely important we avoid the Russia syndrome or the China syndrome, where they don't have contracts worth anything. In this country we maintain the sanctity of contracts. It is time to do that again. It is time to do that, particularly to protect the people working for small businesses in this country so they will continue to have insurance.

This amendment is particularly important because it does several things. First, it allows both the employer and the employee to be certain about what benefits are covered under the health plan. If they can't know that, then what's the point of the contract. Second, the amendment will virtually guarantee that all health plan contracts will now have a great definition of medical necessity, which is the clause in a contract that's used to make many decisions on claims for benefits. If a health plan or employer chooses not to adopt a strong definition, as defined in this amendment, then they forgo their right to rely on that definition in making decisions on claims for benefits. That's achieved by allowing the independent reviewer in the external appeals process to ignore that definition if it's not among those listed in the amendment.

This amendment brings to bear two important consequence that go a long way helping this bill become law. Again, the contract, upon which not just the breadth of benefits is determined, but also the cost of health coverage to both the employer and employee is based, is made whole. And, the quality of health care in this country is set at a standard that will assure patients receive medically necessary care as determined by the standards in the best programs, namely the Federal Office of Personnel Management's definition for fee-for-service plans.

Mr. President, I again commend my colleagues for their work. Enacting this amendment is as important to preserving the employer sponsored health care system as anything else we may do on this bill. There's simply no reason why Members would vote to undo a health plan contract or against requiring that health plans adopt a strong definition of medical necessity.

Mr. NELSON of Nebraska. We reserve our time.

Mr. KENNEDY. We have 30 minutes?

The PRESIDING OFFICER. That is correct.

Mr. KENNEDY. I yield myself 10 minutes.

I agree with our friends and colleagues, the Senator from Oklahoma, about the competency of my good friend, Senator NELSON, as well as the Senator from Wyoming, Senator ENZI. I learned, as I worked with Senator ENZI on a number of different issues, including OSHA, about his enormous capabilities as an accountant in dealing with numbers. I have also had the good opportunity to work with Senator NELSON on this issue. I think there are few Members of this body outside the committee or inside the committee that have taken more time than the Senator to understand the details of this legislation. He has a commanding knowledge of this legislation and a very healthy understanding and respect about what is happening in the State and local communities. He has been enormously attentive to detail and concept.

We do not always agree on every provision, but I have certainly developed a deeper understanding of the impact of this legislation from my conversations with him.

Even though we differ on the substance on this particular issue, which I think is an important issue, I have enormous respect for what he has brought to this whole debate on the Patients' Bill of Rights. I value, very much, his continued involvement in this debate.

I will mention briefly what we have in the legislation and why I believe it is wise to retain the approach we have currently. It has the complete support of the American Medical Association, the cancer organizations—I will refer to those later—and the overwhelming support of the medical community. It has evolved over a period of time. I will reference that in just a moment or two as well.

But it does, I think, meet the standard that has been mentioned here about certainty, clarity, and predictability. That is what the proponents of this amendment have asked for. We have just done that on page 35, in establishing the particular details of our standard. I will give brief reasons that we ought to retain this.

The McCain-Edwards-Kennedy bill allows the doctors, not the HMO accountants, to make the important medical decisions and it prohibits the HMOs from using arbitrary definitions of medical necessity. Unfortunately, the proposed amendment would undermine this crucial protection and allow plans to use definitions of care that may harm the patients.

Our legislation asks every Senator the basic question: Do you support the doctors making the critical medical decisions or do you want the HMOs to continue to deny care based on language that puts dollars before lives?

The independent medical reviewer should consider the definition decided by the health plan. However, we should not bind their hands by arbitrary definitions by an HMO. Senators MCCAIN, BAYH, and CARPER will offer an amendment later today that reflects the bipartisan belief that reviewers cannot approve services that are not explicitly covered under any circumstances. If a plan covers 30 days of hospital care, a plan cannot say they should cover 100 days. This amendment underscores the premise in our bill that a reviewer should not be bound by an unfair HMO definition of medical necessity. In circumstances where explicit coverage decisions are subject to interpretation, the reviewer should have the opportunity to weigh all the relevant medical facts.

I gave the example last evening. If the plan says ''no cosmetic surgery'' and there is a cleft palate on a child, I could see an independent reviewer saying as a matter of medical necessity it is imperative that we correct the cleft palate and would be justified in doing so. If, in the plan, it said ''no cosmetic surgery and no cleft palate,'' the medical reviewer would be prohibited from doing so. So there is that degree of interpretation in terms of medical necessity, that aspect of judgment that we want to give to the doctors in dealing with this issue.

The Kyl amendment, once again, I believe gives the HMOs the opportunity to deny critical care by allowing them to use definitions of medical care that are stacked against the patients. This amendment also prevents independent

reviewers from weighing all the relevant factors needed to make a fair decision. In addition, the amendment proposes to institute a complex rulemaking process to define medical necessity. However, administrative rulemaking is only as fair as the participants. If the participants are hostile to patients' rights and sympathetic to HMOs, they could undermine care for millions.

As CHARLIE NORWOOD said, if reviewers are forced to wait on regulation at the speed HCFA moves, leeches might still be considered medically necessary and appropriate.

Also, under this amendment the plan gets to choose any of the numerous definitions for medical necessity. It can seek out the worst of the worst, but consumers get no comparable rights to demand the best of the best. All you have to do is look at the range of definitions and it is easy to see why the disability community, the cancer community, the American Medical Association, and other groups are so vehemently opposed to this amendment. It fails to protect the patient and allows the health plans to continue to deny medically necessary care. That is why the overwhelming number of medical groups support our language.

Some of the standards that they could pick from say cost-effectiveness should help determine whether care should be provided. It might be cost-effective, for example, for an HMO to amputate a young man's injured hand, but what about the cost of having to spend the rest of your life without the full use of limbs? It might be effective for an HMO to pay for older, less effective medication for depression, but what about the cost to a mother trying to raise her family while dealing with the harmful side effects that could have been prevented by newer medication? Why should we subject the American people to them?

I urge my colleagues to reject this amendment. Passing it would reverse the strong bipartisan efforts we have worked out in this legislation.

Let me mention here the letter from the National Breast Cancer Coalition:

> On behalf of the National Breast Cancer Coalition and the 2.6 million women living with breast cancer, I am writing to urge you to oppose the Kyl amendment and to support the McCain-Bayh-Carper amendment on medical necessity. The National Breast Cancer Coalition is a grassroots advocacy organization made up of more than 600 organizations and 10,000 individual members all across the country who are dedicated to the eradication of breast cancer through advocacy and action. With regard to the enactment of a strong, enforceable Patients' Bill of Rights, the NBCC believes the determination about what is medically necessary must remain in the hands of physicians, not HMOs. The coalition is concerned the Kyl amendment would weaken the provisions in the McCain-Edwards-Kennedy Patients' Bill of Rights and would allow financial decisions to override the medical judgments on patient care.

Let me just mention some of the definitions which have been used. Here is a definition that is used in terms of medical necessity. As I mentioned, the history of this is that we did have a definition in the previous legislation that was passed. What we used for medical necessity at that time was this:

> Medically necessary or appropriate means a service or benefit which is a generally accepted principle of medical practice.

That is what virtually every Democrat voted for. That gives the maximum flexibility to the doctor.

When we got to the conference and began to work this out, the HMO industry said this definition was so broad and wide, in terms of interpretation, that it could mean anything. Therefore, it would completely override the contract terms of the HMOs.

Then we altered it and said: In the internal review they will use the definition of the HMO, but in the external we will use a different definition. That is what is in the legislation. That is basically what is in the Breaux-Frist, as well as in the McCain-Edwards-Kennedy.

Basically, it says ''a condition shall be based on the medical condition of the participant''—therefore you look at the medical condition of the principal—''and valid, relevant scientific evidence and clinical evidence including peer review, medical literature or findings, and including expert opinion.''

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

Mr. KENNEDY. I yield myself 3 more minutes.

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

Mr. KENNEDY. The expert opinion is critical. The essential element of that—which I know has been questioned—was talked about and essentially agreed to in the conference last year.

This is the concern we have. Here are some of the definitions which have been used in various HMOs, and even in Federal health insurance. The difference, in Federal health insurance is if there is an appeal of it, they leave it completely open. I asked staff to get the standard that is used. It is completely left to the doctor. That is where we want it, to the greatest extent possible. We have limited it as I have defined it. But these are some of the concerns.

This is in SIGNA, in terms of medically necessary:

> . . . that are determined by our medical director to be no more required than to meet your basic health needs.

So this definition is going to be what the plan's medical director decides. Clearly, they are going to be biased in the HMO.

This is the Hawaii State plan: Cost effective for the medical condition being treated compared to alternative health intervention, including no intervention.

Cost effectiveness is unacceptable. It is more cost effective for the HMO to put someone in a wheelchair rather than for them to have hip surgery. But it is more effective to the individual to have the hip surgery.

Here is another one:

A treatment that could reasonably be expected to improve the member's conditions or level of functioning.

Even though it is used by the Health Alliance HMO in the Federal health insurance, the problem is that for people with disabilities, the treatment may not be for a condition that can improve, but it certainly may improve the quality of life.

Here are the Pacific Care Health plans furnished in the most economically efficient manner.

''Economically efficient'' is a problem.

Again, it is what procedures are the most cost effective.

We have to be very sure about what we are going to have. We have a good definition in this proposal. It is supported by McCain-Edwards and myself and is also essentially the provision in Breaux-Frist.

It has the overwhelming support of the American Medical Association, as well as the Cancer Association, and is spelled out in this legislation. So there is certainty.

If there is a change on this, we can come back and revisit it. I give the assurances to my friends that we can. But the idea that we are going to give the authority to a panel that will be set up by the Secretary—the makeup of which we don't know—which can propose something, still indicates that we don't know what is going to come out. That doesn't seem to me to be the way we ought to go in giving predictability and certainty to patients. If we are interested in that, we ought to get criteria that is sound, responsible, and gives medical professionals the ultimate ability to make judgments to protect the patient.

That is what we do in this legislation. That is why I don't believe we should alter or change the proposal.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. KYL. Madam President, how much time remains on our side?

The PRESIDING OFFICER. Ten minutes.

Mr. KYL. I yield myself 2 minutes.

I am very sorry to have to say this, but the amendment that Senator KENNEDY has just proposed is not our amendment. I want to be very clear about what our amendment does. The amendment that Senator KENNEDY has been talking about was part of last year's bill.

When Senator NELSON came forward this year, he said: Let's try to come up with something new. We did that. So the language we have before us today is not the language to which Senator KENNEDY has been referring.

When he talks about the Signet language and the other plan language, that would be absolutely prohibited by what we are talking about here. That was last year. We would absolutely prohibit that. When he talks about the

plans choosing from among a range of definitions that could include cost effective, that would be absolutely prohibited under our language. That was last year.

Let me again restate what we did this year.

Mr. KENNEDY. Will the Senator yield on my time?

Mr. KYL. Absolutely.

Mr. KENNEDY. What I read here is ''what is determined by our medical director to be no more required than to meet your basic needs.'' That is in the Federal health insurance program. That would be included. The language I have read is ''the treatment that can reasonably be expected to improve the member's condition or level of functioning.'' The Federal employees' plans are included.

The last one, ''furnish in the most economically efficient manner,'' that is Federal employees. That is included. All three are included because the Federal employees' insurance has been included as well.

What is not included is discretion that is given to the medical doctor. The review of that is provided in the Federal employees' plans, and OPM is using it. It is not included in the underlying.

Mr. KYL. If the Senator will allow me to answer, that is a factual matter. I will not argue with his answer. I think I can explain the reason for the confusion. But the answer to the Senator's question is no. What the Senator said is not correct. That was correct a year ago because a year ago the language of the amendment was that you took the FEHBP standard. And the Senator would have been correct a year ago because it was both the fee-for-service standard as well as the managed care contract standard.

So the criticism that the Senator levels would have been correct criticism a year ago. And to some extent, I agree with the Senator from Massachusetts about that criticism. We threw that aside. Instead, we asked: What is the contract that governs the fee-for-service FEHBP plans? The contract that governs, we think, 73 percent of the people—in other words, about 6 million people—is the language that they have approved for the Blue Cross/Blue Shield fee-for-service contract, as well as some others. We didn't want to allow any discretion whatsoever. So we took the five specific provisions of that contract. Those are embodied in the legislation. There is no discretion.

If you want a safe harbor now under this amendment, you would have to write your contract with those five items, and only those five items. That is what the reviewer then would be able to review.

If I could just continue on with respect to the negotiated rulemaking, it was our idea that if anyone didn't like those five items, and all of the stakeholders would want to get together and negotiate something different, we would be very amenable to that. So we set up this voluntary rulemaking procedure.

If the Senator from Massachusetts and others think there is something wrong with that and they would not want to create that option in the bill, we are very amenable to dropping that out. We thought we were doing people a favor by putting that option in so that if somebody didn't like these five items, they could engage in this negotiated rulemaking. But anybody in the negotiations could veto it so that it wouldn't go into effect.

But if people somehow fear that, it is not our intention to try to superimpose some nonspecific standard.

If the Senator would like to engage further on that, we can certainly discuss that. I indicated to the Senator last night our willingness to discuss that. I hope I have cleared it up. I understand the reason for the confusion because that was last year's amendment.

Our amendment language was only available a couple of days ago. So it is understandable that one might not have been able to read our amendment language. But I assure the Senator that our language is very specific and very different from that which he criticized.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. NELSON of Nebraska. Madam President, I understand the passion of my colleague from Massachusetts. He has done such great work in this area, and I truly appreciate and respect what he has done and the fact that he has taken a very careful look at what we are proposing.

I suspect, though, that he would maybe look at me as a person who came to the party late and wants to rewrite the invitation. You can't try to change something where there has been such a history without encountering some resistance to it. I understand there is resistance to wanting to change this because it was dealt with last year. But you don't weaken this bill by making it more certain.

I don't believe there is a problem. But if there is a problem within the Federal Employees Health Benefits Plan because there is not a good standard there, we can correct that by passing this amendment and this Patients' Bill of Rights, and make Federal employees subject to the Patients' Bill of Rights.

My colleague from Massachusetts mentioned that there is perhaps a different manner of review for Federal employees where they have to go directly to the Office of Personnel Management rather than getting an internal or external review. We can correct that. We can make that plan subject to the Patients' Bill of Rights, and we can correct that. Or we ought to take a look at that independently.

But this does not change anything that would be detrimental to those individuals my colleague from Massachusetts mentioned.

For example, of the list of people, such as a person with a cleft palate, the only question about a person with a cleft palate is whether that treatment, in the judgment of the medical professional, the doctor, would be consistent with the standards of good medical practice in the United States. That is the dynamic, and I am sure that it would. There is nothing static about this definition. It will continue to change as the good standards of medical practice in the United States change.

My good friend also mentioned something about making sure that we have our loved ones well protected. I agree with him and include the Federal employees as part of our loved ones. I think we want these standards to apply to all Americans. The way in which you can do that is by adopting this amendment on medical necessity.

What it does not do is, it does not change the doctor's decisionmaking in relation to what kind of care to provide. What it does say is that it has to be consistent with the standards of good medical practice in the United States.

I, for the life of me, do not see what the resistance to this language is, other than the fact that we tried to do it a year ago. We had the Stanford definition. We talked about other definitions a year ago. Now we have come up with a definition which I think is an excellent definition that will do it, that will establish the standard for certainty, for predictability. And now we are saying it may weaken the Patients' Bill of Rights. But certainty will strengthen this. There is no effort here to do anything that would not be consistent with—as a matter of fact, the language requires that the medical profession do something consistent with the standards of good medical practice. Whether it is an amputation, whether it is a cleft palate, whether it is deciding on cancer care, or whether it is deciding on other kinds of care, all we are saying is it ought to be subject to these standards. That is the only point that is being made.

Mr. President, how much time remains?

The PRESIDING OFFICER (Mr. CARPER). The Senator from Nebraska has about 4½ minutes remaining. The opposition has 13 minutes remaining.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I am glad to yield——

Mr. MCCAIN. Will the Senator allow me a couple minutes of time?

Mr. KENNEDY. Yes. Absolutely. The Senator from North Dakota was looking forward to talking, but whatever.

Do you want me to yield 3 minutes?

Mr. MCCAIN. How much time?

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

Mr. MCCAIN. I thank the Senator from Massachusetts, and also the Senator from North Dakota. I would be glad to wait until after the Senator from North Dakota speaks, if he prefers.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. MCCAIN. Mr. President, I have major concerns about the Kyl-Nelson amendment and unfortunately, must oppose it. While I certainly respect the intentions of my dear friend and follow Arizonian, JON KYL, I respectfully disagree with him regarding this proposal.

I simply can't support mandating a Federal statutory definition of ''medical necessity'' that is vague and creates further confusion and barriers for patients attempting to get the medical care their doctor deems appropriate, and is covered by their HMO plan.

This amendment would put into statutory language a vague definition that allows health plans to determine whether services, drugs, supplies, or equipment are appropriate or necessary to prevent, diagnose, or treat a patient's condition, illness, or injury.

While this appears reasonable, it simply is not.

One of the major hurdles currently facing patients is the repeated denial of their medical care on the basis that it is not medically necessary based on a vague or constraining definition. The health plans are intentionally denying care to constrain costs by hiding behind cleverly crafted definitions.

This amendment would allow this practice to continue.

For example, part of the definition allows a plan to determine whether the recommended medical care is, ''primarily for the personal comfort or convenience of the patient, the family or the provider . . .''

It sounds reasonable, but it is not. This is already being used to prevent patients from receiving palliative care for managing the intensive pain they encounter while battling cancer or other serious illnesses.

Another portion of the proposed definitions reads, ''Consistent with standards of good medical practice in the United States'' . . .

Again, appears harmless, but it isn't. Who establishes the standards of good medical practice? What basis is used for developing them? How current, considering the pace of new technology and medical research will these standards be?

Another portion of the proposed Kyl-Nelson Federal definition reads, ''In the case of inpatient care, [the care] cannot be provided safely on an outpatient basis . . .''

Legally, this creates an opportunity for retrospective reviews by HMOs thereby leaving the patient and/or medical provider responsible with the incurred costs from the inpatient care that the HMO determines should have been provided on an outpatient basis.

These are just a few of the problems facing patients if this amendment is adopted.

I wholeheartedly agree with my colleagues that we can't create a method that obviates health plan contracts and that is not what our bill does.

Our bill does not empower the independent medical reviewer to override existing health plan contracts or force HMOs to cover anything and everything despite a service being specifically excluded in the contract.

Our bill relies on the independent medical reviewer to give patients a second medical opinion when such a medical opinion is necessary to interpret the plan's coverage, but it does not empower them to disregard the plan's specific coverage exclusions and limitations.

I will be offering an amendment after the scheduled vote on the Kyl-Nelson amendment that will further clarify this and protect the sanctity of the plan's contract with a patient.

I urge my colleagues to reject the Kyl-Nelson amendment and allow patients to have their medical decisions made by doctors and nurses and not by HMO lawyers or bureaucrats.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, how many minutes do I have remaining?

The PRESIDING OFFICER. The Senator from Massachusetts controls 10½ minutes.

Mr. KENNEDY. I yield 8½ minutes to the Senator.

The PRESIDING OFFICER. The Senator from North Dakota is recognized for 8½ minutes.

Mr. DORGAN. Mr. President, this is a well-intentioned amendment, but it must be defeated because it is aimed right at the heart of this patients' rights bill, right at the core of the bill. The question is, Who is going to make the decisions? Who will make decisions about medical care? An MBA or an MD? Who do we want to make the decisions about medical care?

The McCain-Edwards-Kennedy bill allows doctors and patients to make fundamental decisions about their care. It will be based on medical necessity and appropriateness and supported by valid, relevant scientific and clinical evidence. In other words, if an HMO makes an arbitrary decision about some kind of a treatment they believe is not medically necessary, based on its own inadequate definition of ''medical necessity,'' the reviewers would be able to overturn that and advocate treatment.

Under this amendment put before the Senate, the patient would be bound to the HMO's decision and have literally no options; the independent reviewer would have no authority whatsoever to recommend treatment if it was needed.

The Senator from Massachusetts read a list, and he was challenged on that list. But the fact is, the list he read is absolutely correct.

Let met do this in English, if I can. The amendment, as I understand it, allows an HMO or managed care organization several different approaches to deal with the issue of what is medically necessary. How do you define medically necessary? Several different ways. One is a mechanism described by the Senator from Massachusetts. He read some of those definitions. He was accurate about that. But there are two other mechanisms by which an HMO could describe what is medically necessary.

Do any of us think the HMO will pick the more stringent approach? Of course not. They will pick the least effective approach, the approach that poses the least cost to them. They will pick the weakest of the options. That is what the Senator from Massachusetts was saying.

Give the HMO the opportunity, and they will pick the least possible option, the least costly option for themselves. That is why we are in this Chamber with this patients' protection bill. This amendment strikes a blow right at the heart of the patients' rights legislation. The reason we are in this Senate Chamber is to work on providing patients' rights, not take them away.

Let me do this in a bit more dramatic way.

One of our colleagues has used this photo from time to time. This photo shows a young baby with a cleft lip and cleft palate, which is a very severe problem. We are told that about 50 percent of the time fixing this would be described as ''not medically necessary'' by an HMO. Can you imagine a health care plan saying: ''No, fixing this disfiguring defect is not a medical necessity, therefore, we will not cover it''.

Let me describe what this child will look like with that problem fixed. This photo is of a child with reconstructive surgery. This other photo is of a child with the severe problem before it is repaired. Fifty percent of the time managed care organizations have told those requesting reconstructive surgery for a cleft lip or palate: ''No, you are wrong. This is not medically necessary. And we will not cover it''.

Is that how we want our health care system to operate? It will be allowed if this amendment is adopted.

Let me describe another case. I am going to describe how this case relates to this amendment.

This is a photo of Ethan Bedrick. We have spoken about Ethan before. Ethan was born on January 28, 1992. He had a partial asphyxiation during birth, a very significant problem in delivery. He has suffered from severe cerebral palsy and spastic quadriplegia, which impairs motor functions in all his limbs. At the age of 14 months, his managed care organization abruptly cut off coverage for all of his speech therapy, and limited his physical therapy to 15 sessions in a year. A doctor from his managed care organization performed a ''utilization review.'' He said that there was only a 50-percent chance of Ethan being able to walk by age 5, which is ''insignificant'' and, therefore, they would restrict coverage.

So let me say that again. A 50-percent chance of being able to walk by age 5 was ''insignificant'' and, therefore, they would not cover the therapy.

His parents went to court 3 years later. A judge said:

> The implication that walking by age 5 . . . would not be ''significant progress'' for this . . . child is simply revolting.

But in the meantime, it took 3 years, and this child did not have the therapy he needed for 3 long years.

My point about this is, young Ethan Bedrick, or a young child with a cleft lip and a cleft palate, running into a plan that has a provider service saying: ''These are not medically necessary procedures, and we will not cover them,'' will have no ability to have an independent reviewer overturn that under the amendment that is offered today.

Mr. KENNEDY. Will the Senator yield?

Mr. DORGAN. I am happy to yield.

Mr. KENNEDY. For the benefit of the membership, we had scheduled a vote at 12:30. With the agreement of the leadership, that vote will be postponed until 2. At 1 o'clock, Senator GREGG will be here to offer an amendment for himself. At 2, it is the anticipation of the leadership that there will be two rollcall votes. We have not made the unanimous consent request yet, but that is the intention of the agreement of the two leaders. After the time expires, we will make that unanimous consent request.

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

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. From 12:30 until 1 o'clock there will be general debate on the bill.

Mr. MCCAIN. If the Senator will yield?

The PRESIDING OFFICER. The Senator from Arizona.

Mr. MCCAIN. I note the presence of the Senator from New Hampshire on the floor. We really have an issue of scope, an amendment we need to bring up, and of course the so-called Snowe compromise amendment as well. I hope we will be able to put both of those in some kind of order in some way today.

Mr. REID. Mr. President, the Senator from Arizona is absolutely right. Progress has been made but not nearly enough. Since Senator GREGG is here, I wonder if we could restate the unanimous consent request and have that entered at this time. The only suggestion I would make to Senator KENNEDY is that we should have general debate from 12:30 to 1 on the legislation.

Mr. KENNEDY. That is fine.

Mr. GREGG. Is there a unanimous consent request pending?

Mr. KENNEDY. As I understand, the time will expire in how many minutes for the debate on this amendment?

The PRESIDING OFFICER. The Senator from Massachusetts has 3 minutes to go, and the other side has 4 minutes.

Mr. KENNEDY. As I understand it, there has been agreement to vote on that amendment when the time is used or yielded back; am I correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. KENNEDY. I ask unanimous consent that the vote on that amendment be put off until 2 o'clock.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. KENNEDY. It is the anticipation of the leadership that between 12:30 and approximately 1 o'clock there will then be general debate on the legislation. At 1 o'clock an amendment will be laid down by the Senator from New Hampshire or his designee. It is anticipated there will be a second vote at 2 which will be on that amendment.

Mr. GREGG. Mr. President, I can't guarantee that there would be a second vote at 2 on that amendment, unless the parties to that amendment are agreeable to that.

Mr. KENNEDY. Then I withdraw my request. I was asked to make that request; if there was going to be no objection, that was going to proceed. Otherwise, we will go ahead.

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

Mr. KENNEDY. I had asked if the Senator would yield. The Senator from North Dakota has the floor.

Mr. DORGAN. Mr. President, how much time remains?

The PRESIDING OFFICER. The Senator from North Dakota has about 2 minutes.

Mr. DORGAN. Let me continue by saying, I understand that those who have framed this amendment will not agree with my assertion. But I also understand that they are trying to craft something that defines what is medically necessary in a manner that would give a managed care organization three different options to restrict care.

In my judgment, the managed care organization will clearly select the option that has the least amount of coverage or the least cost to them. That is precisely why we are here in the first instance. We are trying to see if we can create a Patients' Bill of Rights that allows a doctor and health care professionals to make judgments about what kind of treatment is appropriate. We have story after story after story about health care professionals making a decision about what kind of health care is necessary for a patient only to be told later that someone 1,000 miles away an insurance office decided, no, this was not medically necessary at all, and we won't cover it. We don't agree the physician's decision or recommendation for treatment.

The reason the AMA and nurses and others support this legislation of ours is they believe very strongly that health care professionals ought to be the ones practicing medicine. The American Medical Association is very strongly opposed to this amendment.

I ask unanimous consent to print a letter the AMA has sent objecting to this amendment in the RECORD.

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

[From the American Medical Association, June 26, 2001]

AMA OPPOSES KYL-NELSON AMENDMENT THAT LETS MBAS—NOT MDS—MAKE MEDICAL DECISIONS

AFTER 7 YEARS, THE DEBATE HAS SUDDENLY COME FULL CIRCLE

WASHINGTON.—Today the American Medical Association (AMA) called on Congress to defeat a Kyl-Nelson amendment that would negate a core provision of the patients' bill of rights. This new medical necessity amendment would allow insurance company bean counters to make medical decisions.

''Today, after seven years of debate, it seems some lawmakers want to start over at the beginning, with the core question: Who should make your medical decisions—MDs or MBAs?'' said Dr. Thomas R. Reardon, MD, AMA past president. ''For patients and physicians there's no debate: Decisions about the health care a patient needs must be left to those who are focused on patients—not on the bottom line.''

''The Kyl-Nelson amendment uses a medical necessity definition that allows health plans to determine whether services, drugs, supplies or equipment are appropriate to prevent, diagnose or treat a patient's condition, illness or injury.'' Dr. Reardon said. ''This is a big step backward.''

Insurers and business have repeatedly opposed defining medical necessity in legislation: ''A federal standard of medical necessity will raise premiums, threaten quality, and jeopardize efforts to prevent abuse.'' (Blue Cross/Blue Shield, 2/99); ''We fear a congressionally mandated definition of medical necessity, and therefore do not support it.'' (Ford Motor Company 2/99).

''It's clear that health plans put profits before patients when they define medical necessity as the 'shortest, least expensive or least intense level of treatment,' Dr. Reardon said. ''People get health insurance so that they're not limited to the cheapest care—no matter what the outcome.''

''The McCain bill allows physicians to make medical decisions and allows an independent panel of reviewers to determine disputes. AMA calls on the Senate to reject the Kyl-Nelson amendment that guts the patients' bill of rights,'' Dr. Reardon said.

Mr. DORGAN. They are opposed precisely because they understand this amendment absolutely unravels the central and vital section of this bill dealing with medical necessity. Our patients' rights legislation provides a structure by which doctors make decisions and then you have the opportunity for independent review if needed. But in the circumstance as proposed in the amendment up for debate, if we create definitions that allow diminishment of the level of care in terms of what is medically necessary, the independent reviewer will have their hands tied and patients will not get the care they deserve or need.

This is a very carefully drafted bill. I am not in any way ascribing mal-intent to anyone who offers this amendment. This amendment will unravel the bill in a very significant way. We must defeat this amendment. We should defeat this amendment and preserve the patients' protections legislation that we have brought to the floor of the Senate. This has been going on 5 years. This is good legislation. We ought to pass it and defeat the amendment.

I yield the floor.

The PRESIDING OFFICER. The time controlled by the manager of the bill has expired.

Mr. KENNEDY. Mr. President, I think the Senator has 2 minutes. I have 2 minutes; is that correct?

The PRESIDING OFFICER. The sponsor of the amendment has 4 minutes remaining. All time has expired in opposition to the amendment.

Mr. DORGAN. Mr. President, that cannot be the case. The Senator from Massachusetts allotted 8 minutes to me. At that point, he had 10½ minutes remaining. It cannot be the case that we have exhausted our time.

The PRESIDING OFFICER. The time of the colloquy back and forth between the Senator from Massachusetts and the Senators from New Hampshire and Nevada was charged to the manager.

Mr. GREGG. I ask unanimous consent that the Senator from North Dakota have another 10 minutes, if he desires.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. DORGAN. Mr. President, I yield my time to the Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I will take the 2 minutes which I otherwise might have had if we hadn't entered into the request.

Here we go again with greater hope in our hearts that we will be successful.

After the yielding back of the time, we intended to vote on the Nelson amendment. At the request of the leadership, I ask unanimous consent that that vote be put off until 2 o'clock.

Mr. REID. Reserving the right to object, I have been informed that there will be a motion to table made on the amendment. That will be done at the appropriate time.

Mr. KENNEDY. At 2 o'clock. It is anticipated that at 1 o'clock there will be an amendment from the Senator from New Hampshire or his designee. I am informed that it will probably be the Senator from Tennessee, Mr. THOMPSON; and that we will begin the debate on that at 1 o'clock and that the time between 12:30 and 1 will be used for general debate.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. KENNEDY. Mr. President, I apologize to my friend for the interruptions because the Senator has been patient during his presentation and is typically kind and generous to permit the workings here.

I believe we have a good, solid definition in terms of medical necessity that has been reviewed, evaluated and has gotten broad support. It has bipartisan support. It also has the very, very strong support of the medical community: The American Medical Association, all of the cancer organizations, as well as the disability community. They all have great interest in what that definition is.

In too many instances in the past there have been definitions that have been offered and accepted that work to the disadvantage of patients. For example, definitions have been made that do not include palliative care for patients who have cancer or don't recognize the very special needs of the disabled.

We have a definition here. It is defined in the legislation. It has been reviewed. It is careful. It is predictable. It is certain. It does provide for doctors to exercise their best medical judgment. It is completely consistent with the purposes of the legislation.

As I mentioned, I have great respect for my friend and colleague. I think on this we should stay with the language which should be included and which has the broad support, virtually the unanimous support of the medical community.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

Mr. NELSON of Nebraska. Mr. President, I appreciate the opportunity to engage in a dialog with my colleague from Massachusetts. As I indicated earlier, I respect his work and many years of effort in this field. I certainly respect his judgment. If I would disagree with him, it would be that somehow there is a standard that is currently in place. As a matter of fact, last year they tried on numerous occasions to achieve a standard. They could not come up with one where they agreed. So they agreed to disagree and left the standard out.

We have an opportunity now to come up with a standard that is good enough for Federal employees and put that in this bill. If it is good enough for Federal employees, then of course I think it ought to be good enough for the rest of America.

As to the charts that were shown, I ask, is there anybody in this Chamber today who believes that under the definition of consistent with standards of good medical practice in the United States, any doctor would not have ordered that the cleft palate be treated?

I understand the importance of having charts. I understand the importance of having faces put on the patients. But I think it is important that, as we do that, it be very clear that we understand that these cases would be treated appropriately under the standards of good medical practice in the United States. So I think we really have an opportunity today to provide more clarity, so that doctors who will have the opportunity to make medical decisions and order care will be able to do so consistent with standards.

There is no way that this amendment today is designed to take away any of the authority of the doctor at all, or any other health care provider. All that it is aimed at providing is a standard. If they had come up with a standard last year and it were included in the bill, I would not be raising the question this year. This issue today is about whether to have the standard or not. I can't imagine we are even debating it. We ought to be debating what the standard is. That isn't the debate we have today.

As a matter of fact, some of the objections raised earlier about this amendment could be equally said of an amendment that I suspect the Presiding Officer will be supporting today a little later, and that is to make sure you don't have those exclusions from a policy, those exclusions from a contract, ignored by a medical examiner in the whole process of the review.

The important point here is that this will provide an opportunity, upon an internal or external review, for a medical reviewer to make good decisions consistent with good medical practice, consistent with the needs of the patient, so that the conditions in those pictures that were shown here—very vivid descriptions—can and will be taken care of and will not be left open without a definition, without a standard. The boundaries would be set, but they would be far broad enough to cover that and any other condition that was discussed here as an example this afternoon.

It seems to me it is important that we establish a standard, and if I wanted to oppose what I am proposing today, I would come in and I would say that it was going to do something bad, that it was not going to permit something good. But that doesn't make it so. It is important to point out the language and deal with the reality of the words of this amendment, rather than setting up a straw man to attack and say that it is doing something or it won't do something that it is in fact doing.

Mr. President, how much more time is there?

The PRESIDING OFFICER. The Senator has about 8 seconds.

Mr. NELSON of Nebraska. I ask my colleagues to support this amendment and move forward with the important work of the Patients' Bill of Rights. We can do that. This will improve it and will not detract from it.

The PRESIDING OFFICER. The Senator from New York is recognized.

Mrs. CLINTON. Mr. President, I have the greatest respect for my good friend, the Senator from Nebraska, and I rise reluctantly, but firmly, to oppose the amendment he is sponsoring, along with Senators KYL and NICKLES, because I am concerned not only about the general issues that have been raised by other opponents, I am concerned also by the American Medical Association's very strong and vigorous opposition to this amendment, which they have made very clear to me and my office, as well as, I believe, every other Senator, because of their deep concern that this would be a step backward, permitting health plans to determine the services, drugs, supplies, or equipment necessary to prevent, diagnose, or treat a patient's condition, illness, or injury.

But I have a very specific reason for opposing it. I direct this to my good friend from Nebraska because this is something that deeply concerns me. This amendment allows health plans to define ''medically necessary and appropriate'' in a way that poses a great threat to all patients and families who

require hospice and palliative care to treat the suffering associated with terminal illness.

The Washington Post, just a week ago, published a story outlining the various ways in which recent advances and end-of-life care have not yet reached children with terminal illnesses, causing an enormous amount of suffering for dying children and their parents and loved ones who have to watch that suffering at the end stages of a terminal illness. The article quotes one mother who says, looking back on her daughter's death, that ''pain is such a huge problem.''

There are two specific phrases within the safe harbor of the ''medically necessary care'' language in the Kyl-Nelson-Nickles amendment that directly undermines the needs of dying patients. First, the amendment declares that care provided ''for the comfort of the patient'' is not medically necessary care.

Any health care professional—or really any person, such as myself—who has stood at the bedside of a dying friend or a loved one knows that comfort of the patient is absolutely necessary and is often the most appropriate goal of care in those last days, weeks, and even months sometimes. At the very center of palliative care, and particularly in the hospice movement, is the belief that each of us has a right to die free of pain and with our human dignity as intact as possible.

The Institute of Medicine released a ground-breaking report in 1997 that concluded ''too many people suffered needlessly at the end of life.'' A second Institute of Medicine report released last week also concluded that patients are suffering unnecessarily. Furthermore, studies have shown that specific types of patients—patients who are elderly, female, African-American, or children—are less likely to have their pain adequately controlled at the end of their lives.

The Kyl-Nelson-Nickles amendment is legislation that could be termed as declaring that the comfort of dying patients is not a legitimate goal of medicine. But to me, that has it backwards. Isn't the relief of suffering exactly what doctors are supposed to be concerned about?

A second and related problem is that this amendment allows plans to define as ''medically necessary'' care that is appropriate ''to treat a medical condition, illness, or injury.'' This narrow definition compromises the delivery of appropriate care to dying patients by failing to recognize the legitimacy of care that focuses on the palliation of pain rather than a cure. This definition actually encourages overuse of invasive—and often futile—medical treatment and the underutilization of hospice and palliative treatment.

The Institute of Medicine report released this month concludes that ''policies and practices that govern payment for palliative care hinder delivery of the most appropriate mix of services.'' A chapter of that report focuses on the terrible effect these policies have had on children. It found that services necessary to provide dying children and their parents with comfort and counseling are not recognized and certainly not even reimbursed by many insurance programs.

I believe the definition of ''medically necessary care'' proposed by this Kyl-Nelson-Nickles amendment would further obstruct access to hospice and palliative care services for patients suffering from terminal illness.

We have not done enough to relieve pain and suffering at the end of life. I served for many years on the board of a children's hospital. Back in those days, the idea of giving strong medication to a dying child was really not even considered a possibility for many reasons. People were not sure about the appropriate dosage. Some people were worried even with a dying child that the child might become addicted to strong pain relief medicine.

I have also seen friends who, at the end of their lives, had to cry out for and demand pain relief from an almost unbearable burden. They did not want to leave this wonderful life, but they knew that was going to happen and they wanted to do it in a way that relieved both them and their loved ones of the agony that comes at the end of so many devastating illnesses.

There are many wonderful hospice programs in our country, and many academic development centers are developing comprehensive palliative care programs specifically to focus on patient comfort at the end of life.

The Kyl-Nelson-Nickles amendment places the comfort of dying patients and their families beyond the language of the legislation, really rendering it illegitimate; providing this comfort would no longer be medically necessary or appropriate.

I ask unanimous consent to print in the RECORD the article I referred to earlier from the Washington Post called ''Children of Denial.''

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

[From the Washington Post, June 19, 2001]

CHILDREN OF DENIAL—RECENT ADVANCES IN END-OF-LIFE CARE HAVEN'T REACHED THE YOUNGEST PATIENTS

(By Abigail Trafford)

The leukemia had come back. Liza Lister, 5, leaned on her mother's shoulder. As her mother later recalled, Liza asked, ''Will I die soon?'' She quickly went on, ''I want to die on your lap. I want to have my lullaby tape on.'' Just days after her fourth birthday, Liza had been diagnosed with acute lymphocytic leukemia. Now her last chance for a cure, a bone marrow transplant, had failed.

Her parents, both physicians in New York City, had access to the most advanced therapies to wage war against her disease. But when a cure was no longer possible, they found themselves outside the mainstream of modern medicine.

Hospitals had no formal support system for families caring for a child who was going to die. There was no one health professional to offer consistent guidance throughout the up-and-down course of Liza's illness. The medical team never mentioned a hospice program.

At a time when strides have been made in easing the pain of death for adults, most children who die of chronic illness do not receive state-of-the-art care at the end of their lives—mainly because no one wants to admit they're dying. The majority die in hospitals, often in intensive care units where they are hooked up to life support machines. Drugs that could ease pain go unprescribed.

Yesterday the Institute of Medicine, in a report on end-of-life cancer care, called for a stronger focus on children, for better relief of suffering, education of doctors and changes in health plans to cover supportive services.

''Kids are suffering. The ones who are sensing they are dying and haven't been told are suffering from loneliness, from a lack of permission. Kids are suffering pain because people are reluctant to give narcotic pain relief to children,'' said pediatric oncologist Joanne Hilden, who founded the end-of-life care task force for the Children's Oncology Group, a national network of pediatric cancer specialists.

''Parents are suffering because they feel they have failed their child. Doctors and nurses are suffering for wanting to do better in a system that is getting in the way at every turn.''

THE INVISIBLE DEATH

Death in childhood can be a taboo subject in the United States. The roughly 28,000 children who die every year of chronic illness such as cancer, heart disease, degenerative disorders and congenital anomalies are like medical orphans in a health care system dedicated to cures and longevity.

''Childhood death is completely invisible,'' said nurse Cynda Rushton, director of the palliative program for children at John Hopkins Children's Center. ''People don't want to be reminded of it. The grief is so profound, it's almost unspeakable.''

The medical team generally recognizes that a child is dying several months before the parents do—but doesn't usually tell them. In a study published last November in the Journal of the American Medical Association, physicians tended to realize there was no chance of recovery nearly seven months before a child's death from cancer; parents, on the other hand, did not come to that realization until about 3½ months before. Only about half the parents learned it in a discussion with the doctor.

The communication gap between physicians and parents is a major barrier to quality end-of-life care, pediatric specialists said.

No one at the hospital could bear to discuss death with Liza Lister. She had pressed her doctors: ''What will happen when I die? How will I know I'm dying?'' Her oncologist promised to let her know when death was imminent. But on the final night, as she lay in her mother's arms next to her father and older sister, and everyone knew the end was near, Liza asked, ''Why didn't the doctor call to tell me?''

The Listers were able to put together hospice care for Liza for the last three months of her life. But fewer than 10 percent of children who die in the United States receive such care, according to the National Hospice and Palliative Care Organization.

Palliative programs, focused on pain control and quality of life, are aimed at making patients comfortable rather than curing their disease. In addition to doctors and nurses who treat pain and other symptoms, counselors, social workers and spiritual advisers address the patient's emotional and developmental needs. The team also supports

the parents and siblings, and helps the bereaved family after the child dies.

A study published last year in the New England Journal of Medicine concluded that many children with cancer ''have substantial suffering in the last month . . . and attempts to control their symptoms are often unsuccessful.''

Researchers interviewed the parents of 103 children who had died between 1990 and 1997 and were cared for at Boston's Children's Hospital and the Dana-Farber Cancer Institute. Nearly half the children died in the hospital—half of those in the intensive-care unit. Overall, nearly 90 percent of the children suffered ''a lot,'' according to the parents.

Thirty years ago, when childhood cancer was generally fatal, ''we were experts in end-of-life care,'' said oncologist Joanne Wolfe at Dana-Farber, an author of the study. Today, 70 percent of patients survive. ''We have to turn our focus on the percent who are not cured,'' she said. ''We have to focus on palliative care.''

A more recent review of children who died in hospitals in Canada showed similar results. These children suffered from a range of conditions including AIDS, organ failure, cystic fibrosis, heart disease and cancer. Of the 77 patients studied, more than 80 percent died in the ICU and most were attached to tubes and ventilators. The children were rarely told they were dying, according to the report in the December issue of Journal of Pain and Symptom Management.

MOMENT OF DECISION

When a life-threatening illness is diagnosed in a child, most families start out with aggressive treatments.

Terri Wills, a single mom in the East Texas town of Newton, thought her son's swollen face was due to allergies. It turned out to be a rare, devastating kidney disease called focal segmental glomerulosclerosis.

Adam, 5, was treated with heavy doses of corticosteroids and other drugs. He gained weight from the drugs, his height was stunted, his moods were in flux. He lived for almost 10 years with his disease—and lived well, his mother said, pitching for his baseball team and trying not to ''let anyone see he was sick.''

In 1996, at the age of 12, Adam went into renal failure and had a kidney transplanted from his mother. The disease recurred almost immediately. A second transplant failed in 1998. At that point Wills and her son knew his death was inevitable. ''I'd rather he die on a bicycle than in the hospital,'' she told his doctors at the Children's Medical Center in Galveston, and she took him home.

For many other children, the prognosis is not so clear. Chronic conditions are highly unpredictable. Many formerly fatal diseases are now curable. Parents are naturally eager to give their child every chance for survival.

Derrick Csati, 9, of Angola, N.Y. has been battling brain cancer since he was 2. His first surgery lasted 17 hours. Since then, he's had several relapses and more surgeries, courses of chemotherapy and radiation, experimental therapies including monoclonal antibodies and a round of stem cell transplants.

He's now on his way to Duke University to receive another stem cell transplant, his fifth in the last year. His family has declared bankruptcy and his mother quit her job to stay with him.

The Csatis are supported with home care nurses and social workers from the Center for Hospice and Palliative Care in Buffalo. They have been on the brink before. Four years ago. Derrick relapsed with tumors invading his spine, causing horrific pain. They were offered several options; one was to stop aggressive treatment and make him comfortable. They chose instead an experimental regimen of chemotherapy and radiation. The tumors disappeared.

''He's had four years of quality life,'' said his mother, June Csati. Derrick goes to school and has a close relationship with his older brother, Ben. His mother knows ''we could always tell them we're done.'' But ''I keep the faith. I think he could pull this off. He's willing. He's not being hurt by this.''

''How can you stop? It's so worth fighting.''

THE PAIN FACTOR

For many families, the crucial decision of whether to treat aggressively or let go takes place in the pediatric intensive-care unit (PIC). Doctors and nurses on the front lines remember the hard cases: The teenager with aplastic anemia who was in so much pain she couldn't be touched. The 13-month-old who was born prematurely and stayed on life-support machines virtually all her life until the technology was turned off.

''I wouldn't put my own children through what we put children through here,'' said Ivor Berkowitz, Director of the PICU at Johns Hopkins. ''It is very wrong when you look at it in retrospect.''

But he quickly adds that each case is unique and that there are no overall guidelines on how to treat patients with advanced illness in an era of expanding biomedical options. Many children survive crisis that would be fatal for adults.

''At what point do you change your goals?'' Berkowitz continued. ''Where do we set the bar? This is the biggest struggle in the ICUs.''

''The discussions are hard,'' said cancer specialist Hildenof the Cleveland Clinic Foundation. ''Are we going to do experimental chemo for leukemia? Or shall we stop? Do you want to go on or off the ventilator? That's the down-and-dirty stuff. That's not a 10-minute conversation.''

Nor is it covered by insurance, Hilden noted. ''How politically incorrect is it to say I don't get paid to talk to parents about the death of their child?''

All the while, children with debilitating illness need the medical team to address symptoms such as fatigue, nausea, shortness of breath and depression.

Managing pain is difficult in children, especially in those who are not able to talk. Physicians get virtually no training in pediatric palliative care. Doctors and nurses watch for increasing heart rates, crying, agitation, irritability.

''It's very hard to tell what they're feeling,'' said physician Charles Berde, director of pain treatment services at Children's Hospital in Boston. ''The parents say, 'My child screams all the time.' Is the child screaming from pain or something else?''

''Pain is such a huge problem,'' remembered psychiatrist Elena Lister, who described her daughter's death in the March issue of the Journal of Pain and Symptom Management. Liza, who died four years ago, suffered severe bone pain even in her skull.

When Liza was in the hospital, one of the doctors raised the concern that narcotic pain medicines are addictive. ''To me—who the hell cares?'' said Lister. ''She is going to die. The pain is such an inhibitor for any remaining pleasure.''

CONTINUITY OF CARE

Several studies have shown that the involvement of the same physicians and nurses from beginning to end helps to minimize a child's pain and suffering.

''Continuity of care was key. To which I say, 'Duh?' '' said neonatologist Suzanne Toce, director of the palliative Footprints program at Cardinal Glennon Children's Hospital. Whether a child is cured or succumbs to a life-threatening condition, ''we need to integrate palliative care into mainstream medicine,'' said Toce.

Sometimes when parents want to stop aggressive therapies before their physician does, they have to change doctors—accelerating their sense of isolation and abandonment at a crisis point in the child's illness.

That's what happened to Kevin and Brandi Schmidt of St. Augustine, Fla. When their daughter Kourtney was 4 months old, she was diagnosed with a severe form of spinal muscular atrophy, a rare inherited disease. The Schmidts quickly learned that such children die within a year. As the muscles weaken, the child can't eat, swallow, cough, even breathe.

Kourtney underwent surgery to have a feeding tube inserted. She received extra oxygen to breathe. She was revived several times.

But the Schmidts did not want to put Kourtney on chronic ventilation. ''We went to see a little boy. He was 2 years old and hooked up to a machine. We couldn't see doing that to Kourtney,'' said Brandi Schmidt. ''We wanted her to have a better quality of life. We didn't want to do any measures that would only extend her life.''

The low-tech approach did not sit well with their physicians, especially the lung specialist. ''It was like all or nothing,'' said Schmidt. ''He wanted to take the big guns out.''

When the Schmidts refused to use more technology to take over Kourtney's breathing, the lung specialist withdrew from the case, ''I don't have the knowledge and experience to counsel the family,'' he said, and he recommended hospice care.

That meant the Schmidts had to find a new physician. The local hospice program was not geared to children. The hospice nurse was afraid to touch Kourtney. After negotiating a special arrangement with their health insurance, the Schmidts were able to keep their home care nurse and still receive hospice benefits.

Kourtney died in her parents' king-size bed. She was 8 months old. ''She wasn't in any pain,'' said Schmidt. ''It was very peaceful.''

FOCUS ON CHILDREN

In a national survey by oncologist Hilden, bereaved parents were asked what they most wanted from their doctors in a palliative care program. She summed it up:

''Tell us exactly what different options mean. . . . Some parents, for example, didn't know that patients could talk on a ventilator. . . . Tell us you can control pain, even at home. . . . Tell us that not pursuing curative therapy is okay. . . . Tell us the truth about prognosis. . . . Tell us you won't abandon us. . . . Tell us how to prepare for the funeral.''

The American Academy of pediatrics called last summer for regulatory changes in Medicare, Medicaid and private health plans to improve access to end-of-life services for children. Several comprehensive programs have been developed in such cities as St. Louis, Seattle, Buffalo, Boston and Baltimore. These programs offer supportive care from the time of diagnosis and follow some children for years. A study on end-of-life care for children is underway at the Institute of Medicine.

''We have to acknowledge that some kids are going to die,'' said Houston pediatrician Marcia Levetown, founder of the palliative Butterfly Program in Texas.

Research suggests that when children have an opportunity to discuss death, they are less anxious and feel less isolated from their parents and caregivers.

''What Liza taught us was not only can you talk about this, you must,'' said psychiatrist Lister. ''Otherwise, the child dies and there's never been a chance for intimacy.''

For many families, the intimate bonding that can occur during the dying process is what constitutes a ''good'' death.

Teenager Adam Wills of Texas lived another year and a half after the second kidney transplant failed. ''When I die, you wear hot pink or bright red,'' he told his mother. He got a new bike. He made friends at the dialysis center. Just before he died, he gave an elderly man at the center a harmonica. Then he ordered a lemon tree for his mom.

''He was saying his goodbyes,'' said Terri Wills. Adam suffered a massive stroke in October 1999, and was rushed to Children's Hospital in Galveston, where he died in his mother's arms in the Butterfly room. ''It was the most beautiful thing I've ever experienced,'' she said. At Adam's funeral, the elderly man from the dialysis center played the harmonica. Four months later, the lemon tree arrived.

Mrs. CLINTON. Mr. President, I urge my colleagues to oppose this amendment not only for all the reasons others have enumerated but for this very specific issue. We are at the beginning of work that needs to be done in hospice care and palliative care, and I would hate to see us turn back the clock before we really started the race to determine what we should do to care for those who are in the last stages of life.

I urge all of my colleagues to join me in opposing this amendment and to support the ongoing efforts to provide more pain relief, more palliative care and, yes, more comfort to those who are leaving this life.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, I want to make two points. One has to do with a colloquy that was underway when I had to leave to introduce someone in committee about moving to the Defense supplemental appropriations and an effort to tie limitation of amendments on this bill to that effort. I also want to address the underlying amendment.

It never ceases to amaze me that when we debate these issues, we talk all around the issue, but we never get to the heart of the issue and why it is important. We have 1,001 examples of terrible things that happen to good people, but we never talk about what is the issue.

Let me make it clear that I am going to vote for the pending amendment. I think there is a better way of fixing this problem than the way they fix it. I am working on what might hopefully be a compromise to fix the problem, but I want to be absolutely certain that it is clear to anyone who has any intent to be objective that there is a big time problem with the bill on this issue. Let me clearly define the problem.

The question is: For example, I have entered into a contract on behalf of my family with standard option Blue Cross/Blue Shield. I could have bought the high option, but I looked at cost and benefits. I made what I thought was a rational judgment, and I decided not to pay more to get the extra coverage. I made a decision, and it involved cost and benefits.

Every day in America, people enter into contracts to buy health care. Obviously, a big question in the bill before us is: Are those contracts binding? Are they binding on the purchaser of the health care? Are they binding on the seller?

As is usual with this bill, on page 35, gosh, it sure looks like they are binding. On page 35, line 14, it says in a bold headline: ''No Coverage For Excluded Benefits.''

Then you read on. It says:

> Nothing in this subsection shall be construed to permit an independent medical reviewer to require that a group health plan, or a health insurance issuer offering health insurance coverage, provide coverage for items or services for which benefits are specifically excluded. . . .

Gosh, it seems in this bill they are saying contracts are binding, but when you read on, as is true over and over in this bill, you find that exactly the opposite is true. When you read on, it says:

> . . . except to the extent that the application or interpretation of the exclusion or limitation involves a determination described in paragraph (2).

Then you go back two pages to find paragraph (2) and you find that paragraph (2) has to do with anything that is medically reviewable and anything that has to do with necessity or appropriateness.

Let me explain what this language says. This is a classic bait and switch. The language says that if something is precluded in a contract, it is not covered, except if it is medically reviewable—and all medical decisions are medically reviewable—and unless it has to do with ''necessity and appropriateness.''

What this provision actually says is the contract is not binding. The medical reviewer can determine that someone needs care, and even if it is precluded by the contract, the plan is required to provide it.

Gosh, that may sound wonderful to some people. Let's take the standard option Blue Cross/Blue Shield policy. I have a limit of 60 days in the hospital. Let's say I have the misfortune or someone in my family does that they are in for 90 days. The plan says you are not covered. I go before a reviewer and say: Look, I want the medical reviewers to determine as to whether I need this care or not. They determine I need it, they override the contract, and so I paid for the standard option Blue Shield policy, but I got the high option. Is that great and wonderful?

What do you think is going to happen when it is time for me to renew that insurance policy? What is going to happen is then I am going to have to pay for the high option. That is not going to be such a big deal for me because I can afford to pay the high option, but what about millions of Americans who cannot pay the high option?

If we let these external review committees decide what people need, independent of the contract they entered into to provide care—I got a lower price by saying I did not want heart and lung transplant services in my policy, and yet I come down with an acute heart problem and my physician stands up in front of this board and says, I am going to die if I do not get this surgery. Then the review committee says it is medically necessary and under this bill it is covered, even though my plan I paid for did not include it. The net result of this is to cause health insurance costs to skyrocket.

Also, if I am a health care provider as an employer and I have joined my employees in buying health insurance, now the contract is not binding, so the health insurance company obviously is going to want to change the amount they charge us because they are not going to have the protections of their contract.

I do not think the way we are doing this is the right way to do it. I think there is a cleaner way to do it. I hope to do it better later if this succeeds or fails, but this brings us to a fundamental question of this bill, and that is, Are contracts binding?

What we are saying in this bill is, no, not if they relate to health care. I think that is very dangerous. This is another reason, if we don't fix it, the explosive cost of this provision unfixed is greater than the liability cost about which we spent most of our time talking.

I hope my colleagues vote for this amendment.

Now the final point. Senator BYRD and Senator STEVENS were talking about the necessity of passing a supplemental for national defense. I am for this defense supplemental. I want it to come forward. I don't see why we can't do it tonight and get it over with, provide the money for national security. I know there will be one controversial amendment. I intend to vote against it; maybe some will vote for it. However, there is no reason that tonight we cannot settle this issue and vote first thing in the morning.

Several of the people who spoke on the issue suggested we will not be allowed to go to that defense supplemental bill unless we have set out a limit on amendments to this patients' bill of rights. I urge the majority leadership to not commingle this bill with the defense supplemental. It may well be that in the end we will reach compromises on the 6 to 10 major issues on which we will have to reach some accommodation to see the bill go forward. I am encouraged by the willingness of Senator MCCAIN to sit down and talk. I hope it is the beginning of a recognition that this bill is not perfect and it can be improved.

This morning when we voted down an amendment that exempted small employers with 50 or fewer employees

from this massive liability burden that they can be sued for simply helping their employees buy health insurance, I took that as a very bad sign for this bill. I have to congratulate the majority. Oh, that I could be in an army that had that kind of discipline. I can't imagine there is a city in America where Members could defend the provisions of this bill, which basically say that if you are covered by ERISA, you are subject to being sued as an employer for helping people buy health insurance.

There was an amendment that said just exempt the little employers because they will almost certainly have to cancel their health insurance if they are subject to lawsuit. I don't believe there is a city in America that any Member of the Senate could go into and successfully defend a vote against that provision. Yet that provision was defeated. I am afraid we are moving in the wrong direction in terms of building a consensus.

I want to see this bill completed. I don't think anybody benefits from holding this bill up. There are going to have to be certain accommodations. If we don't deal with some of these issues, the President will end up vetoing the bill, and what have we achieved? unless your objective is simply a political issue so one can say, well, we were for this bill, the President was against it, Republicans were against it.

If we really want to pass this bill, we are going to have to deal with the sanctity of contracts, we are going to have to come to grips with suing employers and the liability question, we are going to have to come to grips with scope.

If States have good functioning plans, should they be able to stay under their own plan or should they be forced under the Federal plan? There are a handful of issues that could be counted on your 10 fingers on which we will have to come to some accommodation.

My concern is, the clock is running. Today is Wednesday. Unless we begin to reach an accommodation on these issues, we are headed for a train wreck at the end of the week, and it is because of that I urge those in positions of leadership to please not try to tie stampeding Members on this bill, by limiting their rights to offer amendments, to passing a defense supplemental appropriation that I assume we are all for.

Why not pass this bill? I would be willing to pass it on a voice vote so it could be done tonight, get it over with, and then focus our attention on this bill. I hope we don't have an effort to tie limiting our rights on this bill to even bringing up the defense supplemental. If that happens, the net result will be the defense supplemental will not be brought up. No one will benefit from that. It is not good public policy. I urge the two not be tied together.

I yield the floor.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. I will respond to the plea from my friend from Texas, his plea that we finish this bill. No one wants to finish this bill more than the authors of the bill, Senators MCCAIN, KENNEDY, and EDWARDS. They have been working to compromise; they have been working with Republicans. That is the reason we are winning these votes on amendments, because we are getting Republican and Democratic votes and carrying the majority. We also want to finish this bill and do things the right way.

Why do folks stand up and talk about issues that are already taken care of in this bill? I know there is a disagreement on the fine print. That is what the frustration level is. I hope my friend will work with Senator SNOWE as she seeks to craft a bipartisan amendment dealing with the employer liability.

Right now, as I read the bill, employers do not have liability; they cannot be sued unless they personally make the decision to withhold care from the patient. Most employers do not do that. They contract with providers, and those providers will be held responsible.

I find it very interesting that my friends on the other side of the aisle—most of them, certainly not all of them; and we are happy to have Senator MCCAIN and other Senators joining with us on many of these amendments—I find it intriguing that they keep talking about these poor HMOs and insurance companies. We know, and we have said it a number of times, all we want is to see HMOs treated the same way in our society as we treat every other business, every other individual. If any of us goes outside this Chamber and we knock into someone and we hurt them, we are responsible. We are held accountable if it was our fault.

The reason we have the safest products in the world is that we have the toughest liability laws and they act as prevention. People make safe products, one, because most of them in their hearts want a good, safe product. But we have harsh laws if you intentionally hurt someone. If the brakes on the car don't work, if the crib bars are too wide, wide enough so a child can be strangled, we have laws on the books. All we are saying to HMOs is, if you in fact hurt people, you should be held accountable as well.

Members can stand up and pick apart one sentence in the bill, but the fact is this debate goes much deeper. It is not about paragraph 1 on page 2; it is about the essence of what we are trying to do. Do patients deserve care that is prescribed by their physician or should they be at the mercy of some accountant wearing a green eyeshade saying, no, that is money we cannot spend because our CEO will not make his $200 million this year.

Patients deserve to have their care prescribed by physicians. Certainly, physicians are making that statement to us, and almost every group in the country, and certainly every respected group, makes those decisions to support the McCain-Kennedy-Edwards bill. Patients deserve to be able to know their doctor is taking care of them. You would not go to a doctor to get a tax form filled out; you would not go to an accountant to get your health care. We should keep medicine with the people who went to school, with those who know what good care is, and we should keep the bean counting and the bookkeeping with the people with the green eyeshades; they don't have white coats. I would rather go to someone in a white coat if I am in trouble and need a course of treatment.

Do patients deserve the medications the doctor prescribe? The HMO says: We have another one we can substitute. If the doctor believes you need a certain medication, you should have it.

Do patients deserve to get into a clinical trial if, in fact, they have no other recourse? Absolutely they do. That is why the McCain-Edwards-Kennedy bill is so important.

Let's face it; HMO executives are making millions of dollars while denying needed care to our people. This is about who you stand up for, who you fight for. I have many stories.

I ask the Chair what is the order now? It is 1 o'clock.

The PRESIDING OFFICER (Mr. WYDEN). The Chair advises that the Senator from Tennessee is expected to be recognized to offer an amendment.

Mrs. BOXER. I will yield then in 1 minute, if I might, and leave the floor at that time. But I want to sum up.

On Monday morning early I held a hearing in San Francisco. I had patients and families of patients testify. I had doctors testify. I heard stories that absolutely brought tears to my eyes—not just to my eyes but to those of everyone in that room.

No. 1, a husband whose wife was diagnosed with breast cancer had to literally put his work aside. He is in his 50s. He had to fight for her to get the treatment she deserves and needs because the HMO was trying so hard to save money. He had to threaten to go to the Los Angeles Times and tell his story—threaten—in order to get the care she needs.

I had the mother of a little girl who was diagnosed with cancer in her eyes. She had to struggle and fight. She said: I gave up everything else I was doing. I could not be with my daughter.

This is wrong. Senators can offer amendments until the cows come home and I know one thing: It is delaying passage of this bill. It is delaying the chance to vote on a strong Patients' Bill of Rights.

Bring your amendments on. We are voting them down, most of them. If some of them are good, we will support them. But we want a strong Patients' Bill of Rights that says to our people: You are paying for this care. You deserve this care. If you are turned down for care, you deserve the right to a

speedy appeal, and then for sure we want to hold the HMOs accountable if they hurt you or your family. We say: Treat them as we would anyone else in society.

I am grateful for the honor to speak on behalf of the underlying bill. I yield the floor.

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

AMENDMENT NO. 819

Mr. THOMPSON. Mr. President, I do intend to offer an amendment shortly. I believe it is being finalized as we speak. We will have that before the Senate in a moment.

Listening to the debate, listening to the discussion this morning, I am once again reminded of what passes for policy discourse nowadays. I was reminded of the article that was written by David Broder in the Washington Post yesterday. Mr. Broder is obviously one of the most respected members of the press corps. Some refer to him as the dean. He is certainly not right of center. I don't know what you would call him except a very thoughtful, highly respected individual.

As I listened to this debate this morning, I thought a few of his words would be appropriate. He says this:

> The Senate debate over the Patients' Bill of Rights has become, in large part, a battle of anecdotes. . . . Backers of the Kennedy-McCain-Edwards bill, the sweeping legislation President Bush has threatened to veto, come armed each day with stories about the youngsters whose brain tumor was missed because an HMO denied his parents' request for a specialist referral or the mother whose breast cancer was ignored until it was too late.

Mr. Broder goes on later in the article and says:

> Would that the issue were that simple and straightforward. But it is not. Anecdotal evidence, no matter how powerful, gives no guidance to the scope of the problem being addressed.

Later on in the article he says:

> Still less do the anecdotes define the proper remedy. Instead, by narrowing the question to dramatic horror stories, they pull the debate away from the genuine policy tradeoffs that must be made.

I could not agree with him more. The incessant recounting of horror stories and the using of these poor and helpless people as instruments in this debate, indeed, pull us away from the genuine policy decisions that have to be made.

I would like to discuss one of those briefly this morning. That is the subject of the amendment I intend to introduce. It has to do with the exhaustion of administrative remedies.

That sounds to be an arcane legal issue that should not be of much interest to very many people. I think the contrary is the case. Basically what the exhaustion principle is saying is that under the law, generally speaking, if you have a remedy before you get to court, go ahead and use it before you go to court. The importance of that principle of exhausting your administrative remedies—going through the administrative process before you leap to court—is firmly embedded in our system. We see it working all the time with regard to run-of-the-mill kinds of lawsuits.

We have lawsuits in State court where you have to go through a commission or some body or some bureau has a chance to make a determination—usually because that entity has some expertise in the area. We give the entity, under looser rules of evidence and a lot less expense for litigants, an opportunity to take the first pass at this problem. In the process of doing that, a lot of things shake out, a lot of frivolous claims are made obvious and are dropped at that level. A lot of times the merits of a particular claim are seen and the State or whoever it is—oftentimes it is in the State system—sees that and they settle.

It is designed to have someone with some expertise, some objectivity, hash out the facts in a way that would be much faster than a court system, much less expensive than a court system, and would be to the benefit of everyone involved. It still doesn't mean you can't go to court later, but a lot of things get winnowed out in the process.

We know how clogged up our court systems are in many cases. In our Federal system, under the speedy trial act, the courts have to consider all the criminal cases first. With all the drug cases we have in Federal court and everything else, sometimes in some jurisdictions it takes a long time to get your case heard in the Federal court system. So this administrative process before you ever go to court, in winnowing those cases down to the ones that really belong in court and providing expedited expertise to the litigants, is very important.

In our system, also, when we go through that process and we get that determination made by those who have the first look, so to speak, with the expertise, then you give some credence to what they found. Then you can go to court, but you do not turn your back on the fact that this process has been followed and they came up with a certain result. The court can live with that result, usually, or it doesn't have to if it doesn't want to. But it is out there and it has served its purpose.

That is the general, overall system we have through our system. Not everything goes through this administrative process before it goes to court, but a lot of things do. This Health Care Bill of Rights we are considering today does that.

It sets up independent decision-makers to consider these claims in a rather elaborate and detailed way before they ever get to court. The process that is set out in this bill is a good one. It sets forth a several-step process where experts who are independent and objective have a chance to take a look at a claim. We all know, with as many horror stories as are paraded around here by those who support this bill, that we cannot cover everything, all the time, for everybody, at any cost whether or not it is in the plan or it is something you have contracted for or something your employer covers or not.

If we did that, the cost would be so high that nobody could afford insurance, and nobody would be covered for anything. So it is a tradeoff. It is the kind of tradeoff that David Broder is talking about. Yes, we want these pitiful people to have coverage, but we also want to have it so that people are not totally driven out of the market because the cost doesn't match the benefit for the amount of money they expend.

That is the process and the balance that we are trying to achieve.

We got into the health care business because the medical costs were going up at almost 20 percent. We created their managed care system. We like to deride it now, but we created it because health care costs were going up at almost 20 percent and we tried to respond to that.

Assuming that, if it is not in the plan, if it is not in the deal, and if it is not in the contract, there will be some cases that are legitimately, after being looked at by all experts, not appropriate, this bill assumes there will properly be some cases that are not. If you are going to have some that aren't and some that are, what do you do? You set up a process to find out what is just. You set up a process to find out what is right.

How do you do that? This bill does a lot of things. It has an internal review process. It is an internal process, first of all, to even grant or deny a claim.

Let's say under the plan that someone comes in and their claim is denied. Maybe they haven't worked there long enough. Maybe they don't even work there at all. Maybe a determination is made that this is not a medical procedure that is covered or it is experimental. For whatever reasons, there are many cases that are denied.

Under this bill, there is a process to review that denial, even at the internal stage when the employer still has some say-so with regard to some of these plans. Especially even at that stage, this bill begins to set up expertise and objectivity.

At the internal review level, it says the person making that review cannot be associated with the prior decision. He has to be someone who is independent of that prior decision. It also says it has to be someone with expertise. It also says if it is a medical issue, it has to be a physician.

Even before we get to the external review, while it is still an internal review, this bill sets up expertise and independence in the process to make sure this claim is adjudicated or decided in an appropriate manner. All right. You go through that.

Let's say the claim in this external review process is still denied. This person denies the claim. Then, under this

bill, there is an external review process. At this stage of the game, the person is totally independent of the plan. The legislation demands that he be totally independent, that he have expertise, and that he have nothing to do with the plan or the employers or anybody else. The bill spent several pages of setting up a procedure whereby he is objective and independent.

The Secretary here in Washington has authority to review what he is doing and to look at the cases he has considered to make sure he is not prejudiced in any way, where it looks as though maybe he is denying too many claims or something such as that. There are elaborate processes to make sure this external appeals process is fair, independent, and objective. All right.

Let's say we go through that level. Let's say that entity decides that there is a medical issue. Then they hand it over to yet another level of independent review. That is the independent medical review.

Once again, the bill sets up someone who is totally independent, totally objective, sets forth supervision by the Secretary, and sets forth how he is to be compensated to make sure he is well qualified.

That is the third level, you might say, in terms of some degree of independence and objectivity—totally at the last two levels and somewhat at the first level.

You have the internal review; you have the external review; and you have the independent medical review—all set up to make sure that someone who comes with a medical claim gets fair consideration, and you don't have these big, bad, mean HMOs that we hear so much about making these decisions. They are not. These people are under this act.

What we do, and what we say in this amendment that I am going to submit is, let's use it. What I have just described, let's use it.

After setting up this process that ought to be used because it is a good process, this bill also says it can be circumvented at any time. It can be. A claimant can stop it if he doesn't like the way things are looking and go to court by alleging that they have received irreparable injury or damage—not that they are about to but that they have received it.

There are two things wrong with that: No. 1, you obviously lose the benefit of the administrative process. For example, part of the problem could be or may be the sole problem could be a question of coverage. You have this process set up. You are maybe in the middle of it. Why not just decide whether or not you are really covered under this bill? It is a factually intensive exercise under this plan: how long you have been working here, and that sort of thing.

The second thing that is wrong with the bill as it is now, and allowing them to circumvent this process that I have discussed by alleging irreparable injury—they do not use the word ''allege,'' but it is the same thing. The only way you can get into court is by ''alleging.'' That is the way you get into court. It is a low threshold.

You can circumvent this plan at any time, or this process at any time along the way.

The second thing wrong with it is it doesn't have a claimant in it because we are talking about money damages. To circumvent this process in order to allow a claimant to go over here in the middle of it and file a lawsuit for money damages, all he is doing is getting in line over at the courthouse. He doesn't get any expedited treatment for that. It doesn't help him. Why would you do that when you are in the midst of this, admittedly, excellent, objective, costly administrative process?

I don't think that it makes any sense. Costs are relevant because it is going to show up in somebody's price for insurance.

This plan costs money. This process is expensive to set up. If you are going to have it, you ought to use it. Of course, if the result goes in the claimant's favor, it is binding on the plan. But if the results of the independent process go against the claimant, then of course he can go to court.

But my problem this morning or today is not that he can go to court. It is that he can go to court before he exhausts administrative remedies.

My friends who oppose this—I am going to anticipate this a bit because we have had some prior discussions about this. Some of my friends have pointed out that there obviously can be a need from time to time for emergency care. What if you are in the midst of this process and you have some kind of an emergency situation that ought to justify your circumvention of it?

My first answer is, the bill, as drafted now, is not going to help any claimant with regard to an emergency because, as I say, we are talking about money damages. All he can do is file a lawsuit. If that makes him feel better, 2 years later he may get into court to try his case. That might help him. But other than that, that is not going to help the person with some kind of an emergency.

What will help that person, though, is in this bill. It is already provided for. In the first place, you have a provision that is in ERISA, that we adopt in this amendment, that says you have all of the coverage that is given under ERISA, which allows you to go into court at any time to recover benefits that are due you, to get a mandatory injunction or to whatever you might be entitled under ERISA, under current law. That remains. That will be the same. We have adopted that and made that clear in this bill.

The second thing is, under section 113 of the bill, the claimant has access to emergency care. There is a provision in the bill that if you have an emergency—of course, the general law requires hospitals to take care of you anyway, but if it is an emergency-type situation, under this bill already, under section 113, an emergency is taken into account.

What if you have a situation that is not an emergency, not an immediate thing, but you do not want to go through the administrative process for just and reasonable reasons? What kind of situation could that be?

That could be a situation in the middle that is not an emergency but maybe you are entitled to an expedited review or determination. There is a provision in the bill that covers that situation also, under section 103 on internal appeals.

At the internal appeals level, if the initial claim is turned down and if a person believes they are entitled to an expedited determination, even at that level, they can go forth and pursue that. Then, at the next level, at the external appeals level, if they believe they are entitled to an expedited determination, if a physician certifies that they are entitled to expedited consideration—at either of those levels—they can get that. So the claimant is covered.

The claimant is covered under those situations, which allows us to go back to the basic legal proposition that I mentioned in the very beginning in relation to the exhaustion of the administrative remedies, which work so well in so many aspects of our judicial system, which is set up under this bill but then has massive carve-outs. That process should be allowed to work.

There is one other point in this amendment, and then I will offer it; and that is, after you go through this process, after you exhaust your administrative remedies, after you go through the internal appeal, the external appeal, the independent medical review, and after you get a result—whatever that result is—the trier of fact, when you go to court, ought to know about that result. It is not determinative on the trier of fact—whether it be the judge or the jury in the court—but it is relevant.

If you are not going to do that, you are really wasting a whole lot of time, money, and expertise and creating additional problems for yourself in terms of cost in reaching a just result. So that is what it does.

I think we all agree we want doctors making medical decisions. When these claims are made, in this review process, if it is a medical claim, doctors are going to be making that medical decision. But if you do not like it, then you can go to court. But let that doctor, let that independent, qualified physician make the first determination before you go to court.

Are we so desirous of speeding everything to court, with the attendant costs that we know are going to come about? And these are not costs to some HMO, these are costs to the American

people. We have 44 million people who already are uninsured in this country. Even if we add just 1 million to the uninsured in this country because of what we do here, that ought to bother us. We should not be in the business of doing that.

So let's let doctors make that initial determination instead of lawyers. This is one of those issues that is doctors versus lawyers.

If you want to go to court, if you want to rush to court at any time in the process, regardless of what has happened—regardless of whether or not anybody independent has had a chance to look at this—you are going to decide, with a lawyers' bill, to do that. The way it is constructed right now, you can sue anytime, for anything, in any amount. We can discuss those issues later.

But with regard to this issue, exhausting administrative remedies, let's let the doctor, let's let the medical people have the first crack at it. Who knows. When we get that result in, it might resolve a lot of these potential lawsuits.

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

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Tennessee [Mr. THOMPSON] proposes an amendment numbered 819.

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

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

The amendment is as follows:

(Purpose: To require exhaustion of remedies)

On page 150, strike line 17 and all that follows through page 153, line 8, and insert the following:

''(9) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—A cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102 and 103 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

''(B) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) or paragraph (10)(B), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met.

''(C) RECEIPT OF BENEFITS DURING APPEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

''(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

''(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

The court in any action commenced under this subsection shall take into account any receipt of benefits during such administrative processes or such action in determining the amount of the damages awarded.

''(D) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 103 of the Bipartisan Patient Protection Act of 2001 shall be admissible in any Federal court proceeding and shall be presented to the trier of fact.

On page 165, strike line 15 and all that follows through page 168, line 3, and insert the following:

''(4) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—A cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102, 103, and 104 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

''(B) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) unless the requirements of subparagraph (A) are met.

''(C) RECEIPT OF BENEFITS DURING APPEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

''(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

''(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

''(D) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 104 of the Bipartisan Patient Protection Act of 2001 shall be admissible in any Federal or State court proceeding and shall be presented to the trier of fact.

Mr. THOMPSON. Mr. President, the amendment has been offered. I have made my statement. I hope we have adequate time to deliberate with regard to this important amendment.

I yield back my time and yield the floor.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. TORRICELLI. Mr. President, during my nearly 5 years in the Senate I have heard the debate of managed care reform many times. I have participated in repeating statistics, engaged in legal analyses, participated in political analyses, all of which convinced me a long time ago of the need for this Patients' Bill of Rights.

But there is no substituting that which many of my colleagues have brought to this Chamber; that is, the life experience of American families with the system as it is currently designed and how it has dealt with the tragedies of their own lives.

Many of my colleagues have brought the experiences of frustrated families: People who get up every morning, go to work, pay for medical insurance, and participate in a managed care plan, only to find that in a moment of crisis in their own families, that which they purchased, that which they have relied upon, was not available to them.

As do my colleagues, I want to now share with you just two stories that give meaning to all the statistics and illustrate all the failures of the system.

I begin with Kristin Bollinger, a young girl from Spottswood, NJ. Kristin's experiences illustrate some of the troubling practices of HMOs and how ineffective and unresponsive they can be in dealing with the needs of a child who requires long-term care when chronically ill.

Kristin suffers from a unique condition of seizures and scoliosis, both of which can be managed with proper treatment and care. Her family was forced in an HMO by their family's employer in 1993. Kristin's parents have been fighting to ensure their daughter receives specialized services ever since.

The HMO told Kristin's family she could no longer see a pediatrician and the specialists who had treated her all of her life. From birth, she had this condition. She saw a certain specialist, received specialized care. When Kristin needed to see a neurologist and other specialists, her parents had to pay for the specialists because they were not in her managed care plan. After a major surgery in 1997, Kristin's specialized nursing care was canceled without notice. She wasn't even told. The HMO even discontinued coverage for physical therapy because it was deemed medically unnecessary.

Eventually, after fighting months and even years, the care was restored. But here is a family dealing with repeated seizures, a child who was not able to function, massive medical bills, although they were in a managed care plan, an inability to get the specialists who were deemed medically necessary, and they had to fight their way back to coverage while caring for a child—case in point.

What would have worked? First, a right to get to a specialist; second, after you have been receiving care from a specialist and your plan changes, the right to keep the specialist; third, when you are denied the right to an appeal, for someone without an interest to hear your need where you can explain the need. In three important ways, this Patients' Bill of Rights would have addressed Kristin's problem and dealt with the problem of her family. None of those three rights exists in law, and so she was failed three times.

Second, Morgan Earle, a 10-year-old from Chatham, NJ, born with cortical dysplagia, a devastating developmental

brain injury that causes severe seizures. Morgan's parents, like any parents, were unprepared for dealing with the care of an infant experiencing these seizures—sometimes every 6 minutes—making it impossible for her to even eat or sleep.

When Morgan was 3 months old, her parents sought treatment from a team of pediatric neurologists and neurosurgeons to develop a strategy for dealing with Morgan's lifelong medical needs. By the time she was 8, Morgan had endured extensive tests, clinical trials, and two major brain surgeries.

Through the unbelievable genius of medical science, her team of specialists reduced her seizures that were interrupting her life. But in 1999, one of the specialists who headed Morgan's medical team, through changes in his own career, abruptly transferred to another hospital in Chicago. Morgan's parents were shocked to learn that the specialists selected by her new medical team were not part of the HMO. Throughout her life, she had relied upon these same doctors. Medical science had found a way to control these continuing seizures that were interrupting her own life and the life of her family. She had found an answer. But the new team was not part of her managed care.

Imagine the frustration, that the genius of medical science found a way to deal with the suffering of your child in continuous seizures only to find that now you could not avail yourself of it.

Morgan's parents appealed the decision to the HMO. They were denied. Doctors wrote that they and only their specialists could provide an answer. They were denied. In fact, the doctors report their letters weren't even answered.

The HMO provided Morgan's parents instead with a list of in-network specialists. They were not even board certified. They could not perform. They were not capable. They could not even understand the kind of medical care Morgan was receiving.

Last Friday, after 2 years of fighting an appeal, Morgan's parents received a two-sentence e-mail from her HMO that her original specialists, the doctors they had requested, would now be covered—2 years, no money, no care, no answers. It isn't right. It is not a system that anyone in this Chamber can defend, to Kristin, to Morgan, to her parents, or to millions of other Americans who are paying for this managed care or whose employers are paying for it, believing they are covered, and tomorrow morning they are but a single tragedy in life away from Morgan's or Kristin's experience. It could be anyone in this Chamber. It could be anyone we represent. That is what this legislation is about.

It is not a gift. It is not some benefit provided by the larger society, as if that in itself would not be right or fair. It is something that has been earned and paid for, but it is not being provided. That is why we call it a Patients' Bill of Rights. It is not a gift. It is a right. It is a contract. And it is our responsibility to provide it.

That is what this legislation is about:

One, ensure that patients with disability conditions have standing referrals to specialists so they don't have to get permission; the 2-year wait of suffering and bills and lost care never happens.

Two, allow patients in these circumstances to designate a specialist as their primary care doctor. It is right, and it is efficient.

Three, require HMOs to allow access to out-of-network specialists, if in-network specialists are inadequate, at no cost. It just makes sense.

Four, ensure that chronically ill patients can keep their doctors even if they are forced to change plans or their doctors leave the HMO. That is not only right and fair; it is just not being cruel to patients and children in these circumstances.

The truth is, the alternative Republican plan does not allow these decisions to be made by patients and doctors. It means that an HMO that does not have a pediatric neurologist can force a child to see someone who is not trained or capable.

What are the costs of all this? If you take this one element of the Patients' Bill of Rights I have addressed, just this one narrow, critical element for the chronically ill who need these specialists and a continuum of care, if you just take this small element I have addressed, CBO estimates that it would add .2 percent to the cost of insurance.

Is there a family in America, given these circumstances, who would not bear that burden? Is there an employer in the country that would not want their employees to have this peace of mind in coverage, just knowing that what they are already purchasing might now be relevant and available in a moment of need?

Mr. President, I have participated in this debate over these years. I have offered the statistics. I have offered the case. I have argued the politics. I have discussed the merits. I have reviewed the bill. Now I submit Kristin and Morgan's cases as the most compelling cases of all of why there is only one piece of legislation available on this floor that truly addresses these circumstances. It is offered by Senators KENNEDY, MCCAIN, and EDWARDS.

The case is overwhelming, and I urge my colleagues across the aisle to join us. They will be proud and pleased that they did it.

I yield the floor.

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

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant bill clerk proceeded to call the roll.

Mr. KENNEDY. 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. KENNEDY. Mr. President, for the benefit of our colleagues, we are now still committed to voting at 2 o'clock on the Nelson amendment which we debated earlier today. We will then return to a conclusion of the Thompson amendment. We just saw that amendment a short while ago, and we are trying to study that more closely.

After the completion of the vote on the Nelson amendment, we will be able to indicate to Members when we will either vote on or dispose of the Thompson amendment.

There has been a proposal made to our colleagues on this side for votes going through the afternoon and times allocated to the different amendments and then into the evening, also being sensitive to the needs of our colleagues on the other side of the aisle for a window, and then returning to the Senate for consideration of legislation.

Hopefully, at the end of the vote at 2:30 p.m., we will be able to give the Members a clearer idea both of the substance and the time for moving the process along. We have had good debates on these issues to date. We still have work to complete on the issue on medical necessity. Also, our colleagues, Senators SNOWE and DEWINE, held a press conference at 11:30 this morning on their proposals, which hopefully we will consider later this afternoon, to tighten up language in the area of employer liability. We are familiar with the thrust of the proposal. It seems to be extremely valuable and helpful in resolving some of these issues.

We will move on hopefully to the issues of scope later in the afternoon and into the early evening.

This is how we hope to proceed. We are never sure until the actual proposal is made, but we want to give assurance to Members we are making progress, and we will continue to move as rapidly as we can on the measure.

Again, the liability issue will be the last outstanding issue. There is still no consensus on that particular proposal. We will consider the alternatives in a timely way and hopefully be able to conclude the legislation in a timely way as the majority leader has stated.

I thank all of our colleagues for their cooperation. These have been good substantive debates. We have had very few interludes. A number of our colleagues welcome the opportunity to express their views on the legislation, and we will try to accommodate as best we can when we see the opportunity to have a focused debate on a particular subject matter and dispose of that matter in a timely way. I thank all of our colleagues.

At the conclusion of this next vote, which we expect will start in just a very few moments, we will then have further news for Members.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant bill clerk proceeded to call the roll.

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

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

VOTE ON AMENDMENT NO. 818

Mr. McCAIN. Mr. President, I move to table amendment No. 818 and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll.

Mr. NICKLES. I announce that the Senator from North Carolina. (Mr. HELMS), is necessarily absent.

The PRESIDING OFFICER (Mr. ENSIGN). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 54, nays 45, as follows:

[Rollcall Vote No. 200 Leg.]

YEAS—54

Akaka	Dodd	Levin
Baucus	Dorgan	Lieberman
Bayh	Durbin	Lincoln
Biden	Edwards	McCain
Bingaman	Feingold	Mikulski
Boxer	Feinstein	Miller
Breaux	Fitzgerald	Murray
Byrd	Graham	Nelson (FL)
Cantwell	Harkin	Reed
Carnahan	Hollings	Reid
Carper	Inouye	Rockefeller
Chafee	Jeffords	Sarbanes
Cleland	Johnson	Schumer
Clinton	Kennedy	Snowe
Conrad	Kerry	Stabenow
Corzine	Kohl	Torricelli
Daschle	Landrieu	Wellstone
Dayton	Leahy	Wyden

NAYS—45

Allard	Enzi	Nelson (NE)
Allen	Frist	Nickles
Bennett	Gramm	Roberts
Bond	Grassley	Santorum
Brownback	Gregg	Sessions
Bunning	Hagel	Shelby
Burns	Hatch	Smith (NH)
Campbell	Hutchinson	Smith (OR)
Cochran	Hutchison	Specter
Collins	Inhofe	Stevens
Craig	Kyl	Thomas
Crapo	Lott	Thompson
DeWine	Lugar	Thurmond
Domenici	McConnell	Voinovich
Ensign	Murkowski	Warner

NOT VOTING—1

Helms

The motion was agreed to.

Mr. KENNEDY. I move to reconsider the vote.

Mr. KYL. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, it is our understanding that the Senator from Arizona is going to offer an amendment at this time on behalf of a number of our colleagues.

Hopefully, we can have order, Mr. President. This is a very important amendment.

The PRESIDING OFFICER. The Senate will be in order.

The Senator from New Hampshire.

Mr. GREGG. Mr. President, I ask unanimous consent that the pending Thompson amendment be laid aside without prejudice so that the Senator from Arizona may proceed.

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

The Senator from Nevada.

Mr. REID. Mr. President, it is my understanding that the Senator from Arizona would agree to an hour of time evenly divided on his amendment.

Is that right?

Mr. McCAIN. That would be agreeable. But I think we can do it in a shorter time than that, depending on the view of the Senator from New Hampshire on the amendment.

Mr. GREGG. I am not sure I have seen the amendment.

Mr. McCAIN. I say to the Senator, I will get it to you right away. Why don't we do that.

Mr. REID. I would also say, it is my understanding, having spoken to all the managers, that Senator SNOWE of Maine is ready to offer the next amendment, whenever the time arrives that we complete this McCain amendment.

Mr. BYRD. Mr. President, would the distinguished Senator from Arizona yield to me so I might ask a question without his losing his right to the floor?

Mr. McCAIN. I am always pleased to yield to the Senator from West Virginia.

Mr. BYRD. I thank the Senator.

The PRESIDING OFFICER. The Senator from West Virginia.

SUPPLEMENTAL APPROPRIAITONS

Mr. BYRD. Mr. President, earlier today the distinguished Senator from Alaska, Mr. STEVENS, and I entered into a colloquy with several other Senators here anent the possibility of reaching an agreement on the amendments that would be considered at such time as the majority leader calls up the supplemental appropriations bill. I have asked the distinguished Senator from Arizona to yield for that purpose again.

I wonder if it might be possible at this point to get an agreement, or at least to get ourselves on the way to an agreement, that would limit the number of amendments to be called up to the supplemental appropriations bill to those amendments that we have ascertained are out there via the hotline in the Cloakroom and a managers' amendment, the contents of which Senator STEVENS and I are ready to reveal to any Senator who wishes to know what is in the managers' amendment.

May I ask, with the permission of the Senator from Arizona—I am about to lose my voice for the second time in 83 years—the distinguished majority leader for a reaction to this request?

Mr. DASCHLE. Mr. President, I appreciate the chairman's concern for moving the process along. And since we discussed this matter this morning, we have issued a hotline request for amendments. We have now received the response. A number of Senators have indicated a desire to ensure that they have been included in the managers' amendment. Once that confirmation can be made, I think on our side we would be prepared to then enter into a unanimous consent agreement which would take on or schedule the debate with an appreciation for a managers' amendment and a designated list of amendments that could be accommodated.

So we are just about at a position where I think a unanimous consent request could be propounded. If Senators could just check with the distinguished senior Senator from West Virginia and the Senator from Alaska to ensure that the managers' amendment is as it has been reported to them, we will be able to move forward.

Mr. BYRD. Mr. President, I thank the distinguished majority leader. I wonder if we can't set the hour of 3 o'clock as the time when the majority leader could propound a request in this regard.

Mr. DASCHLE. Mr. President, I would be happy to attempt to propound an agreement at 3 o'clock and see what happens. No harm done in making the effort.

Mr. BYRD. Yes. The distinguished Republican leader has already indicated his strong support for such an effort.

So I thank the majority leader. And I thank the distinguished Senator from Arizona for yielding.

The PRESIDING OFFICER. The majority leader.

Mr. DASCHLE. Mr. President, just to clarify, I would be happy to enter into a unanimous consent agreement that would limit the number of amendments and provide for an understanding about how the supplemental would be addressed. But, of course, we cannot schedule the supplemental until we have completed our work on the Patients' Bill of Rights. I know the senior Senator from West Virginia understood that.

Mr. BYRD. Yes, I do.

Mr. DASCHLE. But I wanted to clarify that for the sake of anybody who may have misunderstood.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arizona.

AMENDMENT NO. 820

Mr. McCAIN. Mr. President, I have an amendment at the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Arizona [Mr. McCAIN], for himself, Mr. BAYH, Mr. CARPER, and Mr. EDWARDS, proposes an amendment numbered 820.

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

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

The amendment is as follows:

(Purpose: To clarify that nothing in the bill permits independent medical reviewers to require that plans or issuers cover specifically excluded items or services)

On page 36 line 5, strike ''except'' and all that follows through ''(2)'' on line 8.

On page 62, between lines 10 and 11, insert the following:

(V) Compliance with the requirement of subsection (d)(1) that only medically reviewable decisions shall be the subject of independent medical review and with the requirement of subsection (d)(3) that independent medical reviewers may not require coverage for specifically excluded benefits.

On page 62, line 20, after the period insert the following: ''The Secretary, or organization, shall revoke a certification or deny a recertification with respect to an entity if there is a showing that the entity has a pattern or practice of ordering coverage for benefits that are specifically excluded under the plan or coverage.''.

On page 62, between lines 20 and 21, insert the following:

(vii) PETITION FOR DENIAL OR WITHDRAWAL.—An individual may petition the Secretary, or an organization providing the certification involves, for a denial of recertification or a withdrawal of a certification with respect to an entity under this subparagraph if there is a pattern or practice of such entity failing to meet a requirement of this section.

On page 66, between lines 10 and 11, insert the following:

(5) REPORT.—Not later than 12 months after the general effective date referred to in section 401, the General Accounting Office shall prepare and submit to the appropriate committees of Congress a report concerning—

(A) the information that is provided under paragraph (3)(D);

(B) the number of denials that have been upheld by independent medical reviewers and the number of denials that have been reversed by such reviewers; and

(C) the extent to which independent medical reviewers are requiring coverage for benefits that are specifically excluded under the plan or coverage.

Mr. MCCAIN. Mr. President, I say to the Senator from New Hampshire, I hope he and his people will examine this amendment. I apologize for not getting it to him sooner. Perhaps we could agree on this amendment and not have to have a rollcall vote.

Mr. KENNEDY. Would it be agreeable to have an hour, so we could get——

Mr. MCCAIN. Mr. President, I ask unanimous consent that there be 1 hour on this amendment evenly divided.

I withhold my unanimous consent request.

Mr. GREGG. Reserving the right to object, in just a minute I believe I will be able to respond.

Mr. REID. I did not hear the Senator.

Mr. GREGG. I said, I believe we will be able to respond to the Senator in about a minute.

Mr. MCCAIN. I thank the Senator.

Mr. President, concerns have been raised that under this legislation, independent medical reviewers can order a health plan to provide items and services that are specifically excluded by the plan's contract.

The amendment I am offering clarifies that the bill does not do this, and that specific limitations and exclusions on coverage must be honored by the external reviewers.

There are a numerous safeguards already in the bill to ensure that external reviewers cannot order a group health plan or health insurer to cover items or services that are specifically excluded or expressly limited in the plain language of the plan document.

First, the external review entity who is responsible for determining which claims require medical review and which do not, may refer claims to independent medical reviewers only if the coverage decision cannot be made without the exercise of medical judgment.

I repeat: The external review entity, the one that is responsible for determining which claims require medical review and which do not, may refer claims to independent medical reviewers only if the coverage decision can't be made without the exercise of medical judgment. For example, the plan document says that the plan doesn't cover heart transplants. Even if the patient has no other treatment options, the external review entity should not forward the claim for a heart transplant to an independent medical reviewer because no medical determination is needed to understand that the procedure is not covered.

Second, even if the external review entity makes a mistake and forwards to the independent medical reviewer a claim for an item or service that is specifically excluded or expressly limited under the plan, the legislation states that the independent medical reviewer cannot require the health plan or insurer to cover such excluded benefits.

The amendment I am offering clarifies this limitation on the independent medical reviewer to make it perfectly clear that although we are relying on the independent medical reviewer to give us a second medical opinion when such a medical opinion is necessary to interpret the plan's coverage, we are not empowering them to disregard the plan's specific coverage exclusions and limitations.

The third safeguard and the one we are further strengthening with this amendment is designed to ensure the objectivity and quality of the external reviewers. The bill provides already for their certification and sets out factors that must be considered before they can be recertified, including the external reviewer's compliance with requirements for independence and limitations on compensation. To the recertification considerations already in the bill, this legislation additionally requires the certifying authority, before recertifying an external reviewer, to consider whether the external reviewer has breached the other safeguards by ordering a provision of items or services that are specifically excluded by the plan.

The amendment allows a health plan or insurer to petition the certifying authority to revoke an external reviewer's certification or deny recertification and requires the certifying authority to do this upon a showing of a pattern or practice of wrongfully referring for medical review claims that don't require medical decisions or of ordering the provision of specifically excluded benefits.

Finally, the amendment requires the General Accounting Office, within 1 year after the bill takes effect, to report to Congress on the number and the extent to which independent medical reviewers are requiring coverage for benefits that are specifically excluded under the plan or coverage.

I guess what we are saying here is that we are trying to make the language as tight as possible. We know there may be a temptation on the part of reviewers to violate the plan with regard to those procedures which may be specifically excluded. We will have follow-up action, including a requirement for taking into consideration, on recertification or even revocation of certification, a study by the General Accounting Office which will tell us about the extent to which independent medical reviewers are requiring coverage for benefits that are specifically excluded.

My friend from Arizona, Senator KYL, had a very good amendment. We could not quite go that far, and we came close to agreement. I hope this amendment does clarify some of the concerns.

It strikes the language on page 36 of the bill that says: Except to the extent that the application or interpretation of the exclusion or limitation involves the determination described in paragraph 2.

This removes what was viewed by many as a possible loophole. So we were willing to strike that portion of the bill in order to try to inspire some confidence that in no way does this legislation expect or anticipate or even allow in any way exclusions on coverage that are not specifically listed in the medical plan, in the insurance plan.

I yield the floor.

The PRESIDING OFFICER. The Senator from Indiana.

Mr. BAYH. Mr. President, before my colleague Senator MCCAIN leaves the Chamber, I thank him for his leadership on this issue. He has demonstrated his courage in battle and in service to country and is doing so again by leading this important battle for patient care for all Americans. I thank Senator MCCAIN for his leadership once again.

I thank my colleague Senator CARPER from Delaware. We served together as Governors for many years, and we now have the privilege of serving in this body. I thank him for his leadership on this issue, for his insight. There is no deeper thinker who cares more about the public policy details of what we do in the Senate than Senator CARPER. He is new to this body but has already made a substantial contribution to the Senate and to the laws that govern our country.

I express my appreciation to Senators EDWARDS and KENNEDY for their leadership in this important battle on behalf of patients. I express my gratitude to two of our colleagues who are not on the floor at this time: Senator NELSON of Nebraska and Senator KYL from Arizona.

In particular, I thank Senator NELSON for his heartfelt work on the last amendment. Although unsuccessful, I know he cared deeply about striking the right balance. We share many of the same objectives, although we differ in terms of how we go about achieving those objectives. I salute Senator NELSON for his work in this regard. I hope our amendment will meet many of his concerns. I believe it does in terms of striking the right balance for the American people.

Our amendment accomplishes both of the important objectives that the American people seek in debating and enacting this Patients' Bill of Rights. First, we ensure that all decisions that involve the practice of medicine, all decisions that involve medical discretion will be fully reviewable by an independent panel to ensure the quality of health care for all insured Americans across our country.

Second, this amendment seeks to accomplish quality medicine at affordable cost, keeping the prices as reasonable as possible for consumers and patients across the country. We do this by removing unnecessary ambiguity from this bill, thereby ensuring that we can accomplish quality medical treatment but keeping the risks, the uncertainty, and therefore the costs to patients and consumers as low as possible.

The bottom line will be quality health care for all Americans at an affordable cost. That is the balance all of us should be seeking to strike in this debate. That is the balance this amendment will help us to accomplish.

Very simply, we seek to honor the original intent of this bill, that doctors should make medical decisions, that lawyers should draft contracts and practice law, but neither should be in the business of practicing the other's profession. We have removed through this amendment ambiguous language that ran the risk of one encroaching on the other's territory.

Specifically, let me read the provisions that will remain in the bill. They are explicit and unambiguous. I quote from the legislation:

> Nothing in this subsection shall be construed to permit an independent medical reviewer to require that a group health plan or health insurer offering health insurance or health insurance coverage provide coverage for items or services for which benefits are specifically excluded or expressly limited under the plan or coverage in plain language of the plan document.

Under the bill before this amendment, Mr. President, there had been several exceptions which had consumed the rule, making this clear exception for express limitations or prohibitions under the terms of the contract null and void. We put a period at the end of this language, removing the exception language, thereby making it very clear that the terms of the contract, in terms of contract language, will govern. This helps to keep the costs low because the uncertainty and the ambiguity will be removed.

At the same time, there can be no uncertainty or ambiguity that medical decisions involving the practice of medicine, anything involving medical discretion, will be fully reviewable by the external appeals process, as it should be.

In addition, there are other precautionary measures included in our amendment that I was interested in and I know the Senator from Delaware was interested in. He may elaborate on these provisions in just a few moments. These ensure that the independent reviewers are truly independent. We want to make sure they adhere to the provisions of this legislation, hopefully as amended by this amendment, and that we don't have the risk of panels exceeding their authority by changing the terms of the contract where they are expressly provided for, and there is no ambiguity in the language in terms of limitations or exclusions from the terms of the contract.

Once again, this amendment will ensure that independent review panels do not exceed their authority, inappropriately driving up costs without improving the quality of health care for the American people.

Finally, we have a rare opportunity to achieve bipartisan consensus on this amendment.

Not only is Senator MCCAIN helping to lead the charge once again, for which we are very grateful, but I listened with great interest and gratitude to something that the Senator from Oklahoma, Mr. NICKLES, said last evening. He recited the very same language that I recited about exclusions and limitations in the contract. And then he said if you put a period at the end of those provisions and remove the exception language, that would be—to use his word—''great.''

Mr. President, that is exactly what we have done. We have placed a period there and removed the exception language, thereby removing the ambiguity, the risk, the unnecessary cost to consumers without a health care benefit. Senator THOMPSON, earlier today on the floor of the Senate, indicated that this action we have proposed in this amendment would also go a substantial way toward correcting what he thought was a potential defect in the legislation.

So I ask all Senators, regardless of political affiliation, who seek to strike the right balance between quality health care on the one hand and affordability on the other hand to support this amendment. We have taken a step that some of those who have been concerned about the ambiguity in the language have encouraged us to do, thereby ensuring quality affordable health care for every American. We can accomplish that with this legislation, with this amendment. I urge my colleagues to vote in the affirmative.

I yield the floor, and I thank my colleagues for their patience and attention.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. CARPER. Mr. President, I rise in support of the amendment. I am pleased to be an original coauthor with Senators BAYH and MCCAIN. The Senator from Indiana is very modest in giving to others the credit, but this is really an idea that I first heard from him. Early this week, Senator BEN NELSON and Senator BAYH and myself were trying to deal with issue of medical necessity. It is a difficult issue around which there are competing interests—doctors, nurses, insurers, patients—who really find consensus hard to reach.

I thank Senator BAYH for helping us to find this middle ground on which I am encouraged that maybe we will have strong bipartisan support. I express my thanks to Senators MCCAIN and KENNEDY and EDWARDS for their leadership in getting us here this day, and to my friend, Senator GREGG from New Hampshire, for his thoughtful comments, as well as those I heard on the floor yesterday, alluded to by Senator BAYH, from Senator NICKLES. As I recited, earlier today PHIL GRAMM of Texas echoed almost those same comments.

Before I return, I want to step back a little bit and go back in time. I used to be State treasurer of Delaware before I was a Congressman, before I was Governor, before I became a Senator. Senator BAYH was Governor of Indiana and was the secretary of state. We worked in those venues before we came here to work. With our State treasurer at the time, we administered benefits of State employees. Among the things I was mindful of was health care costs.

In the 1970s and 1980s, health care costs went up enormously. It was not uncommon to see increases then of 20, 25, or even 30 percent annually in the cost of health care for State employees. These really mirrored increases that inured to other employees outside the State of Delaware.

Along about the late 1980s, a dozen or so years ago, a number of people began working seriously in this town to figure out how to introduce some competition into the provision of medicine. In a fee-for-service approach in medicine, I might see my doctor and he says, ''You are not well; I will order tests A, B, C and D, and to be sure we will order E, F, G and H,'' and he owns the lab where the tests are administered. Then he says, ''Come back and we will see how you feel next week.'' There really wasn't much impetus for containing costs. As a result, costs spiraled out of control.

Managed care was designed and conceived to try to stop that spiraling and introduce some market forces and competition in order to control the cost of

health care. It really succeeded better than I think any of its proponents had imagined. Those costs that were going up 20, 25, even 30 percent, back in the 1980s, by the time we got to the end of the 1990s, were going up by 2, 3 percent, in some years nothing at all. As we went about controlling costs, the concerns switched to a different area, and that different area was quality of health care.

Instead of a lot of our doctors and nurses making decisions, a lot of decisions for the care to be offered or given to us was made within the HMOs running the managed care operation. In some cases, they were doctors and nurses, and in some cases they were not.

What we are trying to do in the context of the Patients' Bill of Rights legislation is restore some balance to the system. We don't want to see costs spiral out of control or employers cutting off health care for employees. By the same token, we want to make sure that more of the medical decisions that affect us if we are covered by an HMO, especially if it falls under a Federal regulation, which ERISA is—we want to make sure we are getting the kinds of protections that inure to folks who are in State HMOs.

How do we do that and not lead us back to spiraling, out-of-control costs in a way that is fair to doctors and nurses, and in a way that is fair to employers and at the same time fair to the HMOs? The issue we are trying to address is this: I am in an HMO; I don't like the decision my HMO renders with respect to my health care. I appeal that decision, and it is reviewed by an internal mechanism within the HMO. If they don't provide a decision my doctor and I like, we can appeal to an external reviewer. In some cases, certainly in my State, an external reviewer can override the HMO's decision and mandate the provision of that health care under a State-regulated plan.

What about in a case where there is a federally regulated HMO, one that falls under ERISA? What do you do in a case when the language of the plan explicitly excludes the treatment that a member of that plan desires? What do we do when the language of the plan explicitly excludes the very treatment that I or the member of a managed care plan desires?

Unintentionally, the language of the bill as drafted says to the external reviewer that you have license to go beyond that which is explicitly excluded in treatment for a patient. That external reviewer can order additional explicitly excluded treatment for a patient. That might be great for the patient, might be appreciated by the patients' doctors and nurses. But how fair is that to the insurer who is trying to cost out a plan, to charge for that plan and have a sum certain to operate with?

What Senator BAYH has fashioned, something that he and Senator NELSON and I worked on, is a way to provide that certainty for the insurer and also to provide certainty for the consumer, the patient, and the health care providers. It is a simple change—one endorsed, at least indirectly, by Senator NICKLES and today by Senator GRAMM. By simply striking a couple lines in his bill and putting a period where a period ought to appear, we helped solve a problem. It doesn't solve all of the problems in this bill, but it solves one of the problems. It is clear, clean, and easy to understand.

Let me close my remarks with some comments about another one of our colleagues who, before he was in the Senate, was a Governor, BEN NELSON of Nebraska. Before he was Governor, he was insurance commissioner for his State. He has forgotten more about these insurance matters than most of us will ever know. His insights and perspectives on these issues have been enormously helpful to me in this debate. I thank him for joining with Senator BAYH and me and others in the conversations that really led to the emergence of this proposal.

Senator NELSON offered an amendment with Senator KYL a little bit earlier today to try to define medical necessity, which is really the kind of issue we are talking about here. People have been trying to do that for years without a lot of success. While we are not going to agree to change the language in the bill with respect to that, we can say here clearly, if a health plan that falls under the jurisdiction of ERISA explicitly excludes a particular kind of coverage, then in all fairness the external review committee in reviewing an appeal, cannot override the explicit exclusion in that health care plan. That is fair; that is reasonable; it provides certainty for the insurer, and I think it is fair to consumers as well.

I am pleased to rise in support of it, and I hope that all of us in this Senate, Democrats and Republicans, and Independent as well, can support this amendment. Thank you very much.

I yield back my time.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Mr. President, before he leaves the floor, I thank my friend from Delaware for all his work on this issue. It is very important to the progress we are making to finally protect patients in this country, along with Senator BAYH, who led this effort, and Senator NELSON and others involved in this issue. We very much appreciate all of their input.

The issue of medical necessity, which means how we determine whether any particular care is covered and is medically necessary for the treatment of the patient, is a critical issue in the bill. We have now agreed on language that we believe appropriately balances the interests of the contract between the insurance company or the HMO and the employer on the one hand, and the interest of the patient and having some flexibility on the other.

Basically what we have said in this amendment is if the contract explicitly excludes a particular treatment, a test, then that will be excluded from care, period, and the independent reviewers are bound by that language.

On the other hand, to the extent we need some flexibility in what is proper and good medical care, we have managed to maintain that. I think we have struck the right balance between the sanctity of the contract on the one hand, so people know they can rely on the provisions of the contract and, secondly, allowing enough flexibility to provide the proper care to patients when they go through the review process.

More important is this is another step in a very important process. When we began last week, we were confronted with trying to get real patient protections in this country with numerous obstacles—disagreement among our colleagues, different issues being raised by Members of the Senate and a written veto threat from the President.

As we have moved forward through the end of last week and through the mid part of this week, we have continued to make progress every step of the way. We keep resolving issues. We keep making progress.

On the issue of employer liability, about which many of our colleagues have expressed concern, making sure that employers around this country are protected from liability, we have worked with our colleagues—Senator SNOWE, Senator NELSON, Senator DEWINE, and others—to work out compromise language that satisfies a large number of Senators on both sides of the aisle so that there is consensus on the need to protect the employers, on the one hand, but keeping in mind the rights of the patients on the other. Issue resolved.

No. 2, scope: What this legislation covers and who it covers. Senator BREAUX and I and others have been working very hard on this issue. We believe we have reached a resolution that will result in an amendment being offered later today that strikes a compromise and a balance between the interests of the States, being able to maintain the work they have done in the area of patient protection, while at the same time making sure every single American has a floor on the level of patient protection.

On the issue of medical necessity, as a result of the work of many of my colleagues, we have been able to reach consensus. On the issue of scope, who is covered, we have been able to reach consensus. On the issue of employer liability, we have been able to reach consensus.

Every day we have continued to make progress, but the importance of this is not for what is happening specifically within this Chamber and what is happening in Washington, DC, and what is happening among Senators. The winners in this process are the

families of America because it is now becoming clearer and clearer that we may finally be able to provide those families with the protections they so desperately need and to which they are entitled.

That is what this debate has been about. That is what all this work among Republicans and Democrats in the Senate has been about. We have shown over the course of the last week that we can work together, we can find ways to provide real patient protection in this country. Up until now, we have a model in problem solving, in trying to give real protection to the families of this country so they can make their own medical decisions. That is what this debate has been about; that is what our work has been about.

We are not finished. We have important issues left to resolve, but I am confident, given the good will and hard work that has already been done, that if we continue in that same way, we will be able to reach a resolution and hopefully be able to put a bill on the President's desk and that he will sign a real Bipartisan Patient Protection Act that gives power to patients and lets them make their own health care decisions.

I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON of Florida. I thank the Chair. Mr. President, over the past few days of debate on this Patients' Bill of Rights, we have heard the many horror stories of what happens to people when HMOs put profits ahead of patients. We have heard of one man in a wheelchair whose HMO ordered his oxygen tanks removed from his house; we heard of a youngster whose brain tumor was missed because the HMO refused to allow the necessary test; and we heard of others pleading with their HMO to get coverage for critical procedures either for themselves or their families.

These, unfortunately, are not isolated examples. They are happening every day all across this country which is why the people of America are demanding reform and why we are seeing the public surveys now showing support for this legislation to the tune of 81 percent in favor of this legislation.

The people also realize the system is not working for the doctors either. Just last week, I learned of a doctor who is assessing his existing patients a $1,500 annual membership fee for the privilege of continuing their treatment. He wants to cull his current patient list from 3,000 patients down to 600, and by charging this annual membership fee, the doctor shrinks his practice and yet he maintains his profits. The patients who cannot afford the annual membership fee have to find another doctor. I find this outrageous and unethical, and it sets a bad precedent for the future of our health care industry.

All of these incidents and the debate over this legislation have made one thing very clear: Our health care system is failing most of the people in the country.

Mr. President, I rise today to reiterate my strong support for this Bipartisan Patient Bill of Rights. It represents a critical first step, an important first step in a long journey of a thousand miles of reforming America's health care system.

In short, this legislation puts medical decisions back in the hands of doctors and patients instead of HMO bureaucrats. It gives patients the right to see a specialist when needed, fixing a system that so often blocks a woman's access to necessary care. This legislation will ensure direct access for a woman to an OB/GYN if that is who she wants as a primary care physician. This bill gives patients access to the emergency room without first seeking clearance from their health care provider. We have heard many horror stories recounted in the Senate of people denied access to a certain emergency room because they had to go to another.

This legislation also protects the doctor-patient relationship, a very sacred relationship, by ending restrictions on which health care options doctors can recommend. Currently, we know doctors say they fear retribution from the health insurance industry if they pursue more costly medical treatment for their patients.

This bill also prohibits HMOs from offering financial incentives to doctors for recommending limited care. It prohibits HMOs from punishing doctors who seek top-notch care for patients.

What we are trying to do in this legislation is reinject common sense and good medical practice in protecting the doctor-patient relationship so the patient knows the doctor is going to prescribe what is the very best medical treatment appropriate for the circumstances.

In spite of claims to the contrary, yesterday the American Medical Association and other health groups reported in States with recently enacted accountability and legal remedies, the new laws did not produce any documented increase in the number of uninsured, one of the specious arguments that the opponents to this legislation have advanced.

The most crucial issue is whether a patient can seek legal recourse for the wrongdoing by a managed care company. This bill will enable patients to hold their insurance companies accountable for harmful actions. Under current law, if malpractice is committed, if there are grievous wrongs, a patient can recover from a doctor, from a hospital, from other providers, but under current law they cannot recover from an HMO. That is one of the main fundamental principles of this legislation, to change that, so they can hold those HMOs accountable.

Before I came to the Senate, I was the elected insurance commissioner of Florida for 6 years. I saw how some insurance companies—and I don't say all because I am proud of those insurance companies that would stand up for the rights of their patients and would stand up to protect their patients, but I saw how some insurance companies tried to put profits ahead of patients. Unfortunately, many patients often have little or no recourse.

There is no reason why HMOs should have special protection from lawsuits. The AMA has so stated and endorsed a patient's right to sue. It is estimated more than 190 million Americans are enrolled in health plans, and 75 percent of them under current law are unable to sue their health plans for anything but the cost of denied treatment. Clearly, the status quo works for the industry, but it fails consumers. We need this legislation to enable people to be able to redress their wrongs in State courts for damages limited only by State regulations.

It has been a long time coming. It has taken 5 years to get this legislation to the floor because for 5 years special interests have prevented this bill from becoming law. As a result, the people of Florida and the people throughout this Nation have suffered. We must end the industry strangle hold on this legislation and we must take the first meaningful steps toward overall health care reform. I submit that this legislation is a major first step in the overall journey toward health care reform. We must put the people before the special interests. We must put an end to these consumer horror tales that we have heard with all too much frequency during the course of debate on this legislation.

I thank colleagues for the privilege of addressing this issue and for indulging me in my comments.

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

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

The legislative clerk proceeded to call the roll.

Mr. NELSON of Florida. Mr. President, I ask unanimous consent the order for the quorum call be dispensed with.

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

(The remarks of Mr. NELSON of Florida are located in today's RECORD under ''Morning Business.'')

Mr. NELSON of Florida. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. JOHNSON). Without objection, it is so ordered.

Mr. REID. On behalf of the majority leader, I ask unanimous consent that at 5 p.m. the Senate vote in relation to Senator MCCAIN's amendment No. 820; that prior to that vote, when the

quorum call is ended and the unanimous consent agreement is reached, Senators BREAUX and COLLINS be recognized to offer a first-degree amendment on scope—they can, after the vote tonight, either stop or come back tonight, but we will have a vote at 5 o'clock for the convenience of some Senators—that the Breaux and Collins debate occur concurrently today; and when the Senate resumes consideration of the bill tomorrow, Thursday, at 9:15 a.m., there be 30 minutes for debate equally divided between Senators COLLINS and BREAUX prior to votes in relation to these two amendments; that there be 2 minutes for debate equally divided before each vote with the first vote occurring in relation to the Collins amendment; that upon the disposition of these amendments, Senator GREGG be recognized to offer an amendment relative to liability; that there be 1 hour for debate equally divided prior to a vote in relation to that amendment; that upon the disposition of Senator GREGG's amendment, Senators SNOWE and FRIST each be recognized to offer a first-degree amendment, and that will be on liability; that there be 4 hours for debate equally divided in the usual form to run concurrently; that at the conclusion or yielding back of time, the Senate vote in relation to Senator SNOWE's amendment; that after disposition of her amendment, the Senate vote in relation to the Frist amendment; that no second-degree amendments be in order to any of the amendments listed in this agreement prior to the vote in relation to the amendments.

Mr. GREGG. Reserving the right to object, I ask if the Senator from Nevada would be willing to amend the agreement, so it would be Senator GREGG or his designee.

Mr. REID. Absolutely.

Mr. GREGG. I have no objection.

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

Ms. COLLINS. I ask unanimous consent that the pending amendment be set aside.

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

AMENDMENT NO. 826

(Purpose: To modify provisions relating to preemption and State flexibility)

Ms. COLLINS. On behalf of myself, Senator NELSON of Nebraska, Senator ENZI, Senator VOINOVICH, Senator HUTCHINSON, and Senator ROBERTS, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Maine [Ms. COLLINS], for herself and Mr. NELSON of Nebraska, Mr. ENZI, Mr. VOINOVICH, Mr. HUTCHINSON, and Mr. ROBERTS, proposes an amendment numbered 826.

Ms. COLLINS. I ask unanimous consent reading of the amendment be dispensed with.

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

(The amendment is located in today's RECORD under ''Amendments Submitted.'')

Ms. COLLINS. I am very pleased to join with my colleague from Nebraska as well as the other Senators whom I mentioned in offering this amendment. Our amendment will give true deference to State laws and the traditional authority of States to regulate insurance while ensuring that each State addresses the specific patient protections provided in this legislation.

We should pass a strong, binding Patients' Bill of Rights. We should pass a bill that holds HMOs accountable for promised care and that ensures that patients receive the health care they need when they need it. However, we should do so in a responsible way that does not add excessive costs and complexity to an already strained health care system.

Congress should act to provide the important protections that consumers want and need without causing costs to soar and without preempting State insurance laws. We can do so by passing a carefully crafted bill.

I strongly believe we should not preempt or supersede but, rather, build upon the good work the States have done in the area of patients' rights and protections. States have had the primary responsibility for regulating insurance since the 1940s. For more than 60 years, States have been responsible for protecting insurance consumers. As someone who has overseen a bureau of insurance in State government for 5 years, I know firsthand that our States' bureaus of insurance do an excellent job of protecting consumers' rights.

One of the myths in the debate on this legislation is that unless the Federal Government preempts State insurance laws, millions of Americans will somehow be unprotected in their disputes with HMOs. That simply is not true. For example, as this chart demonstrates, the States have been extremely active in passing patient protections. In fact, they have been way ahead of the Federal Government and they have acted without any prod or mandate from Washington. Look at this activity: 44 States have dealt with the issue of emergency room access; 49 States have passed laws prohibiting gag clauses in insurance contracts that restrict what a physician can tell a patient. Whether it is access to OB/GYNs, continuity of care, or many of the other issues such as internal or external appeals or patient information, the States have been extremely active in this area. Every single State has acted to pass some sort of patient protections.

As is so often the case, it has been the States that have led the way. They have been the laboratories for insurance reform. Moreover, we know one size does not fit all. What may well be appropriate for one State simply may be unworkable or unneeded or too costly in another. What may be appropriate for California, which has a high penetration of HMOs, may simply not be necessary in a State such as Alaska or Wyoming where there is virtually no managed care. In such States, a new blanket of heavyhanded Federal mandates and coverage requirements simply drives up costs that impede rather than expand access to health insurance. That is why the National Association of Insurance Commissioners and the National Conference of State Legislators are very concerned about the language in the McCain-Kennedy bill. The language in that bill will force all States to adopt virtually identical Federal standards.

I recently received a letter from the president of the National Association of Insurance Commissioners. She writes that States have faced the challenges and produced laws that balance the two-part objectives of protecting consumer rights and preserving the availability and affordability of coverage. For the Federal Government to unilaterally impose its one-size-fits-all standards on the States could be devastating to State insurance markets.

I think we should heed that caution. I think we should heed that warning. The Federal Government does have an important role to play in regulating the self-funded plans under ERISA. That is where our effort should be focused.

States are precluded from applying patient protections to these federally regulated plans, and that is why we need a Federal law to ensure that consumers, enrolled in insurance plans beyond the reach of State regulators, have strong patient protections. But the Federal Government should not be in the business of second-guessing and overriding and preempting the carefully crafted patient protections that have been negotiated by our State legislators and Governors to meet the needs of their States' citizens. States which seized the initiative and acted on their own should not have to revise their carefully tailored laws simply to comply with a one-size-fits-all Federal mandate.

Under the McCain-Kennedy bill, the Federal Government would preempt existing State laws unless the State has enacted protections that are ''substantially equivalent to and as effective as'' the Federal standard.

A reasonable person's interpretation of that standard is the States will have to pass new laws wiping out their carefully crafted work, that are virtually identical to the standards in the McCain-Kennedy bill.

The approaches taken by the 50 States to the same type of patient protection vary widely, and with good reason in many cases. Why should States that have already acted on their own to provide strong, workable patient protections have to totally change and make extensive changes in their laws? That is why the National Council of State Legislators supports the Collins-Nelson amendment. It is extremely important to State legislators that they

do not have to spend valuable time recrafting and rewriting and reenacting laws already on the books that meet the needs of their citizens.

In a recent letter to Senator Nelson and myself, the National Council of State Legislators wrote:

> [We] support this amendment. States are best situated to provide oversight enforcement of the patient and provider protections established in this legislation. The record of the states is strong. We are looking for an approach that supports the traditional role of States in the regulation of insurance and that recognizes the differences in State insurance plans and provides a mechanism for States to protect those markets.

Again, let me be clear. There is a role for the Federal Government, and that is to make sure that those plans, regulated under ERISA, beyond the reach of State regulators, include patient protections. That is why we need a Federal law to accomplish that goal.

It is all well and good and appropriate if Congress decides it wants to impose a specific requirement or mandate on these federally regulated insurance plans. But the Federal Government needs to be careful in respecting the good work the States have done.

Moreover, let's look at the practical consequences of what would happen under the McCain-Kennedy bill. If a State fails to revise its laws to conform to the Federal standard, under the McCain-Kennedy bill the Health Care Finance Administration, HCFA, would displace the State as the enforcer of insurance patient protection.

Talk about a right without a remedy. If there is no enforcement, there is no protection, and experience has already shown that HCFA is completely incapable of carrying out this responsibility.

The Health, Education, Labor, and Pensions Committee on which I serve has held yearly hearings to examine the problems that HCFA has experienced as it has attempted to implement and enforce the 1996 Health Insurance Portability and Accountability Act. There are many GAO reports. This one is entitled: Progress Slow In Enforcing Federal Standards in Nonconforming States. That is because HCFA is totally ill-equipped to take on this task.

Our States' bureaus of insurance know how to do the job. They have been doing it for 60 years, and they have been doing it well. Consumers should be very concerned, since HCFA has already proven that it is not capable of enforcing existing Federal insurance standards in States that don't conform. In fact, HCFA has shown it cannot even assess the degree of compliance with those Federal laws, where HCFA does play a role. We should be very concerned that we are proposing an empty promise.

The States have the systems, the infrastructure necessary to receive and process consumer complaints in a timely fashion and to hold insurers accountable to ensure that they comply with State laws. To me, the bottom line is very simple. My constituents would much rather call the bureau of insurance in Gardiner, ME, than have to deal with the HCFA office in Baltimore if they have a problem with their insurance.

Another problem of the McCain-Kennedy approach is that it would create a dual enforcement structure that would be extremely confusing for consumers and, frankly, completely unworkable. Under this bill, if some State laws met the new standards but others did not, who would be the regulator? Would it be HCFA or would it be the bureau of insurance? Would it be HCFA for some parts of the insurance contract and the bureau of insurance in the State for other parts of it?

This simply does not work. We would be creating a situation where a patient may have to go to a State bureau of insurance for questions or problems associated with certain patient protections and then try to deal with HCFA if the patient has problems or questions with other parts.

Therefore, Senator NELSON and I, supported by a number of our colleagues, are offering an amendment that will give true deference to State laws and the traditional authority of States to regulate insurance. At the same time, we will ensure that each State considers and addresses the specific patient protections proposed by this legislation.

First, our amendment would grandfather all State patient protection laws that are in place prior to the effective date of this act. That is October 1 of next year. A State would just certify to the Secretary of HHS that it has addressed one or more of the patient protection requirements to be in compliance with the law. This provision would also give States that have not considered these patient protections an incentive to act before the effective date to avoid Federal intrusion and challenges to their laws.

Second, if by the effective date a State has been certified as compliant with all the patient protections in the legislation, it will immediately become eligible for funds from a new patient quality enhancement grant program. States that are not in full compliance by the effective date of the legislation would be required to meet a higher standard in order to be eligible for funds under this new program. If a State has not acted by the effective date, it would have to certify to the Secretary, for each of the remaining protections, that either the State has enacted a law that is ''consistent with the purposes of the Federal standard'' or decline to enact a law because the adverse impact of the law on premiums would lead to a decline in coverage or simply because the existence of a managed care market in the State is negligible; it is just not relevant to that State.

Our amendment would recognize the States are the experts in this area. They have led the way. Consumers are best protected if we continue to respect the work that the States have done and give deference to the State's traditional authority to regulate insurance.

I reserve the remainder of my time but yield to the Senator from Nebraska, my principal cosponsor, who is a true expert in this area. He knows more than any other Senator. I hope my colleagues will listen very carefully. It has been a great pleasure to work with him on this issue about which we both care a great deal.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. NELSON of Nebraska. I thank my colleague from the New England State of Maine for such a glowing recommendation. I hope my colleagues do not think I believe I know more than they do. But it is a subject I have spent a good deal of my life involved in as an insurance regulator and as a Governor, somebody who has dealt with the business of insurance.

I appreciate so much the opportunity to join with Senator COLLINS to bring this amendment to the attention of our colleagues.

It typically is a lot more instructive to talk about the importance of patient care and to talk about those who aren't getting good patient care and certainly to bring to our attention those folks who suffered great injustices under their current health care system. I respect that. I certainly am interested in that aspect. That is why I support a Patients' Bill of Rights. That is why I continue to do that.

But I have found that any bill which comes before this body or that comes before any legislative body is hardly ever such without some amendment and some improvement. I think what Senator COLLINS and I are offering today is in that category of an improvement.

When our founders created this Union they established a system of Government that, pursuant to our Constitution, provided for a divided Government, a Government consisting of our States, and under a well-considered principle of Federalism, a Federal Government. We have been best served by this Government when we have permitted it to work for us. While pursuant to the 10th amendment, the Federal Government may preempt States in certain respects, it seems clear from that amendment and from the practice over the last 200-plus years that such preemption should be limited to those areas where the States have failed to act in some manner. This is not one of those cases.

The bill before us presents a dilemma for me and for my colleagues because most of us believe that, with some modifications, this is a good bill. The same may be said of the Frist-Breaux-Jeffords bill.

At the outset, let me state unequivocally that I support the purpose and the protection of this bill. What I don't support is its preemption of State laws in an unnecessary manner. Let me explain.

As my colleague has indicated by the chart, the States have acted. They have acted rather aggressively and consistently and in many ways. As a matter of fact, they acted so aggressively and so consistently that the best of those protections which the States passed were assembled to create this bill. Let me ask you if that isn't some action on the part of the States.

When Congress passed the ERISA preemption in 1974, it did so because some multi-State employers were having problems complying with the diversity of the State regulation of health insurance.

First, it was described as a pension issue to which they couldn't quite comply. Then they said, as long as we are getting a preemption, let's grant it in the health insurance area as well. So Congress exempted certain plans from State law. That level of exemption involved fewer insured than were continued to be served by State regulated insurance plans.

What we are faced with today is dealing with the problem that began in 1974 with the exemption from consumer protections of these Federal plans. Now we are faced with solving that problem.

Some have said, as long as we are solving that problem, let's move away from diversity and go to uniformity. I am not opposed to having uniformity. But to serve uniformity for uniformity sake and ignore what the States have done, the fact is that under the principles espoused by Thomas Jefferson States have only been acting as laboratories of democracy by experimenting. Fortunately—and thank goodness—the States have experimented because it is from these experiments and from this diversity that we are now able to assemble for the protection of the ERISA plan this group of patient protections.

That is what is important about this. If we look at it to a certain extent that virtually all content is taken from various State laws, that is at least some form of congratulations to the States for their efforts. But they ought not to be rewarded by that great effort by the preemption where it is unnecessary.

The framers of the legislation that is before us as well as those of the Frist-Breaux-Jeffords bill have really worked hard to try to find a way to balance this out. I commend them for that. Their work does not go unnoticed. I appreciate their efforts. But whether the standard is substantially equivalent as in the McCain-Kennedy Edwards bill or in the Frist-Breaux bill consistent with or in a compromise that is under consideration right now which says substantially compliant, the fact is the States are going to have to come to the Federal Government with the plans and say, ''Please let us out'' or they will not be able to get out from under the requirements of this legislation unless they are ''substantially equivalent to.''

''Substantially equivalent to'' means the filings of these State protections would have to be made by their Governors to the health and human services agency, and they will have to find out whether or not the plans they are submitting are substantially equivalent—not whether they are good or bad but whether they are substantially equivalent.

The theory is, if they are substantially equivalent, they are at least as good as or better. But I don't know why we should engage bureaucracies in the Federal Government to try to look over the shoulders of the States that have seriously considered each and every one of these protections.

Why are we doing it? Because we want to solve the problem that exists. Why should we try to solve a problem where there is no problem?

Under the Collins-Nelson effort, we give the States the opportunity to opt out if their plan is consistent with the purposes of this law.

It seems to me that we just simply make it clear that the States can continue to experiment. It is easy to suggest that if you take away the incentive of the State to experiment, the experimentation will either wither or will at least stagnate.

We want to continue to be sure that there are incentives for the States to continue to experiment because I suggest to you right now this is a dynamic process. Over the next several years, we are going to find some better patient protections, and we are more likely going to find those from the States than we are engaged in the body of this legislative Chamber trying to find those answers.

I would prefer that experimentation continue. Then we can pick and choose the best of the class in each case.

I spoke today with the Secretary of Health and Human Services, Tommy Thompson, also a former Governor, and I asked him whether he thought his agency could do this. He said simply that he doesn't think that it can.

Let me add that I think that translates into, ''I can't unless I have a larger bureaucracy of several dozens or more Federal bureaucrats and more staff to look over and second-guess Governors and second-guess State legislatures.''

I asked if that is necessary. Quite frankly, I don't believe that it is. And with the stroke of the pen this bill can be amended so that it won't become law so States can opt out and Governors will have the opportunity, as State legislatures, to decide what is the policy that will work within their State.

We are looking for balance with this legislation. All of us want to balance being able to have the right kind of protection for patients and the availability and affordability of insurance. The last thing we need to do is to tip the balance one way or the other and end up with a more severe problem than we are trying to solve with this effort.

I suggest to you that Thomas Jefferson might be looking at us at the moment. Furthermore, I think he would be pleased if we had a dual system that recognized that this Federal bill and these Federal protections would apply to the Federal plan, and we would allow the States to continue as they have to protect the people at that level and to serve to provide experimentation and better ideas along the way and permit us to allow them to continue as they have to protect the citizens.

I truly believe that government, when it is functioning at the local level, will function best and certainly can function better in this area than we can function.

We have already taken the step of exempting the Federal plans. Let us not now make a mistake of applying what we need to permit for those State plans where there is already much protection and probably even more protection.

Just this week, Delaware added additional patient protections. It seems to me that we ought to continue to support that. We ought not to do anything that detours it or takes away the incentive for the States to continue to do as they have been doing.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, I thank the Senator from Nebraska for his comments. He has stated the case extremely well. He has had the experience not only of being a Governor but of actually being a commissioner of insurance.

I spent 5 years in State government overseeing a bureau of insurance. We have confidence in our State's abilities to protect the rights of insurance consumers. Indeed, the States have been way ahead of the Federal Government in this area.

I have shown my colleagues the charts of the numerous laws that the States have passed during the past decade dealing with patients' rights. Each State has taken action on some of these consumer protections. They have done so without any mandate from Washington. They have done so because they want to make sure that in State regulated insurance plans these kinds of protections have been included.

In fact, the States have passed over 1,100 laws and regulations dealing with patient protections. So this is not a case where the States have failed to act and the Federal Government has to come to the rescue. Rather, it is a case where the States have been far ahead of the Federal Government. We have been slow to provide these kinds of State protections to federally regulated plans under ERISA. That should be the primary focus of this legislation.

Both the Senator from Nebraska and I support a strong Patients' Bill of Rights. We want to make sure, in writing this legislation, we do not wipe out the good work of State governments.

Every single State has at least one law on the books dealing with portions

of the McCain-Kennedy bill. But no State law is identical to the provisions in the McCain-Kennedy bill. States have dealt with these issues in different ways, depending on the negotiations between the State legislatures and their Governors, to meet the needs of that particular State. There is no need to impose a one-size-fits-all Federal mandate on the States when they are already doing a good job.

When I was Commissioner of Professional and Financial Regulation in the State of Maine, we had a very active bureau of insurance that lead the way in proposing many reforms in insurance and health insurance that were enacted by our State legislature. In fact, I believe that Maine was the first State in the Nation to pass legislation requiring automatic continuity of coverage, renewability of insurance contracts. We did that way back this the 1980s. We were ahead of the Federal Government by many years in this area.

Why should the State of Maine, which has been a leader in insurance regulation, have to go back and revisit its laws, recraft them, and rewrite them to meet the dictates of the McCain-Kennedy bill? That just does not make sense.

I think we should respect the work that has been done by the States in this area by honoring the laws that already exist and are on the books. We can encourage those few States—and they are just a handful—that have not acted in some area to do so, and then to bring their plan to the Federal Government or to tell us why they chose not to.

Why does it make sense for a State such as Wyoming or Alaska, which has virtually no managed care, to have to adopt a host of new laws that are irrelevant to their insurance market?

States have been strong in this area. They have worked hard to protect their health care consumers. I think we should be assisting them, providing incentives for them to act still further in this area, not preempting their good work.

I yield the floor but reserve the remainder of the time on the Collins-Nelson amendment.

The PRESIDING OFFICER. There is no time on this amendment.

The Senator from Nebraska.

Mr. NELSON of Nebraska. I again commend my colleague from Maine who has a wealth of experience in the regulation of insurance by having dealt with the professional agencies in her State. I suggest to you that she knows exactly of which she speaks, that the States have been active and have taken a very strong role in trying to protect the patients within their States.

The legislatures, the Governors, and the regulators have all worked together to try to create an environment in which patients are protected. They have succeeded in doing that.

The one missing piece, though, is not in what the States have failed to do but in what the Government today at the Federal level, in Congress, is now trying to do, and that is to cover the federally exempted plans.

There would not be any discussion in this Chamber today about this bill if it had not been for the exemption granted in 1974, as a result of Congress' action to exempt certain plans from State laws.

There is no criticism of what the States have or have not done. There isn't any suggestion that the States have not been active or that the States have not attempted to do a good job or that they have not done a good job.

What we have is, overcoming an omission, taking care of something that has not been done; that is, applying these protections to the Federal laws that have been exempt from State law. That is exactly what this is about.

I certainly want to praise, again, Senator KENNEDY, who has been extraordinarily tolerant of those of us who have had something to say about his labor of love. He has been very tolerant. He has been very helpful. And he has been very suggestive about solutions along the way. I want him to know that I personally appreciate that.

I am somewhat embarrassed to be suggesting that I might have some area of improvement, given the fact that he has worked on this for so long. It is a fact that I come fresh. I said this morning, I feel like somebody who came to the party late who now wants to rewrite the invitation.

It seems to me that this bill is such that it can involve some additional improvement. This is an area where I think it could be greatly improved, by giving the States the opportunity to make their case—not that they need to be treated as though their laws are substantially equivalent—but to give them the opportunity to come in and say: We have done this. We chose not to do this in our State after carefully considering it. The Governor may have wanted it, but the legislature, in its infinite wisdom, chose not to do it, or vice versa. It works that way. That system ought to be continued.

It will serve the people of our great Nation very well: The people of South Dakota, the people of Maine, the people of Nebraska, the people of Massachusetts, the people everywhere, because it has served this Nation so very well and has served the people so very well.

That is a minor modification. I think it has major implications, but it is a minor modification to say that the Governors can certify, and they can seek to support that they have attempted to deal with these issues in their way, that they do not have to do it our way. That is the difference.

I hope that my colleagues will see it that way and will find the capacity to continue to recognize that States have done, are doing, and can continue to do a good job. Even though there is an effort made to limit the amount of the preemption, I believe this preemption simply goes further than is necessary and further than we certainly would like to have it go.

That is what the National Conference of State legislatures have said and other State organizations have said. They would prefer to have less preemption and a better recognition of their efforts and a recognition that they will continue to work to increase the level of patient protection.

I yield to my colleague from Maine.

The PRESIDING OFFICER (Mrs. MURRAY). The Senator from Maine.

Ms. COLLINS. Madam President, I know we are about to vote shortly on another amendment.

Let me just summarize this part of the debate—we will be resuming the debate after the vote—by quoting a letter from the National Association of Insurance Commissioners to Senator NELSON and myself. They raise exactly the point that Senator NELSON and I have raised:

> Members of the NAIC are also concerned about enforcement. As you know as a former state regulator, if there is no enforcement then there is no protection. States have developed the infrastructure necessary to receive and process consumer complaints in a timely fashion and ensure that insurers comply with the laws. The federal government does not have this capability, and [these] proposals [before the Senate] do not provide any resources to federal agencies to develop such capability. It has taken the Health Care Financing Administration (HCFA) years to develop the infrastructure required to enforce the Health Insurance Portability and Accountability Act (HIPAA) which included only six basic provisions that most states had already enacted. The proposed patient protection bills are far more complicated than HIPAA and will require considerable oversight.

If we pass the McCain-Kennedy bill without this amendment, we are holding forth a hollow promise to consumers.

AMENDMENT NO. 820

The PRESIDING OFFICER. The hour of 5 o'clock has now arrived. Under the previous order, the question now is on agreeing to the McCain amendment No. 820.

Mr. REID. Madam President, on behalf of Senator DASCHLE, this will be the last vote of the evening. There will be further debate on the two amendments now pending. The next vote will be at 9:45 a.m. tomorrow.

I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second. The clerk will call the roll.

The legislative clerk called the roll.

The result was announced—yeas 100, nays 0, as follows:

[Rollcall Vote No. 201 Leg.]

YEAS—100

Akaka	Bond	Cantwell
Allard	Boxer	Carnahan
Allen	Breaux	Carper
Baucus	Brownback	Chafee
Bayh	Bunning	Cleland
Bennett	Burns	Clinton
Biden	Byrd	Cochran
Bingaman	Campbell	Collins

Conrad	Hollings	Nickles
Corzine	Hutchinson	Reed
Craig	Hutchison	Reid
Crapo	Inhofe	Roberts
Daschle	Inouye	Rockefeller
Dayton	Jeffords	Santorum
DeWine	Johnson	Sarbanes
Dodd	Kennedy	Schumer
Domenici	Kerry	Sessions
Dorgan	Kohl	Shelby
Durbin	Kyl	Smith (NH)
Edwards	Landrieu	Smith (OR)
Ensign	Leahy	Snowe
Enzi	Levin	Specter
Feingold	Lieberman	Stabenow
Feinstein	Lincoln	Stevens
Fitzgerald	Lott	Thomas
Frist	Lugar	Thompson
Graham	McCain	Thurmond
Gramm	McConnell	Torricelli
Grassley	Mikulski	Voinovich
Gregg	Miller	Warner
Hagel	Murkowski	Wellstone
Harkin	Murray	Wyden
Hatch	Nelson (FL)	
Helms	Nelson (NE)	

The amendment (No. 820) was agreed to.

Mr. REID. I move to reconsider the vote.

Mr. DURBIN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. REID. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

AMENDMENT NO. 830

(Purpose: To modify provisions relating to the standard with respect to the continued applicability of State law)

Mr. BREAUX. Madam President, I ask for the reporting of an amendment that is at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Louisiana [Mr. BREAUX], for himself, Mr. JEFFORDS, Mr. KENNEDY, Mr. MCCAIN, and Mr. EDWARDS proposes an amendment numbered 830.

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

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

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

Mr. BREAUX. Madam President, this amendment is offered on behalf of myself, Senator JEFFORDS, Senator KENNEDY, and Senator EDWARDS as well. It attempts to deal with the question of whether States would be allowed to continue their programs dealing with Patients' Bill of Rights or will it be dealt with on a Federal level.

We have tried to bring about an agreement between all of the parties and, to a large extent, we have been successful in the sense that we have taken ideas and concepts that have been brought before this body on previous occasions and implemented them in this amendment, a provision that I think makes a great deal of sense.

A great deal of the credit should go to the staffs who have been negotiating this amendment for several days in order to bring it to the attention of our colleagues.

Most of our colleagues recognize the need that States have addressed this problem in a fashion that guarantees to patients that they will have certain rights, and they should be allowed on a State level to run and manage these programs. Very few people would be suggesting the Federal Government knows the answers to all of these problems.

My State of Louisiana, for example, is a State that has already enacted into law some 39 guarantees under our State program, guaranteeing to patients they will be protected when they deal with their insurance companies and their managed care companies. They can be assured that these rights, in fact, are in place.

There are a number of other States that have done the same thing. The point is that while we in Washington are passing a national Patients' Bill of Rights, there are many States that have already done this. They were ahead of the Federal Government. They did it before us, and these States should be allowed to continue to run their State programs as they see fit.

What we had suggested in the original Frist-Breaux-Jeffords legislation is that a State would not have their programs superseded by the Federal Government if their plans were consistent with the Federal statute.

The Senator from Massachusetts, the Senator from North Carolina, and the Senator from Arizona took the approach that States could only allow their plans to continue if they were substantially equivalent with the Federal program.

Our staffs have come up with a realistic compromise, a compromise between those two standards, something that I think makes a great deal of sense.

The amendment at the desk tries to reach an agreement and compromise that recognizes the role of the States is very important. Our language simply says the State plan will not be superseded by the Federal Government when the State plan substantially complies with the patient protection plan we have written on the Federal level.

Where do we get that language, ''substantially complies''? I think that is very important. ''Substantially complies'' is the test that we instituted when we passed the so-called SCHIP programs for children's health insurance. We basically said in that legislation the States would be able to carry on their State programs for insuring children if it substantially complied with the guidelines of the Federal Government. That language is in the existing law of this Government; it is being interpreted by HHS, and they interact with the States now on the ''substantially comply with'' test. They know how to handle it; they know what it means; they have interacted with the States on this basic test.

We take that language from that legislation and incorporate it into what we are doing with the Patients' Bill of Rights. Senator JEFFORDS was a major author of that SCHIP program, and he will speak to this issue. We took the language, the test of ''substantially comply,'' and we now have that in place in this amendment.

The decision on ''substantially comply,'' whether it is or is not being complied with, is a decision of the Secretary of Health and Human Services, who will look at the State plans and make a determination as to whether or not they substantially comply with the Federal statute. They have time lines within which they have to make that decision. I think that is appropriate so they do not just languish in Washington. They have a certain time period in which they have to make a decision on a request by the State to be in substantial compliance with the Federal statute.

It is important to note we want the State to move in this direction. There has to be an enforcement mechanism. As in the original Frist-Breaux-Jeffords bill and the original McCain-Kennedy-Edwards bill, if the States decide to do nothing, they will have to be in compliance with the Federal standards on a patients' protection bill of rights.

The difference in our approach and my colleague from Maine and my colleague and friend from Nebraska is, if States decide to take a walk on this, if a State decides, we don't care what you are doing in Washington, folks, we are not going to pass any Patients' Bill of Rights in this State, and we are not listening to anything you are suggesting, their bill is defective in that there is no enforcement mechanism to get the States to move in a direction which is in the interests of everyone in this country.

One defect in their amendment is that the only penalty the State can potentially suffer is to have grant money for this program terminated. Therefore, you could have a situation where the State simply thumbs its nose at the concept of a national patient protection right and does not enact anything if they don't want to, and yet I think that would be a serious mistake.

I think it is in the interests of this Nation to have a Patients' Bill of Rights that can be enforced, and what we have offered as a reasonable compromise between the Kennedy bill and the Frist-Breaux-Jeffords bill I think is one that is balanced, it has been well thought out, and uses language that is already in Federal law as the ''substantially comply'' test is already being enforced by the Secretary of Health and Human Services.

I encourage Members, after having a chance to look at what we have offered, to be supportive of this compromise effort.

I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. I will follow up on the Senator's explanation of what we are trying to do, to make sure we have a less complicated situation with respect to who is in charge and with whom to deal.

We have some problems, but the biggest problem, in what was the Kennedy-Kassebaum bill called HIPAA, was we made the mistake of using such language that it ended up that many of the States declined to do anything, in which case the Federal Government, under the bill, came in and tried to do it. That has not worked out. This comes from experience in trying to recognize the States will do good a job and want to do a good job and this is the best place to do it. We will do nothing that prevents that from continuing.

Senator COLLINS has worked hard on this over the year to make sure we come up with something that will be signed into law and allow the President to sign it into law. The protections in the Frist-Breaux-Jeffords Patients' Bill of Rights apply to all 170 million Americans covered by the private sector group health plans, individual health plans, and fully insured State and local government plans. It covers all of them.

At the same time, our legislation recognizes the Federal Government does not have all the answers. States need to play the primary role in enforcing the bill's requirements with respect to health insurers. However, if a State does not have the law or does not adopt the law similar to the new Federal requirements, Federal fallback legislation will apply.

Our amendment strikes a new compromise under scope between the Frist-Breaux-Jeffords standard of ''consistent with'' and the much more preemptive standard in the McCain-Edwards-Kennedy bill that states laws ''be substantially equivalent to'' and ''as effective as'' the new Federal patient protections. This leaves a lot of indefiniteness in the situation. The Breaux-Jeffords amendment uses a new standard that the State law would be certified if it ''substantially complies,'' meaning that the State law has the same or similar features as the patient protection requirements and has a similar effect.

Also, we require that the Secretary give deference—try your best to make sure the State can do it if they want to do it —to the State's interpretation of the State law involved and the compliance of the law with the patient protection requirement. This amendment represents a true compromise. We believe it will make it less likely that the Federal Government will have to enforce these new standards and more likely that it will get signed into law.

I think we have made a good improvement. I am hopeful it will be accepted. I urge its acceptance. I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Madam President, I will make a couple of comments. I compliment my colleagues, Senator COLLINS and Senator NELSON, for offering an amendment which does recognize State roles in enforcement of insurance contracts. Unfortunately, I don't believe that is the case under the Breaux-Jeffords amendment. We will have to make a decision: Do we believe States should regulate insurance? Or should the Federal Government? Do we believe one size fits all?

I understand there is a little change and there may be some improvement over the underlying bill, but the improvement is very small. The underlying bill, the McCain-Kennedy-Edwards bill, has language in it that says all these protections that we are getting ready to tell the States they have to do, the States have to have ''substantially equivalent'' and ''as effective as'' the standards we are getting ready to pass in the bill.

I think the Senator from Maine said there are 1,100 State protections—State protections dealing with ER, State protections dealing with OB/GYN, State protections dealing with clinical trials, and so on. Almost none of the States has identical protections as what we are getting ready to mandate.

Unfortunately, the language that now is being talked about may be an improvement. Instead of ''substantially equivalent,'' it says ''substantially compliant'' with the Federal standard. ''Substantially compliant'' was written under the SCHIP program, and that was, if they did this, they would get a pot of money. That is a little different scenario than coming up with: States, you must do this or we will regulate your State insurance—even though the States have always done it. Historically, the Federal Government has never regulated State insurance.

Under the McCain-Kennedy bill or now under the Breaux-Jeffords substitute, you are still going to have the Federal Government telling the States, comply with what we are telling you substantially or else we will supersede your regulation and the Health Care Finance Administration is going to do it.

There are a couple of problems with that. HFCA can't do it. Maybe nobody cares. Maybe we should just go ahead and pass this. We might just pass it and laugh at it because I absolutely know, with certainty, HFCA can't do it.

The Secretary of HHS, Secretary Thompson, basically made that statement before the Finance Committee on June 19. HFCA is already overloaded. They haven't even enforced the Medicare rules we passed years ago. They are not even enforcing HIPAA that we passed several years ago.

Under HIPAA that is the Kennedy-Kassebaum bill that deals with portability—there are five States that have not complied. We have testimony that HFCA is not enforcing that. They are supposed to. We passed a couple of other bills. Guess what. HFCA is still not enforcing those. There is one dealing with mental parity. They have never enforced it. They never have. They are well aware they are not enforcing it; that they are not compliant. We have records of that. I will submit a bunch of these for the RECORD tomorrow. HFCA cannot do it.

Yet what are we doing? We are getting ready to say if it is not substantially compliant with the new Federal regulations, HCFA is going to come running at the charge and enforce these regulations, which they were not doing.

The National Association of Insurance Commissioners basically says the same thing. These are State insurance commissioners who work on this issue full time. They are not part time. I should not say we are part-time Senators. As Senators, we are working part time on regulating insurance and we are getting ready to mandate a lot of things to the States they will not be able to do, or we are getting ready to say States do it the way we tell you to do it or the Federal Government is going to come charging in and take over. I want everyone to know that is what we are doing and even ''substantially compliant'' is going to have a State takeover.

Here is one of their paragraphs. They say:

> Members of the National Association of Insurance Commissioners are also concerned about enforcement. As you know —

And this letter is written to Senator COLLINS—

> as a former State regulator, if there is no enforcement, then there is no protection. States have developed the infrastructure necessary to receive and process consumer complaints in a timely fashion and ensure that insurers comply with the law. The Federal Government does not have this capability and the proposals do not provide any resources to Federal agencies to develop such capability. It is taking the Health Care Finance Administration years to develop the infrastructure required to enforce the health insurance portability and accountability act, HIPAA, which included only 6 basic provisions that most States already had enacted. The proposed patient protection bills are far more complicated than HIPAA, and will require considerable oversight.

HIPAA had a few patient protections that almost all States already had, a few States still do not have, and HFCA has yet to really enforce those protections. Now we are going to give dozens of protections and have HFCA determine whether or not the States are substantially compliant with our new protections.

I will give an example. In the State of Delaware, they are in the process of passing a patient protection bill. They have an emergency room provision. In the emergency room provision that the State of Delaware is passing, they don't have poststabilization care included in their provision. We do, under this bill. This bill requires ambulance

coverage. Guess what. The State of Delaware did not include ambulance, for whatever reason. So we are going to tell the State of Delaware, a bureaucrat at HFCA is going to say: State of Delaware, you did not do it good enough. Your legislature is going to have to go back, pass a bill, have the Governor sign it, have some expansion to make sure that your ER provision is as good as the one we are getting ready to mandate.

I could go on and on.

There is an OB/GYN patient protection that basically has unlimited access to OB/GYN and gynecologists. Great. Guess what. The protection we have given to beneficiaries, patients in the Federal Employees Health Benefits Plan, gives one visit. It is not nearly as aggressive.

As a matter of fact, that points out something that maybe a lot of people have missed about all these patient protections. I have heard countless people say we want these protections applied to all Americans. I will inform my colleagues, we did not apply them to Federal employees. We do not provide these protections we are getting ready to mandate on every private sector plan in America. We forgot to include Federal employees. We forgot to include Medicare beneficiaries. We forgot to include low-income people such as those on Medicaid. We forgot to include people who work at the Department of Defense. We forgot to include veterans. We forgot to include Indians, who are under Indian Health Care.

All these patient protections—everybody said we want those to apply to everybody. They apply to the private sector, but we did not include the public sector. Did we just sort of forget that, or are we afraid maybe that would cost too much money? We are going to give all these great patient protections and basically have a Federal takeover of State-regulated insurance unless the States are substantially compliant with it or, in other words, States, you do as we tell you or the Federal Government is going to take charge. Can Federal employees sue the Federal Government? The answer is no. Can a military officer who happens to be serving overseas, or maybe in the United States, and they have something go wrong and they have poor care, can they sue the Federal Government? The answer is no.

Are they entitled to the patient protections that are being mandated on every private sector plan in America? The answer is no.

So there are some things that are really wrong. I think one of the things that is wrong is saying we are going to have the one-size-fits-all Federal Government supersede the States. States, you are substantially compliant with what we tell you to do or else we are going to take over.

I have had the pleasure of chairing the conference last year, where we negotiated patient protections. I negotiated them with my friend and colleague from Massachusetts and other Democrats. We came up with a basic agreement on most of the patient protections. But we never agreed whether or not they should supersede the patient protection laws that are in the States. I would never agree with that and I still will not agree with it.

For whatever reason, I fail to see, when you have 44 States, as the Senator from Maine has shown, that have ER protections in their States—I fail to see that we can write an emergency room provision that is so much better than every State, that we know best what should be in Maine or Oklahoma or the State of Washington or in Massachusetts, what should be in the ER provision in those States.

I really do not like the idea of having a bureaucrat at HFCA determining whether or not those laws are substantially compliant and if that bureaucrat determines they are not substantially compliant, then they have to rewrite their law.

There are legislators who were elected in the various States. The insurance commissioners work with these laws and the application of those laws and the enforcement of the laws day in and day out. I doubt we have the infinite wisdom, when we are coming up with mandated provisions, to know we should supersede all those States.

I do not doubt there are a lot of patient protections in the States that do a much better job than what we have done on the Federal level. I don't doubt there are State protections that are not as aggressive and/or not as expensive as that with which we are getting ready to mandate that they be in substantial compliance.

Again, I urge my colleagues to support the Nelson-Collins amendment. I think it is an excellent amendment. It is one that has been well thought out. It is one that is supported by two of our colleagues who had enormous experience in the insurance field. Both Senator COLLINS and Senator NELSON worked as insurance commissioners in their States. They worked at those jobs for years. They know what they are talking about. They know the Federal Government cannot enforce it. They know the Federal Government should not regulate insurance within the States.

Unfortunately, that is what we are getting ready to do. So this is a most important amendment, and I urge my colleagues to use a little common sense. If we end up passing this amendment and, heaven forbid, should it become law, I will just make a little prediction. Two years from now we will be back here saying you know what, the States are not in compliance. They were not substantially compliant, but HFCA could not tell them that. Or if HCFA told them that, they said they still couldn't be in compliance and so you have a lot of States that are theoretically not in compliance. But the Federal Government couldn't really regulate it anyway. So did they get any additional protection? No. They have a verbal assurance: Here is a bill; you are supposed to have this protection. But it is not regulated by the State and it is not enforced by the Federal Government because the Federal Government could not do it.

Tommy Thompson, Secretary of HHS, and HHS enforcement, they have thousands of employees. They spend billions of dollars and they still can't do it.

They still can't do it. They couldn't do it if we gave it to them. I hope we don't give it to them. You didn't actually extend patient protection. What you give is kind of a false protection. It is not real. You have a whole lot of confusion. Oh, wait a minute. The State has been doing this for 40 or 50 years. Now the Federal Government is supposed to be doing it, and they can't do it. There is no real patient protection in the first place. Maybe it makes politicians feel good if we are telling the States to do this. I sure hope they do it. What is the remedy if they don't do it? The Federal Government is going to take over. That is not a very good remedy if the Federal Government can't do it, especially since the Federal Government should not do it.

I want to again compliment my friends and colleagues, Senator COLLINS and Senator NELSON, for offering an outstanding amendment.

I urge my colleagues to vote no, regrettably, on the Breaux-Jeffords amendment.

I think ''substantially compliant'' may be a tad better than ''substantially equivalent,'' but not much. It is still a Federal takeover. It still has Federal enforcement. It still has HCFA making a determination whether or not you are substantially compliant, and that is not a good solution.

I urge my colleagues to support the Collins-Nelson amendment. That would be a giant step, and one which I might mention that Governors around the Nation are going to wake up to. They have been asleep. But Governors around the Nation, Democrats and Republicans, who want to maintain State control and regulation over insurance are going to wake up to what we are doing one of these days and they are going to be coming up saying: What are you doing? Congress, you can't regulate insurance. You haven't been doing that. You don't know how to do it. What in the world do you think you are doing?

We are going to hear from them. I would venture to say that Democratic as well as Republican Governors are going to be outraged should this provision invade the scope, preempting the State, and mandating to the States that the Federal Government knows best when it comes to patient protection—and not even giving real credibility to what the States have already done; not giving them a grandfather. They have already enacted legislation dealing with those particular patient protections. The Collins-Nelson amendment grandfathers States that have

done patient protections. We should recognize what they are doing and give them credit for it—not try to supersede it with a Government-knows-best solution.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Madam President, I rise in support of the Collins-Nelson amendment. I thank them for their foresight and pointing out to this entire body that Washington doesn't always know best. In this particular case, they are not only saying Washington does not always know best but Washington is incapable of doing the job that this bill gives them to do, even if Washington knew best.

This is a very important amendment. The people who are proposing this bill ought to look at the overburdened responsibilities that the Health Care Financing Administration already has and it is not able to do.

It is from that point that I want to speak about my support for the Collins-Nelson amendment.

I want to make very clear that, as most of my colleagues, I believe that any patient protection we pass must be meaningful and enforceable. But the provisions that the Collins-Nelson amendment deals with, and that they strike and change, are the provisions of the bill that delegates most of its new enforcement responsibilities to an agency that is one of the most overburdened bureaucracies in Washington, DC.

The Washington bureaucrats who work there are not going to be able to take the action necessary to give patients the protections that are determined by the authors of this amendment they ought to have, and that we all would agree ought to be there. But it can be done under State supervision, and it can be done much better and much more expeditiously than it can be done through the Health Care Financing Administration.

It is the difference between going to Des Moines, IA, to get the protections or coming to the Baltimore headquarters of the Health Care Financing Administration—because, historically, this agency has been already slow in publishing regulations, and it lacks in its enforcement of existing Federal laws that we passed putting responsibilities on its back.

Of course, I have high hopes that our new Secretary of Health and Human Services, Governor Thompson, and the new Administrator of the Health Care Financing Administration, Tom Scully, will turn things around. While I hope that and I believe that, I don't expect a radical change is going to be necessary for the Health Care Financing Administration to carry out the responsibilities that the authors of this legislation want them to do, nor that it will be radical enough to change overnight to get the job done of administering this portion of their bill the way it should be.

At this time, shouldering the Health Care Financing Administration with a task of enforcing broad new Federal patient protections is clearly inappropriate.

Our new Secretary and Administrator have walked into myriad backlog regulations, hundreds of unanswered letters, and burdensome internal policies that hinder already efficient and effective work that the taxpayers expect to be done by this agency.

Just last week at a hearing we were having on agency reforms before the Senate Finance Committee that deals with this issue, we had Secretary Thompson and Administrator Scully pleading with us to keep new tasks away from the agency so that the catchup work on these existing responsibilities can be done.

I quote Secretary Thompson on that very point. He used the new name, the Center for Medicare Services. He said:

> The Center for Medicare Services right now is overloaded with HIPAA and with the privacy rules and regulations, with Medicare and Medicaid, and SCHIP, and so on.

Rather than listing all of the other responsibilities, he said:

> I do not think we can really take on any more responsibilities.

That is the Secretary who has the responsibility of carrying out the laws that we already passed, along with the regulations that have to be written to enforce those laws. He would like to get those out of the way before he gets any additional new responsibilities.

I want to take just a few minutes to share some important examples of how this agency in the past has been unable to meet its existing obligations.

In 1996, Congress passed the Health Insurance Portability and Accountability Act. That is the act that Secretary Thompson referred to as HIPAA. We passed it. To date, the agency is over 3 years behind on implementing major provisions of that 1996 act.

The agency is almost 2 years behind in implementing a fee schedule for ambulance services that was mandated in the Balanced Budget Act of 1997. There were several more mandates in the Balanced Budget Act of 1997 that have had no regulations published at all, such as how regional carriers will process clinical laboratory claims, and how durable medical equipment suppliers must comply with the surety bond requirements.

And get this: In 1986, Congress passed very sweeping legislation to make sure that the delivery of quality care in the nursing homes of America, and the agency took 8 years, from the date of enactment, to publish the enforcement regulations on the nursing home laws.

Even more egregious, there are no final regulations published for the Medicaid Drug Rebate Program, a program enacted into law over 10 years ago.

So the list goes on and on. I hope you can see this is an agency that is already overloaded and is seriously behind on many Federal mandates Congress has put in place over the last decade; and in the case of nursing home laws, a decade and a half ago.

We cannot expect, nor should we expect, that this agency is capable of enforcing patients' protections under this legislation.

The Secretary of Health and Human Services has already told us they are working 24/7 to improve operations and responsiveness for their existing programs, such as Medicare and Medicaid.

In the end, it is the patient who is going to suffer when patient protection regulations get delayed or are improperly enforced or, in some instances, such as the nursing home laws, for 8 years, not enforced at all.

That is exactly what will happen under the Kennedy-McCain bill where the sole responsibility of enforcing and implementing patient protection certification falls on the agency that formerly was called the Health Care Financing Administration.

I cannot support the Kennedy-McCain bill with these meaningless enforcement provisions. In fact, it would be irresponsible to do so when the agency itself has made very clear to the public that they will not be able to handle any new patient protection mandates.

I do not presume that Senator KENNEDY and Senator MCCAIN meant for this provision of their legislation to be meaningless in its enforcement. But, as a practical matter, if HCFA is already overloaded, and if they are already not writing the regulations for legislation that has been passed over the past 10 years, the ultimate result of passing this bill this way—putting this responsibility on the Health Care Financing Administration—is that it will not be enforced any more than the nursing home laws, which as I said were left unenforced for 8 years.

So I have come to the conclusion that the Collins-Nelson amendment is the right thing to do. Why fool the American people? Washington bureaucrats do not always know best. And we, as Congressmen, if we have not lost touch with the grassroots of America, and if we exercise a little common sense, we ought to be able to show to a majority of this body—and for a majority of this body to understand—that if HCFA cannot carry out the law, if they have not carried out a lot of mandates of the Congress of the United States in the past decade, why would you put more responsibilities on their back? If you want patient protection, then let it be done where it can be done, and that is in those States that have meaningful enforcement laws already for patient protection, because this amendment allows States to maintain the hard-fought patient protections they have put in place for their own citizens. And the amendment encourages States to develop even stronger protections.

So I urge my colleagues to support this approach, one that recognizes the

vital role that States play in tailoring patient protections to best meet the needs of their respective citizens.

I thank the Chair.

The PRESIDING OFFICER (Mr. DAYTON). The Senator from Wyoming.

Mr. ENZI. Thank you, Mr. President.

I appreciate the other side allowing us this opportunity to state our case at the beginning because of some important considerations we have.

I particularly congratulate the Senator from Maine, SUSAN COLLINS, for her tremendous efforts on this entire Patients' Bill of Rights. On any issue in which she gets involved, you will find that she studies it to a greater depth than anyone. She does additional research; she gets all of the help she can; she gets to the point where she understands what she is doing; and then she works with others to make it better. It does not happen a lot around here. But she is one dedicated Senator who is always willing to look at a better idea.

She has teamed up, in this particular instance, with Senator NELSON, a neighbor of mine, from Nebraska. One of the reasons this is an interesting team is that they have both been State insurance commissioners. They both understand the State side of this. They both understand what is in the bill. I would not want to imply that everybody does not, but these are two people who absolutely understand what is going on in the bill. They have teamed up and said there is a way that we can provide the protections, that we can get the States involved, and that we can enlarge the scope. They put it together. I congratulate them for their tremendous efforts.

For 2 weeks, I have been saying that on 80 percent of this bill both sides agree. On eighty percent of it we agree. It is that other 20 percent where there are some philosophical differences.

I have seen—both in legislating that I did before I got to the Senate and since I have arrived—that one of the keys to passing legislation is to put a good title on the bill. That is something we agree on 100 percent: The Patients' Bill of Rights is a great title. What you do with that can be an abuse of the title. And on 20 percent of this bill, there is an abuse of that title.

There are some substantial changes that need to be made. One of those is, who is going to administer it? There are two very different philosophies involved in the administration of this bill. One side says: Washington knows best. Bring it back to Washington. If the bureaucracy isn't big enough now, we will make it big enough. And we will put enough dollars in it that we will be able to solve it.

For anybody in America who has ever had to work with the Washington bureaucracy, picture the difference between Washington and your local and State governments.

When you call Washington, have you ever gotten to talk to the same person twice? That means that when you call in today with a problem that you have to explain, and then when they do not take care of it—because they really do not have the involvement that they do if they know you—you have to call them back. Well, you would not know by tomorrow; you would not know by next week. You would be lucky to know by next month. But next month, when you are sure Washington has not solved your problem, you have to call again. And I guarantee you, you will talk to a different person who will say: What is your problem? And after you have gone through all of the explanation again, they will say: We will get back to you on it. And you are going to spend another month getting back to them on it.

Contrast that with State and local calls that you have had to make. You can almost always talk to the same person again, so the problem that you discussed yesterday they still remember today. And you do not have to wait a month for the decision because they are doing the job efficiently.

There are various ranges of bureaucracies and efficiencies in Washington, also. This bill has chosen to give the jurisdiction to that agency that is doing the poorest job. Don't believe me. Don't believe the debate. What I ask you to do is call your doctor and ask them what they think of HCFA. Call it HCFA; it is the Health Care Financing Administration. But they call it HCFA because that is a four-letter cuss word to them. You will find that your doctor thinks HCFA is a cuss word. That is how impressed they are with the administration of this agency, the one to which we are about to turn over all of the jurisdiction for the problems you have worked with your State on before. We are going to take what the States have been doing, and doing well for over 50 years, where there are people you can talk to every day, and we are going to say, no, you are not doing a good enough job because there is some bureaucrat in Washington who decided that they know better and they want to handle your problem.

Find out how efficient HCFA is. I am certain under the new administration that it will be more effective, but it will be a long time recovering from the problems it has right now. Yes, we can throw more money at it. Is that where you want your tax money to go?

Right now, your States are paying for that. We are going to duplicate and supersede, without saving you a dime and in fact costing you more.

Does the Federal Government do a better job? One of the things I have been working on since I have been here is OSHA. OSHA allows two different processes. One is State plan States. That is where the States do the work. The other is the Federal plan. That is where the Federal Government takes care. I can tell you that the accidents are less in the State plan States for just the reasons I mentioned before. A bureaucracy operating out of Washington, trying to handle the whole country as a one-size-fits-all problem can't do the same job as the people at home in your State.

What are some of the things they have to handle? I will tell you, the new reason that HCFA is going to become a bigger cuss word is called HIPAA. This has to do with portability of insurance. The change in some of my phone calls this week has been calls from doctors and hospitals. They weren't concerned about a Patients' Bill of Rights yet. They were concerned about the HIPAA privacy rules. Ask your doctors and your hospitals what they think about that.

Privacy is important to all of us, but they have managed to muff that one. The same agency that people are calling me and complaining about right now is related to where we are going to turn over, under the opposing amendment, all of the workload.

This week and last week you heard about a number of amendments. One of the things I am very proud of is that all of those amendments were different solutions that needed to be done on this 20 percent of the bill where there is a problem, different approaches. It was not the same amendment time after time after time, which we have seen here before. It was different approaches to different problems in the bill. There are about six problems that we have to get solved, that we have to get some consensus on in order to have a good bill, one that matches up to the title of Patients' Bill of Rights.

What you are seeing here, of course, is us trying to solve in the committee of the whole what could have been done in committee. You are seeing more amendments here than what you might see on the floor with the bill. But that is because normally we have the committee meetings where we get to put forward lots of amendments in a smaller group and, therefore, be able to get them decided with less discussion because there are fewer people.

I mentioned some phone calls. I have to add that I am starting to get some other phone calls now which are from my school districts, wondering how this bill is going to affect them. They know we just finished the education bill and that there might be some more money under the education bill for them. They are asking: But we provide insurance to our employees; is this going to suck up all that money, and how liable will we be?

Again, I congratulate the Senator from Maine and the Senator from Nebraska for the tremendous work they have done in coming up with a solution—one we talked about last year—on which there was a lot of consensus. There was a lot more give, a lot more understanding, and even people supporting this one who seem to think HCFA is a better solution now.

One of the groups supporting the Collins amendment that I want to point out is the National Conference of State Legislatures. They recognize the value of the State handling these insurance problems.

I ask unanimous consent that there be printed in the RECORD after my remarks a letter from the National Conference of State Legislatures.

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

(See Exhibit 1.)

Mr. ENZI. Among the handful of principles that are fundamental to any true protection for health care consumers, probably the most important is allowing States to continue in their role as the primary regulator of health insurance. It is because of my commitment to preserving existing consumer protections that I am glad to be a cosponsor of the Collins-Nelson amendment. Their amendment recognizes a principle that has been recognized and respected for more than 50 years.

In 1945, Congress passed the McCarran-Ferguson Act, a clear acknowledgment by the Federal Government that States are indeed the most appropriate regulators of health insurance. It was acknowledged that States are better able to understand their consumers' needs and concerns. It was determined that States are more responsive, more effective enforcers of consumer protections.

As recently as last year, this fact was reaffirmed by the General Accounting Office. GAO testified before the Health, Education, Labor, and Pensions Committee saying:

> In brief, we found that many states have responded to managed care consumers' concerns about access to health care and information disclosure. However, they often differ in their specific approaches, in scope and in form.

Wyoming has its own unique set of health care needs and concerns. Every State does. For example, despite our elevation, we don't need the mandate regarding skin cancer that Florida has on the books. My favorite illustration of just how crazy a nationalized system of health care mandates would be comes from my own time in the Wyoming Legislature. It is about a mandate I voted for and still support today. Unlike Massachusetts or California, for example, in Wyoming we have few health care providers, and their numbers virtually dry up as you head out of town. We don't have a single city with competing hospitals. So we passed an ''any willing provider'' law that requires health plans to contract with any provider in Wyoming who is willing to do so.

While that may sound strange to my ears in any other context, it was the right thing for Wyoming to do. But I know it is not the right thing for Massachusetts or California. I wouldn't dream of asking them to shoulder the same kind of mandate for our sake when we can simply, responsibly apply it within our borders. That is what States have been doing with the 1,100 laws they have passed dealing with patients' bills of rights.

What is even more alarming to me is that Wyoming has opted not to enact health care laws that specifically relate to HMOs. But that is because there are ostensibly no HMOs in Wyoming. There is one which is very small. It is operated by a group of doctors who live in town, not a nameless, faceless insurance company. Yet the sponsors of the underlying bill insist they know what is best for everybody. So they want to require the State of Wyoming to enact and actively enforce—that is what the opposing amendment does, enact and actively enforce—what they say is the right thing for our State. They want to regulate under 15 new laws a style of health insurance that doesn't even exist in our State.

It requires States to forsake laws that they have already passed dealing with patient protections included in the bill, if they are not the same as the new Federal standard. The technical language in the bill reads ''substantially equivalent,'' ''does not prevent the application of,'' and under the process of certifying these facts with the Secretary of Health and Human Services, the State will have to prove that their laws are ''substantially equivalent'' or some other variation of words. There are a whole bunch of words that could be used there.

There could be a whole series of amendments to undermine the Collins amendment. This is one of them.

The proponents of this language—whichever version you care to look at, except for Collins—say that it won't undo existing State laws that are essentially comparable, but that isn't what their bill requires. Under either amendment—the bill or the Breaux-Jeffords amendment—they are going to force States to change laws that they have already reviewed, that they believe already work in their States.

Is it that the proponents aren't overly concerned with the implementation of the law versus being able to say that their bill meets the political test of covering all Americans, regardless of existing, meaningful protections that State legislatures have enacted? If the laws just have to be comparable, why don't they use that phrase? I will get into this issue in more detail as the debate proceeds. I believe we can compromise. I don't think this is the compromise. I like the language of the Collins amendment. The only hard proof that we have right now is that States are, by and large, good regulators, while the Federal Government has done a lousy job. The General Accounting Office has been reporting to us that since we passed the Health Insurance Portability and Accountability Act in 1996. And that is the ''consumer protection enforcement'' mechanism around which the bill before us is written.

Wyoming currently requires that the plans provide information to patients about coverage, copays and so on, much as we would do in this bill; a ban on gag clauses between doctors and patients; and an internal appeals process to dispute denied claims. I am hopeful that the State will soon enact an external appeals process, too. This is a list of patient protections that a person in any kind of health plan needs, which is why the State has acted. But requiring Wyoming to enact a series of additional laws that don't have any bearing on consumers in our State is an unbelievable waste of the citizens' legislature's time and resources.

As consumers, we should be downright angry at how some of our elected officials are responding to our concerns about the quality of our health care and the alarming problem of the uninsured in this country.

We are talking about driving up the price of insurance and driving people out of the insurance market. I keep mentioning that insurance in this country is provided on a voluntary basis. We have had amendments that dealt with small businesses to see if they could get any kind of relief. Most of them are strained to the maximum. The smaller your business, the higher your potential risk, so the higher the rates you pay. Insurance is risk protection. We discriminate against the smaller businesses on rates because it is actuarially more difficult to calculate that.

Under this bill, we have had some opportunities to provide some relief to those small businessmen. It hasn't happened. They have been ignored. I will be bringing an amendment that will deal with the large businesses. I almost exclusively work with small businesses. Tomorrow, I will be bringing one that deals with the big self-insured, self-administered companies to see if there is going to be any hope of relief for those people who provide the best insurance in this country.

Mr. President, we will be committing two fouls against consumers if we do not adopt the Collins-Nelson amendment. The first would be to eliminate all meaningful patient protections that are not exactly like the Federal law. Second would be to put in enforcement responsibilities with the agency that has already said it can't do the job. Add to that the third foul that the rest of the bill prices millions of people out of health insurance and we have done anything but hit a home run for patients.

I urge my colleagues to consider the valuable experience and wisdom of the amendment sponsors, as well as the urging of the National Council of State Legislatures. Think about the divergence of philosophy. Do you want your health care to be one size fits all in Washington, determined by HIPAA and HCFA, or do you still want your States to be involved? Do you want your States to have the control? Do you want your States to be able to continue the kind of service they have been providing through your State legislatures that can make decisions based on your State and your needs?

I yield the floor.

EXHIBIT 1

NATIONAL CONFERENCE OF STATE LEGISLATURES,
Washington, DC, June 27, 2001.

Hon. SUSAN COLLINS,
U.S. Senate,
Washington, DC.
Hon. BEN NELSON,
U.S. Senate,
Washington, DC.

DEAR SENATOR COLLINS AND SENATOR NELSON: On behalf of the National Conference of State Legislatures, I would like to take this opportunity to commend you for authoring an amendment to S. 1052, the pending Patients' Bill of Rights legislation. Your amendment recognizes the important work states have done regarding the regulation of managed care entities and supports the continued role of states in the regulation of health insurance.

The amendment substantially addresses concerns we expressed in our recent letter to you and your colleagues. In that letter we urged you to: (1) grandfather existing state patient and provider protection laws; and (2) provide a transition period between the enactment of federal legislation and the effective date of the Act to provide each state an opportunity to preserve their authority to regulate managed care entities. This amendment also addresses our concerns regarding the adequacy of the federal infrastructure to enforce the patient and provider protections established in the bill. Finally, it is important to emphasize that the proposed amendment recognizes that insurance markets differ among the states and a ''one size fits all'' approach may have adverse results among states and within regions of a state. This amendment permits a state to certify adverse impact and head off disruption in its insurance market.

NCSL supports this amendment. States are best situated to provide oversight and enforcement of the patient and provider protections established in the legislation. The record of the states is strong. We are looking for an approach that supports the traditional role of states in the regulation of insurance and that recognizes the differences in state insurance markets and provides a mechanism for states to protect those markets.

NCSL supports passage of Patients' Bill of Rights legislation that makes a promise that can be fulfilled. We believe state oversight and enforcement is an integral part of ensuring fulfillment of the promise and we look forward to continuing to work with you to develop legislation that will improve the quality of health care without adversely affecting access to care.

Sincerely,

GARNET COLEMAN,
Texas House of Representatives,
Chairman, NCSL Health Committee.

The PRESIDING OFFICER. The Senator from Maine is recognized.

Ms. COLLINS. Mr. President, I will be brief because I see the Senator from Massachusetts also desires to speak. First, I thank my colleague and friend from Wyoming for his extraordinarily generous comments and also for his excellent statement. As a former State senator, he has a great deal of experience in this area. As a businessman, he knows what it is to provide health insurance and to try to provide good benefits for his employees. I am grateful for his support.

Very briefly, I want to respond to a couple of comments that have been made tonight. The former chairman of the Finance Committee, Senator GRASSLEY, talked about the burden on HCFA. I think this is very important because the McCain-Kennedy bill—and, unfortunately, the amendment offered by my friend from Louisiana continues this problem—is expecting that HCFA is somehow going to be able to step into the role of insurance regulator, which is something the States have performed well for more than 50 years.

Look at what would be required under the Breaux-Jeffords amendment. Let me read you one part of the burden on the Secretary under the provisions called ''Petition Process'':

> Effective on the date on which the provisions of this Act become effective, as provided for in section 401, a group health plan, health insurance issuer, participant, beneficiary, or enrollee may submit a petition to the Secretary for an advisory opinion as to whether or not a standard or requirement under a State law applicable to the plan, issuer, participant, beneficiary, or enrollee that is not the subject of a certification under this subsection, is superseded under subsection (a)(1) because such standard or requirement prevents the application of a requirement of this title.

In other words, this sets up a process by which the Secretary of HHS is going to be inundated with requests for advisory opinions from anyone who is covered under a State-regulated insurance plan who wants to know whether or not a certain provision of that particular State's laws is superseded by the Federal law. This is just not workable. There is just no way that HCFA is going to be able to take over these responsibilities.

My friend from Louisiana drew the analogy with the State Children's Insurance Plans. I am very proud of that program. I was one of the original cosponsors of the legislation that the Senator from Massachusetts and the Senator from Utah proposed to create this important program to expand access to insurance to low-income children. But these are not analogous situations. We are not talking about a federally funded health program. We are not talking about that. We are talking about the regulation of health insurance.

The Federal Government is not providing funds for this. The Federal Government is not involved in this traditionally. This is entirely different from pointing to a Federal program that happens to be administered by the States but which is federally funded where, of course, it makes sense for the Federal Government to set standards. So it is two entirely different matters.

Finally, I make the point that one should look—and I encourage the Senator from Louisiana to look—at the provisions of his State's laws on consumer and patient protections. They are not identical to the standards in the McCain-Kennedy bill. For example, when you look at the Louisiana law dealing with emergency room access, we find that Louisiana has a law, but that it is crafted in a different way than the McCain-Kennedy bill. So now we have to decide, is it substantially compliant with the provisions of the bill, which would be the standard the Senator from Louisiana would have? It differs in some respects—on reimbursements, on how much is covered, on poststabilization care.

If the State of Louisiana crafted a law dealing with emergency room access, as they have, why should we second-guess that law? Why should we substitute our judgment for the judgment of the good people of the State of Louisiana?

I remind my colleagues that the States have not fallen down on the job. There are more than 1,100 patient protections out there far beyond the confines of this bill.

Unfortunately, while the Breaux-Jeffords amendment is an improvement over the underlying bill, it is still fatally flawed. I urge my colleagues to vote no on the Breaux-Jeffords amendment and yes on the Collins-Nelson amendment.

I thank the Chair, and I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I have great respect for my friend and colleague from Maine, Senator COLLINS. Senator COLLINS is a member of our Health, Education, Labor, and Pensions Committee. As always, she has demonstrated tonight that she is well informed, articulate, and persuasive—I hope in this instance not too persuasive—to her point of view.

As always, she spends a great deal of time thinking through these issues. I commend her for her presentation, and I respect her for her position, although it is a position that I cannot support, and I will urge my colleagues to support the alternative, which is the Breaux-Jeffords amendment.

We have tried over time, although we do not receive great acknowledgment for it, to find ways we can work with the administration. We have had four or five major issues. The administration really did not take a position about the tax incentives in the legislation, although many of us saw that the tax incentives in the legislation, which many of us supported, would have resulted in the end of this legislation for reasons that have been pointed out earlier. The tax-raising power lies with the House of Representatives, and not with the Senate.

Second, on the issue of responsibility of employers, the President made very clear in his statement that he wanted employers who were exercising their judgment in ways HMOs normally do—to bear responsibility if there is injury and harm to patients.

We have been wrestling with that definition for several days. We will have an additional opportunity to wrestle with it, but the President has been very clear about wanting to hold responsible those employers who make judgments that interfere with the medical judgments which adversely affect patients. He wants to hold them responsible. That is what many of our

colleagues have been attempting to do, and they have been doing it in a bipartisan way.

We have had amendments to eliminate all responsibility for employers, and amendments for employers with 50 employees or less. These have been defeated.

The President was talking in ways many of us understood. We may differ as to the language, and we do have differences with the President on the liability provisions, but on those other issues, we are very much along the same lines.

The President, as well, in his support for the Frist-Breaux bill, basically supported the medical necessity provisions we had included in the McCain-Edwards legislation. They are virtually identical to those in the underlying bill, and the President indicated support of the medical necessity provisions. Those are enormously important.

We come to the third of the major issues, and that is scope. Who is going to be covered, and for what particular protections? The President again indicated in his principles for a bipartisan bill that it should apply to all Americans—all Americans; that a Federal Patients' Bill of Rights should ensure that every person—not just some people, not just a few people in some States, not just some who are covered for certain protections in a few States—but that all Americans, every person enrolled in a health plan, enjoy strong patient protections. Those are words that he used.

The Breaux amendment is consistent with that particular principle. It is not drafted exactly the way I would like to have it drafted. It does not go to the extent I would like to have gone to guarantee the strong protections which Americans deserve. But nonetheless, in a very important way, the Breaux amendment complies with this particular provision. It will ensure that all Americans are going to be covered and that they will have strong protections. The Breaux proposal also ensures that protections for Americans will remain in the States. They will be the primary regulator under the Breaux proposal. That is the way it was drafted, and it is a preferable way to ensure not only what the President has stated, but what I think I have heard stated by my good friend, the Senator from Tennessee, our ranking member on the HELP Committee, and others.

As a matter of fact, every proposal that the House of Representatives considered in their debate last year—I believe there were four major proposals offered by Republicans—all of them included all Americans. That was not a debatable point. It is tonight, and tomorrow morning, we will have the opportunity to see where the Senate is going to stand.

I will make a few points, and if I am not correct, Senator COLLINS will correct me—we only received the amendment just prior to the time the Senator offered it, although clearly we were very much aware this amendment was coming and Senator COLLINS told us about that. I will make a statement and a point, and if I am wrong, the Senator from Maine will correct me.

If her amendment is passed tomorrow, or whenever we pass the final legislation, there will no guarantee of one new protection for most Americans. Do my colleagues understand what I am saying? Mr. President, do they understand what I am saying? If the Collins amendment succeeds and is passed, when it goes into law, there will not be one new protection for most people in this country. There will not be any protection for the children who need speciality care; there will not be any new protections guaranteed for women who need clinical trials; there will be no new protections in a wide range of provisions that are included in the underlying legislation. None, unless—unless—the States go about the business of applying and providing them.

Let me be very clear about it, with the passage of her amendment, there is not one new protection from an HMO making the medical decisions they have made in the past.

It seems to me that is why we are here because we have, for the last 5 years, been battling to make sure families in this country receive protections, whether they are in Massachusetts, Nevada, or Maine.

Let's look at what the circumstances are of some of the States. First, there is an authorization for $500 million, a pool—new funds of $500 million. That is in the amendment. Where we are going to get the money for those funds is not in there. We have authorized funds on many other issues and they have not been appropriated. Welcome to the club. This relies on a $500 million appropriation.

When this is passed, there will still be 39 States that do not require any access to clinical trials. In the United States, you might work in Massachusetts today, and maybe you will be transferred to Nevada next year, and then transferred to another State after that. Let me make it clear to you and your family you had better make sure they are one of the 11 States that have clinical trials. Most of the states that have clinical trials are for cancer, but don't include other life-threatening diseases.

When I came to the Senate, you worked at the shipyard, your father worked there, and your grandfather worked there. You graduated from high school and had a good life. Those in the workforce today may have nine different jobs over the course of their life, moving all over the country. We ought to get a dartboard to find out where the protections are in the various States for you and your family, moving from one company to another.

There are 39 States that do not require clinical trials. Zero States affirmatively require timely access to specialists. If we pass the Collins amendment, there will be a signing ceremony at the White House—hopefully and after the bill is in effect, someone will say: I thought when I had a child who had cancer and we went to our HMO, we would get the guarantee of accessing a specialist. And now that is overridden. I thought we would get the protections we needed. I listened to the debate in Washington that said we could get specialty care.

No, no, no, that is not so, because they passed the Collins amendment. The Collins amendment says, only if the States provide it do they get access to specialists.

We have 20 States that do not ban financial incentives for providers to delay or deny care. What is happening in HMOs is, as we heard in the numerous committee hearings we have held, there are financial incentives and disincentives for doctors on the procedures they recommend in terms of treating patients. Do we do anything about that? No, no, we are not going to do anything about that, not in 20 States, not if you live in one of those 20 States. They will have incentives and disincentives for the doctors.

Tell me what consumer knows about that. Ask any Member of the Senate, if they didn't have a briefing sheet before them, whether their State does or does not ban financial incentives. They will not have to worry because we have good Federal employee health insurance. We will not have to worry. But I doubt whether any Member knows whether their State prohibits it or not.

There is nothing under the Collins amendment that will make sure states ban inappropriate financial incentives. Under the underlying bill, there is a prohibition on their use. No HMO ought to provide incentives or disincentives to doctors in terms of providing or recommending necessary treatment. What do we have to learn from this? We have hearings, we find out, we see the affected families, and then do we say, no, Washington does not know best, in this case, ensuring we do not have inappropriate financial incentives? We ought to be able to agree on that. Is that a vast intrusion on States rights?

The list goes on. We have seven States that have not adopted a prudent layperson standard for emergency care. If you live in one of those seven States and you think you are having a heart attack and go to the emergency room, you may end up without that care covered. We have seen a number of States take action. It is important to do that.

The Breaux alternative says, when the States have taken action in these various areas, there will be respect for that action being taken in the State to protect their citizens and deference will be given to them. That is the way it ought to be. In areas where there is no protection, we are trying to establish a federal floor. If the States want to go beyond that, they can, but at least establish a floor of protections.

I listened with interest to both the Senator from Maine and the Senator

from Wyoming about two previous pieces of legislation, CHIP and HIPAA. When we passed the CHIP program we provided incentives and money. That is not the issue. The issue is, we gave the States the certain criteria that had to be met, and if they met those criteria the Federal provisions did not apply. Mr. President, 49 of 50 States have done that.

I monitored that program closely in our HELP committee. Even when I was not chairman, we had meetings with the previous administration to find out what was happening with that program. I am familiar with it. We don't have complaints from the States. We are not hearing from the States about the heavy hand of the Federal Government for establishing CHIP. They can say they were getting money for that, fine; they were also ensuring that children would have the range of services that would meet needs—not the complete range of services I would like to see. We still don't provide the comprehensive care—eyeglasses or hearing that we ought to provide for children. Dental work was left out, along with many other services that children need, but we find States conforming to the package that was developed.

The other reference was with regard to HIPAA. I have heard that speech from the Senator from Oklahoma now eight times. He gets better at it each time he talks about HIPAA and HCFA. I point out, when the GAO recommended $11 million so HCFA would be able to implement HIPAA, he was the one who led the fight against the $11 million, and he was successful. They put in $2 million. And he led the fight to strike out that $2 million so that HCFA could not implement it because they wanted greater flexibility in the States so the insurance companies—that is my conclusion—would be less interfered with. I have had that argument and I will not spend time on it now.

The fact is, tonight there are only five States which are not in complete compliance with HIPAA. It has taken time. Many of the criteria placed upon the States are similar to what is in the Breaux proposal. I personally would like to see a stronger provision. At the time we pass this bill, I would like to see all Americans have protections. We have taken those steps in the past on other issues.

We decided as a pattern of national policy we were going to pass Federal laws to outlaw child labor in this country. We didn't say: You can go ahead and have that up in Massachusetts if you want to. We passed laws. Anyone can visit now in Lawrence and Lowell, go through the mill, look at the museums and read the poems and letters of 9- and 10-year-old children trapped in factories for 10 or 12 hours a day who wrote as they looked outside and saw other children play. We went through that as a nation and passed federal laws to prohibit that.

We also said, we will pass a minimum wage law. We know there are many here who resented it. We passed laws in order to protect our environment because we recognize that environmental issues go through various States and the environmental issues know no borders. I make the same case with regard to workers today, as well. It was not that way in the old days, but it is that way today.

We made the same judgment with regard to civil rights. You can say, well, these patient protections are not of the dimension of the issues on civil rights. I think there is a lot you can say about that. But if you listen to the HMO victims whom many of us have heard, if you see the failure of the recommendations of doctors and nurses and medical professionals—the failure of their recommendations because of an HMO bureaucrat many miles away, and you see how lives have been destroyed and how families have been absolutely destroyed—we can ask ourselves, why shouldn't we give that kind of protection to families in this country?

Americans, I think, are under a lot of pressures today. Working families are under a lot of pressure. They are not asking for much. They are asking for good jobs with a good future. They are asking for schools where their children can learn. They are asking for health insurance that is going to cover them. They want clean water, they want clean air, they want safety and security in their communities, they want to own their own home, they want a national security and defense that are going to protect our interests, and they want human rights policies abroad that are going to represent our fundamental values.

They are not asking for much. But one of the things we can do is protect them when they do get that health insurance. We will be back. We give the other side the assurance we will be back. All those speeches we have heard over these past days asking why are we doing this when we have so many people uninsured—we will be back with legislation on the uninsured. We hope for support from so many of those who have been speaking recently about how we ought to make sure people are going to be covered. We will be back to try to make sure we deal with those individuals.

But when you have an opportunity to relieve families of the anxiety so every time they go to a doctor they are going to get the best the doctor can prescribe and the best the nurse can give —when you give that guarantee to every family in America, you are going to ease their anxiety when they have a sick one.

Why are we going to play roulette? Let's say you live in Massachusetts today, or Florida, or New Mexico tomorrow. You shouldn't have to worry, which one is going to give strong patient protections?

That is what this is about. I do not know what we need as a record. The reasons for this are so powerful, so compelling, so real. We have had statements from every Member in this body about the damage that has taken place and the disruptions to families. We have the opportunity to do something about it. It seems scope is a key issue, a key question. I hope the Senate will come down on the side of the proposal of the Senator from Louisiana.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, I first want to say I very much enjoyed working with my colleague from New England. He is a passionate advocate for children on health care and education issues. He did, however, make a misstatement about the implications of my amendment and has invited me to correct the record if it was wrong. I want to take the opportunity to do so.

In fact, my approach does provide new consumer protections. Let me expand on that because I must not have been clear in explaining it earlier.

Under current law, there are federally regulated insurance plans and there are State-regulated insurance plans. The Federal plans, under ERISA, are beyond the reach of Federal regulators. So all those laws we have talked about, those 1,100 or more State laws and regulations, do not apply to consumers who are enrolled and covered by ERISA plans, the federally regulated plans, because State governments are prohibited from applying regulations to ERISA plans. They are preempted in that way.

All of these great consumer protections that the States have enacted over the last decade do not apply to patients who are covered by ERISA plans. This legislation—and it is one of the reasons I strongly support patient protection legislation at the Federal level—would close that gap. It would ensure that consumers who are part of ERISA plans receive the kinds of consumer protections that are available to patients whose health care coverage is provided by plans that are regulated by State governments.

So it is not accurate to say my approach will not result in any new consumer protections. Rather, the approach my colleague from Nebraska, Senator NELSON, and I have proposed is intended to make sure we can provide the same kinds of protections for consumers in Federal plans that the States have done for consumers who are covered by State-regulated plans.

In addition, there is a requirement under the Collins-Nelson amendment for States that have not enacted consumer protection laws—there are many that have in many areas, but there are some holes here and there. There is a requirement that those States either enact a law that is consistent with the purposes of those patient protections in the McCain-Kennedy bill by the date of enactment—we are not even giving them very long. They have to do it by October 1 of next year. That is going to be difficult for some States that have biennial legislatures. But we require

them to either enact a law that is consistent with the purposes of the consumer protections in the McCain-Kennedy law or, if they decline to do so, they have to certify their reasons for not doing so to the Secretary.

It is just not true to say our approach, the Collins-Nelson approach, does not result in any new consumer protections. In fact, what it does is preserve the good work that the States have done, rather than requiring the States to adopt a one-size-fits-all, made-in-Washington approach that may not work in their particular States. We preserve the State laws, but then we close the gap by requiring federally regulated insurance plans to have similar consumer protections. That is very important. That does result in new patient protections for millions of Americans whose insurance is under federally regulated plans.

In addition, States cannot ignore this issue. They haven't ignored it; they have been very active, but, as I said, there are some holes. What they would have to do as a State is consider this issue and No. 1, enact a law consistent with the purposes of McCain-Kennedy or, No. 2, certify to the Secretary that they did not enact a law because either there is no managed care in their State—such as Alaska or Wyoming, where it is irrelevant—or they believed the costs were such that they would drive people out of the insurance market and cause people to lose access to health insurance altogether.

Let us remember the best consumer protection is having health insurance coverage. That is the best patient protection we can apply and provide. So our amendment, the amendment I have crafted with my colleague, Senator NELSON, which is supported by so many of our colleagues who have spoken eloquently tonight, is an important one. It will advance consumer protections. But it will respect the good work that has been done by the States, the States that have been far ahead of the Federal Government.

Finally, let's remember the important point. States have been regulating insurance for more than 50 years. They have done a good job. They have acted without any prod or mandate from Washington to provide patient protections. They are way ahead of us in this area. Why do we want to second guess their work? Why do we want to supersede their laws? Why do we want to wipe out the good work done by the States? I submit we should grandfather in those good State laws and concentrate on the gaps.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I thank the Senator for her correction. The figures are, of the 195 million Americans with private health insurance, the 56 million who are the self-insured would have coverage. This would leave out the 139 million who are not in self-insured plans, as I understand it. These include state and local public service employees. These include firemen. These would be the police officers. These would be the self-employed. There are 139 million who would not have a federal floor of protections. I have read through this, so I appreciate what the Senator has said.

Listen to this. Under this proposal, there is going to be some $500 million that is going to be out there. A State can make a proposal for a new program, and they can receive grants for the new program.

They say the States can pass laws which are consistent with the purposes of the Federal standard. But they can keep the money and decline to enact a law because of the adverse impact of a law on premiums which would lead to a decline in coverage. So they could get the money to pass it. But, if there is a judgment that there might be a decline in coverage, they could, I guess, keep the money. They do not have to do anything further to enact a law if the managed care market in the State is negligible. There is no additional responsibility for them to take action for additional protections. They still get money from their fund.

I make the point that during the course of this debate there have been a lot of different ways of trying to cut the protections. We heard in our Health, Education, Labor and Pensions Committee about the kinds of abuses that are taking place across the country. The President of the United States recognized that. He indicated that he wanted every person covered. We want to have every person covered. We don't want to carve out a third and say they will be covered, but we will leave out two-thirds who will not be covered with a great many of these protections.

I continue to believe in the power of this issue and its impact on families. Why are we going to draw a distinction between neighbors on the same street? One works for a fire department, their family goes to a doctor, and the kind of medical advice their doctor gives to them for their child is overridden by an HMO, and they don't have protections, but his neighbor is protected because his employer self-insures? What possible fairness is there in that? What is the possible justice in that?

We should be interested in protecting all families. The President understands that. Hopefully the Senate will understand that tomorrow.

If it were left up to me, I would make sure that all of these protections were guaranteed. But we have the Breaux amendment which says: Wait. We are going to say if States have taken action in these areas, there is going to be deference given to the State. There is going to be enforcement and supervision by the State in protecting these areas.

I would have liked to see it stronger. But what is very important is guaranteeing some floor of protections.

Finally, we are talking about commonsense protections. We are talking about access to the emergency room, specialty care, OB/GYN, and continuity of care. If a woman is pregnant, and the HMO and her employer end their relationship, at least she can see her obstetrician until after the baby is born.

We are talking about prescription drug formularies. If the doctor recommends a certain medically necessary drug and it is not included in the formulary, the patient can still get the needed drug. There is going to be a shared expense by the patient as well as the HMO. That has been worked out. We use the same cost sharing that is used in the various formularies.

Point of service: There is a closed panel, and a need for outside expertise. Clinical trials are so important. Every one of the protections that is guaranteed are in existence today either in Medicare and Medicaid, or they have been recommended by the insurance commissioners, or they were unanimously recommended under President Clinton's panel, which was bipartisan and included distinguished representatives of all aspects of the health delivery system. Those are the only ones.

Finally, as we are hopefully coming fairly close to the end of this debate. We have the support of almost every health organization, every professional medical organization, every patients' organization, every children's organization, every women's organization, every disability group, and every cancer organization for this kind of protection.

The reason is very simple. They are out there on the firing line day in and day out. They understand what is happening to families. These are trained men and women who have given their lives for the protection of good health care for families in this country. They have seen what is happening and how many times they are being overruled. They have stated that is what is necessary.

The scope and protections that Senator BREAUX has included are what they strongly support.

We will have a chance to say another word about this tomorrow.

Mr. EDWARDS. Mr. President, will the Senator yield for a question?

Mr. KENNEDY. I thank my friend from Maine.

I am glad to yield.

Mr. EDWARDS. Let me ask the Senator, as somebody who has been involved in this issue for so long, as the Senator knows, we have been working very closely with Senator BREAUX on his amendment in an effort to make sure that all Americans are covered. One of the guiding principles of our efforts in this area is to make sure that families have protections provided in this legislation so that all families in this country can make their own health care decisions. We have worked with Senator BREAUX very closely on his amendment to make sure there is a floor for every family in America.

Will the Senator comment on whether, under the amendment of the Senator from Maine, every family in America will in fact get the minimum protections as provided in our bill as opposed to the language we worked out with Senator BREAUX?

Mr. KENNEDY. As the language is constructed, they will only provide the protections to these self-insured and not to everyone else who has received their health insurance through other means—the self-employed, those who are getting it through state and local employment, those working for employers who purchase health insurance plans. There are 139 million Americans who will not have those protections.

As I mentioned earlier, they will have to rely on protections from the States. There are States that do not require access to clinical trials. There are States that do not require timely access to appropriate, accessible specialists.

I mentioned earlier the ban on inappropriate financial incentives. Twenty States don't ban plans from giving financial incentives and disincentives to doctors to delay or deny care. They won't have those protections.

The point I mentioned earlier was that we are a society in movement. We find so many families are moving from State to State. Members of families are moving with jobs and going back and forth.

We have to ask ourselves ultimately and finally—as the Senator pointed out, this is a federal floor of protections—if you are in a State with clinical trials, why should you have to make sure they have a similar protection requiring access to the clinical trials which your wife might need, but you move to another State and find there is no access to clinical trials?

That is strictly because of the protections that you might have in a particular State.

It makes absolutely no sense. We ought to have that basic federal floor. I know the Senator agrees with me.

The way the Breaux amendment has been devised, it gives the maximum deference to the States if they provide protections in these areas. I mentioned just a half dozen different protections. We could go into others this evening. I will not take the time to do so, but they are illustrative of the protections. These are pretty commonsense protections.

The PRESIDING OFFICER (Mr. MILLER). The Senator from North Carolina.

Mr. EDWARDS. Mr. President, the debate on these two amendments is critical to the issue of whether all Americans—all families in this country—will have access to the protections provided for in this Bipartisan Patient Protection Act. That is the reason this vote tomorrow morning is critical to the vitality of this bill.

We have worked very closely with Senators on both sides of the aisle to ensure that two things are accomplished with respect to coverage: No. 1, that every American is covered by this legislation and, No. 2, we give deference to States that, through their own work, have established good systems for patient protection. We honor those State legislatures and that State legislation.

So that is the purpose of this amendment, the Breaux amendment. It strikes the right balance between making sure every American is covered—every family is covered—on the one hand, and, secondly, giving deference to the States that have already done good work in this area.

We need to ensure that we do not take away the protections we are providing for all Americans by exempting a huge chunk of Americans, which, unfortunately, the Collins amendment would do.

The Breaux amendment, though, is one in a series of consensus agreements that have been reached on this legislation. Starting with the issue of scope, which the Breaux amendment addresses, we now have an agreement which I think a great majority of the Senate will be able to support and be comfortable with.

On the issue of the independence of the appeals, we have an amendment that will be supported, I believe, by virtually all of the Senate, establishing the principle that we believe the HMOs should not have direct control over who is on the independent appeal panel.

On the issue of exhaustion of remedies—exhaustion of the appeals process before a case can go to court—we are working very closely with the Senator from Tennessee to reach a bipartisan consensus on that issue. We have made great progress, and I am optimistic about it.

On the issue of employer liability, from the outset we had—the sponsors of the legislation, along with the Presiding Officer—as a principle that it was important that employers be protected, period. We have worked very hard with Senator SNOWE and Senator NELSON from Nebraska, and other Senators on both sides of the aisle, to ensure that that is being done. Tomorrow morning we will offer an amendment on that issue.

We have worked our way through a series of hurdles, going from the issue of scope, to the issue of exhaustion of remedies, to the issue of clinical trials, to the issue of medical necessity, on which we have worked with Senators BAYH and CARPER to make sure we have a consensus on what is covered, giving proper deference to the contract and the contractual language but making sure the independent reviewers have the ability to make sure that if particular treatments are needed, they can be provided.

So we started 2 weeks ago with a series of obstacles in front of us, starting with scope and running throughout the legislation. What has happened during the course of this debate, and the work that has been done, is that one by one those obstacles, those barriers, have fallen, and we have been able to reach consensus agreement.

There is great momentum to do something that really matters to the American people. The winners in this debate are not politicians. The winners of this debate are not the people within this Chamber. The winners are the American people and the families all over this country.

We have in this body an opportunity to do an extraordinary thing, which is to give people more control over their lives and more control, specifically, over their health care decisions, the things that affect their families and members of their families.

All of us have worked very hard—Republicans and Democrats—to try to get to the place where we have consensus on this legislation, and one by one by one the barriers to passing real patient protection have fallen to the floor.

We have more work to do. We will have issues of liability that remain to be resolved. But the reality is, we are a long way down the road. We have tremendous momentum for doing what there is a consensus in this country to do. Not just in the Senate, not just in the House of Representatives, but all across America, all of us who have spent time in our States have heard over and over that the American people expect us to do something about this issue.

The time has come. It is time to quit talking about it. It is time for the political debate to stop. It is time to do something that can really affect people's lives. We have an extraordinary opportunity to do something important. We have made extraordinary progress toward that goal, but we are not quite there. We need to keep our nose to the grindstone, keep working, keep debating, and finish this legislation, get it through the House, and get it on the President's desk, with great hope and optimism that the President, when confronted with legislation that during his campaign he vowed to support, will stand by his vow and do what he has told us he would do. We are optimistic about that. We believe the President will do what is right for the American people.

So I thank my colleagues for all their work on this issue.

I ask my colleagues to vote, tomorrow morning, against the Collins amendment and for the Breaux amendment, which is a bipartisan consensus that has been reached. And we will continue our work toward providing the American people the protection they need and they deserve.

Thank you, Mr. President. I yield the floor.

EXPLANATION OF VOTE

Mr. HELMS. Mr. President, I regret I was not present to cast my vote on the motion to table the amendment offered by the Senator from Arizona (Mr. KYL) and the Senator from Nebraska (Mr. NELSON). I wish the RECORD to reflect that had I been present, I would have voted ''nay.''

The PRESIDING OFFICER. The Senator from Nevada.

SUPPLEMENTAL APPROPRIATIONS

Mr. REID. Mr. President, Majority Leader DASCHLE was asked earlier today, on several occasions by Senator BYRD and Senator STEVENS, if he would bring to the floor a unanimous consent request that there be a time set on the supplemental appropriations bill that is now with the Appropriations Committee that would set a time certain for filing of amendments on this most important legislation.

Such a request has been cleared by Senator DASCHLE and the majority, but objection has been raised by the minority. So the request by Senators BYRD and STEVENS cannot be met tonight. Hopefully, this request will be cleared by the minority tomorrow so that there can be a time certain set for the amendments on this, as I said, most important piece of legislation, the supplemental appropriations bill.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

MORNING BUSINESS

Mr. REID. Mr. President, I ask unanimous consent there now be a period for morning business, with Senators permitted to speak for up to 5 minutes each.

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

OFFSHORE OIL

Mr. NELSON of Florida. Mr. President, I want to take a moment while the leadership of the Senate is, at this very moment, deciding which course the rest of the day will take with regard to this important legislation, the Patients' Bill of Rights. While we have a moment in which we might reflect on other items, I want to draw to the attention of the Senate the considerable concern of 16 million Floridians that the Bush administration is trying to drill for oil and gas off the shores of the State of Florida.

It is most instructive, if one looks at a map of the Gulf of Mexico, where colored in on the gulf waters are the active drilling leases. One will see clearly that, from the central Gulf of Mexico all the way to the western Gulf of Mexico, almost all of the waters of the gulf are shaded in, indicating active oil and gas drilling leases. Indeed, there is a reason for that. It is because the reserves were there, the oil and gas deposits are there, the future reserves are expected to be there. As a matter of fact, I believe it is 80 percent of all economically recoverable, undiscovered gas reserves on the Outer Continental Shelf—which not only includes the gulf but also the Atlantic and Pacitic—80 percent of the Nation's known, recoverable gas reserves in the central and western gulf and 60 percent of the future recoverable oil reserves are in that area too. They are no in the area off the State of Florida.

The State of Florida has consistently taken the position that we should not have oil and gas drilling because of the high cost and potential damage to our environment and to our economy. One of our primary industries is the tourism industry, which so often is dependent upon those pure, sugary white beaches being unspoiled so millions of visitors who come to Florida to enjoy the sunshine and the waters and the beaches can do so without having to worry about having oil spread across the beach.

I can tell you that 16 million Floridians, in unison, do not want oil lapping up on our beaches. The cost to our environment and the cost to our economy would be simply too high.

Why, you would ask, other than that the oil and gas reserves are in the central and western gulf, is there not any drilling off the coast of Florida? It goes back to the early 1980s, under the Reagan administration and a Secretary of the Interior, James Watt. He offered tracts for lease from as far north as Cape Hatteras, NC, in the Atlantic, south all the way as far as Fort Pierce, FL.

I had the privilege of being a Member of the House of Representatives at the time. So I went to work, knowing the people of my congressional district, in the early 1980s, didn't want oil lapping up onto their beaches. We were able to persuade the appropriations subcommittee on the Department of the Interior appropriations bill to insert language that said no money appropriated under this act shall be used for offering for lease tracts such and such, and then listed the tracts all the way from North Carolina south to Fort Pierce, FL. And we prevailed in the appropriations.

The administration left Floridians alone on offshore oil drilling for a couple of years but came back under a new Secretary of the Interior and tried again. This time it was harder to stop. This time it escalated all the way to the full House Appropriations Committee. But we finally prevailed, interestingly, not on the threat to the economy or to the environment of Florida, and indeed the United States eastern coastline, but prevailed by getting NASA and the Defense Department to own up to the fact that you cannot have oil rigs down there in the footprint of where you are dropping solid rocket boosters off the space shuttle and where you are dropping first stages off the expendable booster rockets that are being launched out of the Cape Canaveral Air Force station. And we have not been bothered since the early 1980s, in Florida, about offshore oil drilling—until now.

The bush administration is pressing a 6-million-acre lease off the northwest coast of Florida in a strange configuration called lease-sale 181, of which the bulk of the 6 million acres is 100 miles offshore but a stovepipe runs northward to within about 20 miles of the Alabama coastline, which is about 20 miles, then, from the white sands of Perdido Key, State of Florida.

In a meeting of the Vice President with a Florida congressional members delegation, the Vice President suggested a compromise, which was to knock off that stovepipe coming off the bulk of the 6 million acres. That is no compromise. That is unacceptable because that is still oil drilling off the State of Florida where the future reserves are shown to be not as abundant. The tradeoff to 16 million Floridians is simply not worth what potentially could be discovered in oil and gas—the despoiling of our environment and the killing of our economy.

Thus, it was such welcome news when we learned last week that the other side of the Capitol, the House of Representatives, added to the Interior appropriations bill an amendment that would prohibit such drilling. The vehicle was the Interior appropriations bill. It prohibits it for only 6 months. It will be my intention, and certainly the intention of my wonderful colleague, the distinguished senior Senator from the State of Florida, Mr. GRAHAM, that we in the future will offer amendments either to the Interior appropriations bill, to bring it in conformity with the House-passed bill, or more likely amendments that would cause a prohibition of lease-sale 181 as well as offering similar amendments to the authorizing bill that will come out of Chairman BINGAMAN's committee.

I want our colleagues to be clear. This is an issue of enormous magnitude to 16 million Floridians. It happens to be of enormous magnitude to New Jersey, the State of the Senator who sits as Presiding Officer, as well as all the States in New England which value so much the pristine waters and the waters particularly as you get on north of New Hampshire and Maine—those waters that produce such delicacies as the Maine lobsters. This is a matter of grave concern to many of us.

It is time to draw the line in the sand—hopefully, not a line that will be washed over by oil on our beaches' sands but, rather, a line that will indicate the unanimity of 16 million Floridians, joined by their sister States along the eastern seaboard, of opposition to offshore oil drilling.

LOCAL LAW ENFORCEMENT ACT OF 2001

Mr. SMITH of Oregon. Mr. President, I rise today to speak about hate crimes legislation I introduced with Senator KENNEDY in March of this year. The

Local law Enforcement Act of 2001 would add new categories to current hate crimes legislation sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred April 15, 1998 in Boise, Idaho. Mark Bangerter was brutally beaten because of his perceived sexual orientation. As a result of this attack, Mr. Bangerter was left with severe facial injuries and blindness in one eye.

I believe that government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act of 2001 is now a symbol that can become substance. I believe that by passing this legislation, we can change hearts and minds as well.

HUNGER AND POVERTY IN AFRICA

Mr. LEVIN. Mr. President, it is my pleasure to join with Senators LEAHY and HAGEL in submitting S. Con Res. 53, which encourages the development of strategies to reduce hunger and poverty in sub-Saharan Africa.

In the year 2000, almost 200 million Africans, fully a third of the total population, went to sleep hungry and 31 million African children under the age of five were malnourished. One child out of seven dies before the age of five, and one-half of these deaths are due to malnutrition. Nearly half of sub-Saharan Africa's population, some 291 million people, live on less than $1 a day, and almost 85 percent of the world's 41 heavily indebted poor countries are in sub-Saharan Africa.

These problems are compounded by epidemics of HIV/AIDS, tuberculosis, malaria, cholera, and other diseases now ravaging the continent. The human costs are staggering. Almost 4 million people are infected with AIDS each year, adding to the over 25 million already infected. Over 75 percent of the people worldwide who have died of AIDS lived in Africa. One million people each year, mostly children, die from malaria.

Hunger only adds to the spread of disease, rendering the poor and malnourished too weak to defend against AIDS and other infectious diseases. Even if treatment clinics are available, those suffering from hunger are unable to afford fees for care or medicine to aid them with their battle against the illness.

Despite funding shortfalls, the U.S. Agency for International Development, USAID, and other U.S. government agencies, foundations, universities, non-governmental organizations, NGOs, and private sector companies are presently implementing many innovative programs directed toward alleviating hunger and poverty in Africa.

While tremendously significant, these actions are not enough to keep poverty and hunger from growing in many African countries. Many of our experts have concluded that the United States is not tapping into the full range of interest, ability, experience and capacity available to address this problem. The introduction of our Resolution, which addresses these issues, coincides with the conference of The Partnership to Cut Hunger in Africa, an independent effort formed by U.S. and African public and private sector institutions, international humanitarian organizations and higher educational institutions. Michigan State University continues to play a strong leadership role in this effort. The President of Michigan State University, Peter McPherson, serves as one of the Partnership's co-chairs and was instrumental in arranging conference-discussion activities in the Senate this week.

The goal of the Partnership is to formulate a vision, strategy, and action plan for renewed U.S. efforts to help African partners cut hunger dramatically by 2015. For three days this week, the Partnership's 22 distinguished policy experts and practitioners from the U.S. and 8 African countries will share their views on hunger in Africa and will open a dialogue on the role the U.S. might play in diminishing hunger and poverty in Africa. On Thursday, June 28, 2001, Partnership experts will culminate their 3-day conference with a roundtable discussion on Capitol Hill, during which time they will share their findings and action plan to effectively combat hunger and poverty in Africa. I am honored to have the opportunity to join in hosting this event.

I ask unanimous consent that the members of the Partnership to Cut Hunger in Africa and the Partnership's expert panel be printed in the RECORD. They are as follows:

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

PARTNERSHIP TO CUT HUNGER IN AFRICA

EXPERT PANEL

From Bamako, Mali:

Dr. Bino teme, Scientific director, Institute for Rural Economics.

Mme. Konare Nafissatou Guindo, Administrative and Financial Director, Ministry of Territorial Administration and Local Government.

Dr. Niama Nango Dembele, Coordinator, APCAM–MSU Market, Information Support Project, Visiting Assistant Professor, Michigan State University.

Dr. Mbaye Yade, Coordinator, Institute du Sahel/MSU, Food Security Support Project, Visiting Assistant Professor, Michigan State University.

From Maputo Mozambique:

Mr. Joao Carrilho, Vice-Minister, Ministry of Agriculture and Rural Development.

Mr. Sergio Chitara, Executive Director, Confederation Of Mozambican Business Associations CTA.

From Accra, Ghana:

Dr. Sam Asuming Brempong, Department of Agricultural Economics, Faculty of Agriculture, University of Ghana.

Dr. Kwaku Owusu Baah, Faculty of Agriculture, University of Ghana.

From Abuja, Nigeria:

Dr. Salisu A. Ingawa, Head of Unit, Projects Coordinating Unit (PCU), Federal Ministry of Agriculture and Rural Development.

Dr. Ango Abdullahi, Special Adviser to the President on Food Security.

From Entebbe, Uganda:

Dr. Isaac Joseph Minde, Coordinator of ECAPAPA Project, ASARECA.

Dr. Fred Opio, International Food Policy Research Institute, Regional Office for the 2020 Network—Eastern Africa.

Dr. Peter Ngategize, Plan for Agriculture Modernization, Ministry of Finance.

Dr. J.J. Otim, Presidential Advisor on Agriculture, Office of the President.

From Addis Ababa, Ethiopia:

Mamou Ehui, Economic Commission for Africa.

From Rwanda:

Edson Mpyisi, Coordinator of Food Security Research Project-FSRP//MINAGRI, Ministry of Agriculture.

Others:

Dr. Akin Adesina, Resident Representative for Southern Africa, The Rockefeller Foundation.

Serge Rwamisarabo—USAID/Rwanda, Francis Idachaba University of Ibadan, Nigeria, Kandeh Yumkella—UNIDO/Nigeria, Mbenga Musa, Executive Secretary of CILSS, Ouagadougou, Yamar Mbodj, Food Security Advisor, CILSS Secretariat, Ouagadougou.

EXECUTIVE COMMITTEE

Peter McPherson, Co-Chair, President, Michigan State University.

Alpha Oumar Konare, Co-Chair, President, Republic of Mali.

Senator Robert Dole, Co-Chair, Special Counsel, Verner, Liipfert, Bernhard, McPherson and Hand.

Lee Hamilton, Co-Chair, Director, The Woodrow Wilson International Center for Scholars.

David Beckmann, President, Bread for the World.

Mary Chambliss, Deputy Administrator, Export Credits, Foreign Agriculture Service, USDA.

Imani Countess, Outreach Director, Shared Interest.

William B. DeLauder, President, Delaware State University.

Stephen Hayes, President, Corporate Council on Africa.

Joseph Kennedy, Co-Founder, Africare.

George Rupp, President, Columbia University.

Emma Simmons, Director, Center for Economic Growth and Agricultural Development, USAID.

Edith Ssempala, Ambassador, Republic of Uganda.

Bob Stallman, President, American Farm Bureau Federation.

THE CHALLENGE OF BIOTERRORISM

Mr. AKAKA. Mr. President, I rise to address the threat of bioterrorism to our Nation's security.

President Bush has asked Vice President CHENEY to ''oversee the development of a coordinated national effort so that we may do the very best possible job of protecting our people from catastrophic harm.'' He also asked Joseph Allbaugh, Director of the Federal Emergency Management Agency, FEMA, to create an Office of National Preparedness to implement a national effort.

On May 9, 2001, Attorney General Ashcroft testified before a Senate Appropriations subcommittee that the Department of Justice is the lead agency and in sole command of an incident

while in the crisis management phase, even if consequence management activities, such as casualty care and evacuation, are occurring at the same time. Clearly, FEMA and the Department of Justice need to work together to shoulder the burden of responding to a large scale event. What is unclear, however, is how the Department of Justice will know that its crisis management skills are needed during a bioterrorism event.

When will a growing cluster of disease be recognized as a terrorist attack? How do we differentiate between a few individuals with the flu and a flu-like epidemic perpetrated by terrorists? When will it be called a crisis? When will the FBI or Justice be called in to handle the newly declared ''crisis?'' In the case of a bioterrorist attack, the response will most likely be the same as if it was a naturally occurring epidemic. The key question is not ''how to respond to an attack'' but ''are we prepared to respond to any unusual biological event?''

What would happen if a bioterrorist attack occurred today? It would not be preceded by a large explosion. Rather, over the course of a few days or a couple of weeks, people would start to get sick. They would go to hospitals, doctor's offices, and clinics. Hopefully, a physician in one hospital would notice similarities between two or three cases and contact the local public health officials. Maybe another physician would do the same and maybe, finally, the Center for Disease Control would be notified. So, the first responders would not be a Federal agency.

Across the country, local law enforcement, fire, HAZ MAT and emergency medical personnel are doing a tremendous job preparing and training for terrorist attacks, and I commend their efforts. But, in the scenario I described, they would not be our first line of defense. Instead, the first responders for a biological event would be the physicians and nurses in our local hospitals and emergency rooms. We need to ensure that hospitals and medical professionals are prepared to deal with this threat. This is not the case today.

This past November, emergency medical specialists, health care providers, hospital administrators, and bioweapon experts met at the Second National Symposium on Medical and Public Health Response to BioTerrorism. A representative of the American Hospital Association, Dr. James Bentley, spoke about the challenges hospitals are confronting and stated that ''we have driven over the past twenty years to reduce flexibility and safeguards.'' Flexibility and safeguards are exactly what is needed by a hospital to go from ''normal'' to ''surge'' operations. Surge operations do not require the extreme scenario of thousands of casualties from a bioweapon. Dr. Thom Mayer, chief of the emergency department at Inova Fairfax Hospital, was quoted in the Washington Post, on April 22, 2001, stating that 20 or 30 extra patients can throw an emergency department into full crisis mode.

Dr. J.B. Orenstein, an emergency room physician, in a recent Washington Post op-ed, wrote about the ''State of Emergency'' the dedicated men and women working in our hospitals and clinics are already facing without the added worry of bioterrorism. Until a year ago, hospitals dealt with surges for only a few days or a week a year during the winter flu, cold and icy sidewalk season. Now, mini-surges occur in the spring, summer and fall due to decreasing numbers of emergency rooms, beds available in any hospital, and qualified nurses. On May 9, 2001, the Society for Academic Emergency Medicine convened a special meeting in Atlanta to discuss ''The Unraveling Safety Net.'' Are we, with all the planning and funding the Federal Government has done over the past few years to address terrorism, providing sufficient help for hospitals to prepare for bioevents?

As Chairman of the Subcommittee on International Security, Proliferation and Federal Services, I am concerned that we are not addressing a fundamental problem. Would a biological event be a national security/law enforcement incident with public health concerns, or would it be a public health crisis with a law enforcement component? I hope that the effort led by Vice President CHENEY will address specifically this question and that the unique problems biological weapons present are not overlooked by any national plan to counter terrorism. I ask unanimous consent that the text of Dr. Orenstein's article be printed in the RECORD.

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

[From the Washington Post, April 22, 2001]

STATE OF EMERGENCY

(By J.B. Orenstein)

It's a typical bad-day crowd in my ER: Here's a wheezing baby who developed a blue spell in front of her panicked mom. This 62-year-old gentleman came in with chest pain 36 hours ago; his worrisome EKG and equivocal lab tests should have put him inside for observation, but there's no room in the ICU so he's been waiting here for 24 hours. This lady, razor sharp at 89, suddenly started acting ''not right,'' so her granddaughter brought her in; she's been in the triage area for three hours, but can't get into treatment because chest-pain guy, blue baby and 18 other patients are parked in the treatment beds while they wait to be admitted.

Our communications nurse just told an approaching ambulance to find someplace else to take its potentially critical passenger because we had no place to put him. Not in the ER, not in an ICU, not even in a plain old bed in a ward. The official term for what's happening here is ''saturation,'' but down in the pit this is known as buttlock.

And it's happening too often, in more hospitals than ours. On May 9, the society for Academic Emergency Medicine will convene a special meeting in Atlanta on ''The Unraveling Safety Net.'' The meeting was called in December because panic buttons were being pushed in overcrowded ERs across the country—Boston, St. Louis, Chicago, New York. It was a medical version of the California power crisis, with our rolling blackouts coming in the form of ambulance ''diversions.''

Up until a year or two ago, we faced this nerve-racking logjam for only a few days or weeks in winter, when flue and cold viruses turn into potentially fatal pneumonia, babies fall prey to respiratory and intestional viruses, depression fills the psych wards and slippery ice keeps the orthopedists busy. But now we're seeing mini-surges in the spring, summer and fall as well.

When I started at Inova Fairfax Hospital in 1991, the ER treated 55,000 patients in the course of the year. Last year the number was 70,000. This is in keeping with the national picture. In 1988, there were 81 million visits to U.S. emergency rooms, according to the National Center for Health Statistics. The number for 1998: 100.4 million. Meanwhile, over the same decade, the number of emergency departments fell from about 5,200 to just over 4,000. Their average annual patient volume rose from 15,500 to 24,800—that's more than 50 percent.

In all of American medicine, the only place that federal law guarantees Americans the right to a physician, 24–7, is the emergency room. This is because of the 1986 ''anti-dumping'' law, the Emergency Medical Treatment and Labor Act, known as EMTALA. ''[A]s enforced by the Health Care Finance Administration and recently upheld by the U.S. Supreme Court, EMTALA is a civil right extended to all U.S. residents,'' Wesley Fields, chairman of the American College of Emergency Physicians Safety Net Task Force, recently wrote. Crowded as we are, if you walk in the door, you'll be treated whether you can pay or not. Just get in line and take a number with everyone else.

I don't like this any more than my dissatisfied, frustrated patients do. I tell them that it's like rush hour on I–66—too many bodies packed into a space built ages ago for a much smaller population.

But like most of life, the mess is more complicated than that. One very important factor is the total number of beds available in any hospital—particularly ICU beds. State and local health agencies regulate the number of beds based on a long list of factors: population, estimates of disease prevalence, average lengths of stay. In the early 1990s, conventional wisdom held that managed care would reduce the occupancy rate. To a significant extent, that happened, and in the mid-90's empty beds forced a number of underused hospitals to close. In 1990, according to the American Hospital Association, there were 927,000 staffed beds in 5,384 community hospitals in America. In 1999, the last year for which there are complete numbers, 4,956 such hospitals provided just over 829,000 beds. Meanwhile, the country's population had grown by 10 percent.

Many of those vanished beds might have been superfluous anyway, due to a sweeping explosion in medical technology and therapeutics. Ten years ago, a heart attack kept a patient in the hospital for just under nine days; by 1998, these folks were out the door in six. Stroke? The average length of stay was down by a half: 10 days to five. Home nursing and IV therapy freed countless patients from the confines of a hospital bed. But the hospital closings were uneven. In booming suburban areas such as Northern Virginia, money poured into expanding both high-tech services and customer-friendly support at mega-hospitals like Inova Fairfax. But some smaller hospitals, like Jefferson Hospital in Loudoun County, found their beds chronically empty and had to close. (The planned shutdown of D.C. General's inpatient facility is a result of forces pushing in the opposite direction, resulting in too many unused beds.)

When hospitals close, it puts more pressure on those that survive. At Inova Fairfax, occupancy averaged a jam-packed 92 percent over the past year. Thom Mayer, chief of our emergency department, put it this way: ''The inpatient population is so high so regularly that a mere 20 or 30 extra patients throws us back into full crisis mode.'' And that can happen during one shift in a busy emergency room.

Beyond the number of beds, just how many are available at any given time often comes down to two letters: RN. A hospitalized patient needs a doctor for just a few minutes each day, but nursing care must be available around the clock. But, like hospital beds, fully qualified nurses have been disappearing fast, too. A widely cited study from Vanderbilt University, published last year in the Journal of the American Medical Association, pointed to some ominous trends. A key finding: The average age of nurses is rising. The number of nurses under the age of 30 fell from 419,000 in 1983 to 246,000 in 1998; by the end of this decade, the study said, 40 percent of working nurses will be older than 50. Retirement will create an estimated shortfall of half a million nurses in the year 2020. The clear reason: A decline in the number of high school girls who go to college intent on becoming nurses. ''Women, who traditionally comprise the majority of nursing personnel, are finding other career options that are less physically demanding, more emotionally rewarding and come with a higher rate of pay,'' Brandon Melton, representing the American Hospital Association, told a Senate subcommittee earlier this year. And men aren't making up for the shortfall.

My wife, a savvy, experienced nurse, last did floor work more than 10 years ago, and though conditions were tough enough then, she recoils at what she would face if she went back now: More and sicker patients on an exponentially higher number of meds; less time getting to know the person who is the patient, and therefore less opportunity to catch early signs of deterioration; widespread use of ''health techs''—people who take vital signs and dispense pills but have no training for more meaningful interaction. No wonder students at nursing schools dread the first few years following graduation, because before they can get to the challenging, rewarding places to work, such as ERs or ICUs, they have to get experience on inpatient wards.

It's crowding in those ICUs that puts the worst pressure on the ER. In the highly sophisticated environment of the ICU, a patient's heart rate or blood pressure can be fine-tuned with a shift of an IV drip. A phalanx of monitors register any number of physiological trends to answer the question, ''Is this person getting better or worse?'' When a patient requires this moment-by-moment scrutiny and all ICU beds are filled, the only place with roughly equal capacity—the only place we can perform the same level of care—is the ER. This ties up our nurses and blocks the bed from the next guy waiting to get in.

And chances are, that next guy is in pretty bad shape. Most people who come to the ER these days have higher ''acuity'' than a decade ago—that is, they're sicker. There's been no easy way to quantify this change, but, like tornado victims, ER does know what we've been big with. We spend more time trying to get a borderline patient ''tuned up'' enough to go home rather than be admitted to a busy, barely staffed hospital floor. We arrange home delivery of nebulizer machines for asthma patients. We check out the patient discharged yesterday after surgery who is back today, feeling weak, wondering if he's really well enough to be home. I kind of miss the good old days when a 10-hour shift meant a string of straightforward technical procedures—like reducing a dislocated shoulder or sewing a complex laceration. These days, it seems more time is spent tracking down a patient's three or four specialists—the oncologist, the psychiatrist, the infectious disease guy—or negotiating with the intake person to authorize a bed or transfer the patient to a hospital that accepts his insurance.

Whine, whine, whine. I started writing this as a letter of apology to all the miserable, aggravated patients who wonder why they have had to wait so many hours to see me, and here I am complaining about my own problems. I'll try to get back on track, because the worst is still ahead. And the worst by far is ambulance diversion.

It happened a lot over this past winter. In Boston—hardly a hospital-deprived town—the Globe reported that 27 area ERs went ''on diversion'' for a total of 631 hours in November, 677 hours in December and more than 1,000 hours in January. And it was worse in Northern Virginia: In January, the area's 13 ERs placed themselves on diversion for more than 4,000 hours. Evenly divided, and it most assuredly was not, that would be every ER refusing ambulances for 10 hours every day. Almost half the time, back in that icy January, if you needed an ambulance to get to an ER you were SOL: severely out of luck.

The American College of Emergency Physicians is certainly concerned about the problem: Last October, an advisory panel proposed guidelines for ambulance diversion, blaming ''a shortage of health care providers, lack of hospital-based resources and ongoing hospital and ED [emergency department] closures.'' But it's easy to get the feeling that others at the national level aren't taking it seriously. At a public health conference in November, at the beginning of the critical winter season, U.S. Surgeon General David Satcher was quoted as recommending that people be ''educated'' not to go the emergency room unless they really need to. Dennis O'Leary, head of the Joint Commission on Accreditation of Healthcare Organizations, a critical monitoring group, was quoted as saying: ''Quite frankly, this problem waxes and wanes . . . but without anything tangibly happening it resolves itself . . . The system will somehow muddle through.''

They're right: I muddle through each shift worrying about patients trapped in the waiting room or ambulances that can't discharge their passengers at our door. I mutter humble apologies to private docs outraged that the patients they sent in specifically for urgent treatment—pain control, antibiotics, whatever—cool their heels for hours on end. I go home exhausted and aggravated with myself after 10 hours of juggling alternatives so as not to put a patient into a scarce bed—telling people to try a ''stronger'' antibiotic, ratchet up the home respiratory treatments, take a few extra tabs of pain reliever each day, and always be sure to follow up with your own doctor tomorrow. I wonder which patients are going to be back in another ER the next day because I missed their real problems or insisted on an ineffective patch.

Doctors and nurses have a bottom line that ultimately distinguishes us from other professions: quality patient care. When we can't provide this, we have failed. Our hospital administrators and department chiefs assume that excellent patient care is a non-negotiable minimum standard. But every winter, and increasingly at other times, the crash of the system is the quite capitulation to these accumulated pressures. When forced to maneuver so many sick patients through an overwhelmed system, I just don't know if I'm doing a good job any more. As a result, I often find myself phoning the patient the next day, checking in: ''Everything okay today?''

Many of the region's hospitals have received, or are negotiating for, approval for more beds. Where more nurses will come from is another problem. Anthony Disser, the chief executive nurse at Fairfax, says the intrinsic value of nursing is already luring a certain number of burned-out software writers or disappointed entrepreneurs for a second career. Yeah, I guess we are muddling through, after all.

I look forward to that ''Unraveling Safety Net'' meeting in Atlanta in three weeks, where I expect to be transfixed, like the audiences at ''Hannibal,'' by the horror stories and dire statistics of other ER docs and public health researchers. Maybe they've been coming up with some solutions. If they have, I hope they haven't been waiting till May to share them with the rest of us.

THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business yesterday, Tuesday, June 26, 2001, the Federal debt stood at $5,656,750,181,308.17, five trillion, six hundred fifty-six billion, seven hundred fifty million, one hundred eighty-one thousand, three hundred eight dollars and seventeen cents.

One year ago, June 26, 2000, the Federal debt stood at $5,647,619,000,000, five trillion, six hundred forty-seven billion, six hundred nineteen million.

Five years ago, June 26, 1996, the Federal debt stood at $5,118,149,000,000, five trillion, one hundred eighteen billion, one hundred forty-nine million.

Ten years ago, June 26, 1991, the Federal debt stood at $3,500,901,000,000, three trillion, five hundred billion, nine hundred one million.

Fifteen years ago, June 26, 1986, the Federal debt stood at $2,040,983,000,000, two trillion, forty billion, nine hundred eighty-three million, which reflects a debt increase of more than $3.5 trillion, $3,615,767,181,308.17, three trillion, six hundred fifteen billion, seven hundred sixty-seven million, one hundred eighty-one thousand, three hundred eight dollars and seventeen cents during the past 15 years.

ADDITIONAL STATEMENTS

TIMOTHY J. RHEIN

• Mr. BREAUX. Mr. President, I rise today to pay tribute to Timothy J. Rhein, who recently retired after 34 years with American President Lines, Ltd. APL is today one of the world's largest shipping and intermodal lines, and a globally recognized brand, thanks in large part to Tim Rhein's leadership.

I came to know Tim through his appearances before the Subcommittee on Merchant Marine, and I can personally attest to his commitment to merchant shipping and his leadership in the U.S. shipping industry. His rise to president and chief executive officer of APL from 1995 to 1999, and then to chairman, was marked by key decisions in a difficult business.

He was instrumental in expanding APL from primarily an Asia-America business into a truly global operation. He gained a decisive edge on his competitors by embracing information technology earlier than anyone else in his business. He knew the numbers and metrics of his business better than anyone. He was rarely at a loss for an answer before our committee, and always worth listening to.

And he worked very hard at developing one particular line of business—the U.S. military—to the point where our government is today APL's largest customer. One of the reasons for that success was his understanding of logistics, of managing supply lines, a critical skill to the military as well as to APL's multinational corporate customers.

But without doubt his toughest decision was to negotiate the sale of APL to a non-U.S. buyer, in order to protect all of APL's stakeholders and to preserve the APL presence and brand. APL was the oldest continuously operating shipping company in America, and a premier US-flag shipping company. He stuck his neck out on that one, put his reputation on the line, and negotiated the sale personally—and successfully.

Tim Rhein understood his business. He was a nimble and gutsy decision-maker, and we in Washington will miss his understanding and knowledge as we continue our pursuit of a policy to promote a strong U.S. flag maritime shipping presence. I hope he will continue to avail us of his knowledge and wise counsel.

Good luck in your retirement, Tim Rhein.●

DEATH OF ROBERT McKINNEY

● Mr. BINGAMAN. Mr. President, earlier today I sent a letter to the oldest daily newspaper in the West, ''The New Mexican'' regarding the death of its publisher, Robert McKinney.

Robert McKinney was well known to the Senate. His decades of service to this country, in one capacity or another, and his remarkable career in business and publishing brought him into contact with many of us, and with colleagues who have preceded us in this body. He and Clinton Anderson, late a Senator for New Mexico, were great friends, and worked together on the San Juan-Chama water project for our State.

Five presidents called on him for service from Harry Truman through Richard Nixon. He put his prodigious skills to work at various times at the Department of the Interior, the Atomic Energy Commission, and the Department of the Treasury. Under President Kennedy, he served as our Ambassador to Switzerland.

He was a fine citizen, and a good friend who will be missed, but whose influence, I know, is ''a widening ripple, down a long eternity.'' The world is a better place for his having lived.

I ask that my letter be printed in the RECORD.

The letter follows:

LETTER TO THE EDITOR OF ''THE NEW MEXICAN''

To the Editor: With so many others, I was saddened earlier this week when word came of the death of Robert McKinney whose American life made him one of the world's distinguished citizens. When he died in New York on Sunday night, this man of the American West had forged great successes in business, journalism, international diplomacy, public service and public policy in the course of his ninety years. His was the ''life well lived'' and much of it was lived in New Mexico where he was the deeply respected publisher of this newspaper.

He was a singular individual with a wide-ranging mind, vast talents, and varied interests. He brought his considerable energy to bear on issues from architecture to atomic energy, war to peace, land use to poetry. He was most certainly a force for good in this world. I was honored to have the benefit of his counsel and the gift his friendship. I will miss him.

JEFF BINGAMAN,
United States Senator.●

UNVEILING OF TIGER STADIUM COMMEMORATIVE STAMP

● Mr. LEVIN. Mr. President, it is with great pride that I pay tribute to a special place in my hometown of Detroit that for the last century has inspired not only our city but our country. This year we are commemorating the tricentennial of the founding of a city that to Americans has long meant great automobiles. To Detroiters, it also means great sports teams and inspiring hero-athletes. Indeed, as Detroit enters its fourth century, our pride in our city is equaled by our pride in the house these heroes built—our storied Tiger Stadium.

Today at home plate, the people of Detroit will gather to unveil one of eleven new stamps commemorating Baseball's Legendary Playing Fields. Of those eleven ballparks, only four still stand, and one is right in Detroit, where baseball was the pastime at The Corner of Michigan and Trumbull for more than a century.

The history of this stadium is in so many ways the history of our city. The spirit of hard work and determination that has always defined Detroit revealed itself early. When the Great Depression hit Detroit harder than most American cities, it was the 1935 World Champion Tigers—and the renowned ''G-Men'': Charlie Gehringer, Goose Goslin, and Hank Greenberg—who renewed the hopes of an entire city. Detroit would forever after be the City of Champions, with four World Series titles to prove it.

When the riots and ruin of 1967 left deep scars of division across our city, it was the 1968 World Champion Tigers led by Al Kaline, Willie Horton, Bill Freehan, Denny McLain and Mickey Lolich who led one of the greatest comebacks in baseball history and who, in their unforgettable victory, united us to celebrate as one city.

It is no exaggeration to state that the heroes of Tiger Stadium also pointed us to a better America. By the time the prize fighter Joe Louis triumphed over Bob Paster in then-Briggs Stadium in 1939, he was more than a hometown hero from the East Side, he was a national hero and a symbol to all people of all races. Even today, I almost weep thinking of ''Hammerin' Hank'' Greenberg's grand slam in 1945 that put the Tigers in the Series and for what that one swing of the bat meant. When Nelson Mandela spoke to a massive rally in Tiger Stadium a decade ago, his words rung out past the rafters to every American on the endurance and inspiring power of the human spirit.

In this City of Champions, the names and feats of champions echo still. Here is where the three time NFL champion Detroit Lions played for more than three decades. Here is where the legends of baseball's Golden Age took to the field in the unforgettable 1941 All-Star Game—Bob Feller, Joe DiMaggio, and Ted Williams. Here is where the Tigers earned three divisional championships, nine pennants, and those four World Series titles. Here is the where the Tiger greats were born, the eleven Hall of Famers: Sparky Anderson, Ty Cobb, Mickey Cochrane, Sam Crawford, Hank Greenberg, Hugh Jennings, Al Kaline, George Kell, Heinie Manush, Hal Newhouser, and Charlie Gehringer. And one more Hall of Famer, broadcaster Ernie Harwell, made sure that when we couldn't physically be at Michigan and Trumbull, the sights and sounds of the ballpark were part of our lives.

This house of heroes may have been built on the shoulders of giants, but someone else sustained it, the fans. If ever a community has unified around a place, Detroiters came together at The Corner. In this city of immigrants, attending a game there became an American rite of passage. The language of Tiger Stadium, as the Detroit News once put it, was not Polish or Armenian or Ukranian, it was baseball. Generations of parents brought their children to those sun-drenched bleachers. Years later, those grown children brought their own children to Tiger Stadium. I know because like many Detroiters I still call the old ballpark the place of my youth, a place where our parents took us and where I took my daughters and granddaughter.

To this day I remember my father leading me through the corridors to see Game 1 of the 1945 World Series. Through all my visits back through all the years since, I have never forgotten the sights, smells and sounds of that day and the unique character of that park. There was the sight of heroes—like Hal Newhouser—who I had only imagined while listening to the radio and could now virtually reach out and

touch. That is, when he wasn't obscured by one of the much-beloved posts that always caused so many of us to strain our necks. There was the smell of the popcorn, the peanuts and the hot dogs. And there were the unforgettable sounds the crack of the bat, and the roar of a hometown crowd.

Like many Detroiters, my feelings on this occasion are best captured by the words spoken by Al Kaline about his first day at Tiger Stadium. He said, ''As I was walking under the corridors trying to find the locker room, I took a peek right behind home plate. I walked out, the sun was shining beautifully, and I thought, 'Man, I never saw anything so pretty in my life.' ''

While over the years, the name may have changed, the address for baseball in Detroit was the same the Corner of Michigan and Trumbull. It is still one of oldest ballparks in one of the oldest cities in America. In it we feel our hometown pride in a national landmark. Our city. Our ballpark. The new commemorative stamp to be unveiled today celebrates their common spirit, and it gives me great pride today to join the people of Detroit, in praise of both.●

REMEMBERING KAREN KITZMILLER

● Mr. LEAHY. Mr. President, I rise today to remember a very special Vermonter, and a good friend, Karen Kitzmiller. Karen, at the young age of 53, lost her long battle with breast cancer on May 20 of this year. In East Montpelier the following Saturday, I joined hundreds of family, friends, colleagues, and admirers who gathered together to share their memories of Karen, and to honor her life.

For the past 11 years Karen Kitzmiller served as Montpelier's Democratic State representative in the Vermont Legislature. Her legislative achievements were many, but most outstanding was her work on the House Health and Welfare Committee. Karen was a determined advocate and principled leader on behalf of the health and well-being of Vermonters. She fought to prevent tobacco companies from targeting children with advertisements designed to encourage youth smoking. To help patients appeal coverage denials by health maintenance organizations, Karen dedicated her efforts to the establishment of Vermont's health care ombudsman. She devoted considerable energies to the provision of health care coverage for the uninsured. This spring, after almost four years of effort, she witnessed the Governor sign legislation to ensure that uninsured patients who volunteer to participate in cancer treatment clinical trials are provided with health care coverage.

Karen was diagnosed with cancer more than four years ago, and yet through it all, she did not give up her work on behalf of Vermonters. She continued to serve in the Legislature, she leant her experience as a cancer survivor in efforts to promote awareness about the importance of support groups, and she helped to establish the annual Breast Cancer Conference in Burlington. These are just a few of the lasting contributions that will serve as a tribute to Karen's life for years to come.

Karen leaves behind a loving family—her husband, Warren, and two daughters, Amy and Carrie. Amy is a student at the University of Virginia, studying government and women's studies, and Carrie is a student at the University of Pennsylvania studying at the School of Arts and Sciences. I had the privilege of sponsoring Amy as a Senate Page in 1996 and as an intern in my Montpelier office in the summer of 2000. They are both bright young women. I know their mother was very proud of them both. Although their loss is great, the Kitzmillers can take some small comfort in knowing how special Karen was to so many people. Her strength, her courage, and her compassion served as inspiration to all those who were fortunate enough to come in contact with her. She will be missed by all.●

TRIBUTE TO SHERRY YOUNG

● Mr. SMITH of New Hampshire. Mr. President, I rise today to pay tribute to Sherry Burnett Young of Concord, NH, on being named as recipient of the Athena Award. The award is presented to an individual who has demonstrated excellence in her business or profession, served the community in a meaningful way and assisted women in reaching their full potential.

Sherry is founder and director of the Rath, Young and Pignatelli law firm of Concord, NH. She began her legal career with Orr and Reno, P.A., of Concord, as an estate and trust attorney.

She is involved in community service with several organizations including: Horizon Bank Board of Directors, New England Legal Foundation, Business and Industry Association of New Hampshire, and the New England Council. Some of her civic and charitable activities include: New Hampshire Historical Society Board of Trustees, Concord Hospital Board of Trustees, Greater Concord Chamber of Commerce and New Hampshire Chapter of the American Red Cross.

Sherry is affiliated with professional memberships at the American Bar Association and the New Hampshire Bar Association. She is the first woman elected to chair the State Capital Law Firm, a global association of independent law firms throughout the Americas, Europe, Asia and Africa. In 2000, she was named as one of the top environmental lawyers in New Hampshire by New Hampshire Magazine.

She is a graduate of Cornell University and Franklin Pierce School of Law and lives in Concord with her husband, Gary, and her three children: Garrett, Valerie and Alanna.

I commend Sherry for her dedicated service and contributions to the citizens of New Hampshire and am proud to call her a friend. Her exemplary performance and civic awareness have benefitted the lives of the people of our State. It is an honor and a privilege to represent her in the Senate.●

TRIBUTE TO RON WELLIVER

● Mr. SMITH of New Hampshire. Mr. President, I rise today to pay tribute to Ron Welliver of Nashua, NH, on being named as Police Officer of the Year by the Nashua Exchange Club.

Ron has been a dedicated member of the Nashua police force and his community for more than twenty years. An exemplary citizen, he has contributed to the civic needs of Nashua serving as a football coach at Fairgrounds Junior High School and baseball coach at Bishop Guertin High School in Nashua.

Ron is a team player at the Nashua Police Department who accepted his award by giving praise and recognition to his fellow police officers. During his career he has worked in nearly all areas of the Nashua Police Department including: detective, undercover narcotics and recruiter assignments.

Ron and his wife, Sue, reside in the Nashua area with their two daughters.

I commend Ron Welliver for his dedicated service to the people of Nashua and our entire State. He is a role model to the Nashua community who risks his own safety as a law enforcement officer to protect the citizens of Nashua. It is truly an honor and a privilege to represent him in the Senate.●

TRIBUTE TO DR. GLENN DUBOIS

● Mr. SMITH of New Hampshire. Mr. President, I rise today to pay tribute to Dr. Glenn DuBois for his service to the State of New Hampshire as Commissioner of the New Hampshire Community Technical College System.

Glenn has taught for more than ten years working with students of all ages and from diverse ethnic and racial backgrounds. He has served for many years in State college and university positions and was appointed by the Governor to the Workforce Opportunity Council and Governor's Kid's Cabinet.

He has served in many other capacities including: New Hampshire Governor's Commission on Information Technology, New Hampshire Post Secondary Education Commission, Job's for New Hampshire's Graduates Program and the New Hampshire Police Standards and Training Council.

Glenn has been the recipient of many awards including: Distinguished Administrative Performance, President's Recognition, Award, Distinguished Service Award by the State University of New York, the highest recognition given by the faculty council, and most currently was named as New Hampshire's Leader for the 21st Century.

Glenn is a tribute to his community and his profession. His ability, dedication and determination to serve the

students and citizens of our State is commendable. It is an honor and a privilege to represent him in the Senate.●

TRIBUTE TO CHUCK CLEMENT

● Mr. SMITH of New Hampshire. Mr. President, I rise today to pay tribute to Chuck Clement of Rochester, NH, on being named by the Rochester Chamber of Commerce as Business Leader of the Year 2001.

Mr. Clement is a third generation owner of Eastern Propane. Thanks to Chuck's leadership and management skills, Eastern Propane is now the 23rd largest retailer in the Nation providing propane, oil, kerosene, diesel fuels, and service throughout New England.

Chuck has provided his customers with high quality service and has implemented several service programs to further enhance his business. Due to his commitment to the community of Rochester, he has moved his central office from Danvers, MA, to Rochester, NH, his new hometown.

He encourages his employees to give back to the community by donating their time and efforts to organizations including: Strafford County YMCA, Rochester Rotary Club, and the Greater Rochester Chamber of Commerce. Chuck was among the first supporters of the Rochester Public Library Fund and the Rochester Opera House Fund drives.

Chuck's outstanding contribution and leadership in his business and community are commendable. His exemplary performance and civic awareness have benefitted the community of Rochester and our entire State. It is an honor and privilege to represent him in the Senate.●

TRIBUTE TO LAURA MONICA

● Mr. SMITH of New Hampshire. Mr. President, I rise today to pay tribute to Laura Monica of Bow, NH, for being named by the Greater Manchester Chamber of Commerce as Small Business Person of the Year 2001.

Laura is president and founder of High Point Communications Group, Inc. located in Bow, NH. Her firm is a strategic communications company that works with companies, non-profit organizations and government agencies throughout New England and the United States. High Point specializes in the areas of public relations, marketing, corporate communications, media relations and media training.

Laura is a contributor to the local community and is active in many civic organizations including: Greater Manchester Chamber of Commerce, Leadership New Hampshire, Greater Manchester American Red Cross, American Cancer Society New Hampshire Division, and Greater Manchester United Way.

She is active in professional organizations and is a member of the Public Relations Society of America and is a former member of the Bank Investor Relations Association and the National Investor Relations Institute.

Laura received her BA from the University of New Hampshire graduating magna cum laude and received her MPA from the University of New Hampshire graduating summa cum laude. She has attended seminars by the Wharton School and by the American Bankers Association, School of Bank Investments. She resides in Bow, NH, with her husband, Bill Verville, and their twin daughters: Brittany and Caitlin.

I commend Laura for her exemplary achievements in business and civic responsibilities. The citizens of Bow and our entire State have benefitted from her contributions to the community and local economy. It is truly an honor and a privilege to represent her in the U.S. Senate.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

REPORT ON BLOCKING PROPERTY OF PERSONS WHO THREATEN INTERNATIONAL STABILIZATION EFFORTS IN THE WESTERN BALKANS—MESSAGE FROM THE PRESIDENT—PM 30

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Banking, Housing, and Urban Affairs.

To the Congress of the United States:

Pursuant to section 204(b) of the International Emergency Economic Powers Act, 50 U.S.C. 1703(b) (IEEPA), and section 301 of the National Emergencies Act, 50 U.S.C. 1631, I hereby report that I have exercised my statutory authority to declare a national emergency in response to the unusual and extraordinary threat posed to the national security and foreign policy of the United States by (i) actions of persons engaged in, or assisting, sponsoring, or supporting, extremist violence in the former Yugoslav Republic of Macedonia, southern Serbia, the Federal Republic of Yugoslavia (FRY), and elsewhere in the Western Balkans region, and (ii) the actions of persons engaged in, or assisting, sponsoring, or supporting acts obstructing implementation of the Dayton Accords in Bosnia or United Nations Security Council Resolution 1244 of June 10, 1999, in Kosovo. The actions of these individuals and groups threaten the peace in or diminish the security and stability of the Western Balkans, undermine the authority, efforts, and objectives of the United Nations, the North Atlantic Treaty Organization (NATO), and other international organizations and entities present in those areas and the wider region, and endanger the safety of persons participating in or providing support to the activities of those organizations and entities, including United States military forces and Government officials. In order to deal with this threat, I have issued an Executive order blocking the property and interests in property of those persons determined to have undertaken the actions described above.

The Executive order prohibits United States persons from transferring, paying, exporting, withdrawing, or otherwise dealing in the property or interests in property of persons I have identified in the Annex to the order or persons designated pursuant to the order by the Secretary of the Treasury, in consultation with the Secretary of State. Included among the activities prohibited by the order are the making or receiving by United States persons of any contribution or provision of funds, goods, or services to or for the benefit of any person designated in or pursuant to the order. In the Executive order, I also have made a determination pursuant to section 203(b)(2) of IEEPA that the operation of the IEEPA exemption for certain humanitarian donations from the scope of the prohibitions would seriously impair my ability to deal with the national emergency. Absent such a determination, such donations of the type specified in section 203(b)(2) of IEEPA could strengthen the position of individuals and groups that endanger the safety of persons participating in or providing support to the United Nations, NATO, and other international organizations or entities, including U.S. military forces and Government officials, present in the region. The Secretary of the Treasury, in consultation with the Secretary of State, is authorized to issue regulations in exercise of my authorities under IEEPA to implement the prohibitions set forth in the Executive order. All Federal agencies are also directed to take actions within their authority to carry out the provisions of the order, and, where appropriate, to advise the Secretary of the Treasury in a timely manner of the measures taken.

I am enclosing a copy of the Executive order I have issued. The order was effective at 12:01 a.m. eastern daylight time on June 27, 2001.

I have issued the order in response to recent developments in the former Yugoslav Republic of Macedonia, southern Serbia, and elsewhere in the

Western Balkans region where persons have turned increasingly to the use of extremist violence, the incitement of ethnic conflict, and other obstructionist acts to promote irredentist or criminal agendas that have threatened the peace in and the stability and security of the region and placed those participating in or supporting international organizations, including U.S. military and government personnel, at risk.

In both Macedonia and southern Serbia, individuals and groups have engaged in extremist violence and other acts of obstructionism to exploit legitimate grievances of local ethnic Albanians. These groups include local nationals who fought with the Kosovo Liberation Army in 1998–99 and have used their wartime connections to obtain funding and weapons from Kosovo and the ethnic Albanian diaspora. Guerrilla attacks by some of these groups against police and soldiers in Macedonia threaten to bring down the democratically elected, multi-ethnic government of a state that has become a close friend and invaluable partner of NATO. In March 2001, guerrillas operating on the border between Kosovo and Macedonia attempted to fire upon U.S. soldiers participating in the international security presence in Kosovo known as the Kosovo force (KFOR). Guerrilla leaders subsequently made public threats against KFOR.

In southern Serbia, ethnic Albanian extremists have used the Ground Safety Zone (GSZ), originally intended as a buffer between KFOR and FRY/Government of Serbia ((FRY/GoS) forces, as a safe haven for staging attacks against FRY/GoS police and soldiers. Members of ethnic Albanian armed extremist groups in southern Serbia have on several occasions fired on joint U.S.-Russian KFOR patrols in Kosovo. NATO has negotiated the return of FRY/GoS forces to the GSZ, and facilitated negotiations between Belgrade authorities and ethnic Albanian insurgents and political leaders from southern Serbia. A small number of the extremist leaders have since threatened to seek vengeance on KFOR, including U.S. KFOR.

Individuals and groups engaged in the activities described above have boasted falsely of having U.S. support, a claim that is believed by many in the region. They also have aggressively solicited funds from United States persons. These fund-raising efforts serve to fuel extremist violence and obstructionist activity in the region and are inimical to U.S. interests. Consequently, the Executive order I have issued is necessary to restrict any further financial or other support by United States persons for the persons designated in or pursuant to the order. The actions we are taking will demonstrate to all the peoples of the region and to the wider international community that the Government of the United States strongly opposes the recent extremist violence and obstructionist activity in Macedonia and southern Serbia and elsewhere in the Western Balkans. The concrete steps we are undertaking to block access by these groups and individuals to financial and material support will assist in restoring peace and stability in the Western Balkans region and help protect U.S. military forces and Government officials working towards that end.

GEORGE W. BUSH.
THE WHITE HOUSE, *June 27, 2001*.

REPORT ON THE FEDERAL LABOR RELATIONS AUTHORITY FOR FISCAL YEAR 2000—MESSAGE FROM THE PRESIDENT—PM 31

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Governmental Affairs.

To the Congress of the United States:

In accordance with section 701 of the Civil Service Reform Act of 1978 (Public Law 95–454; 5 U.S.C. 7104(e)), I transmit herewith to you the Twenty-second Annual Report of the Federal Labor Relations Authority for Fiscal Year 2000.

GEORGE W. BUSH.
THE WHITE HOUSE, *June 27, 2001*.

MESSAGES FROM THE HOUSE

At 3:05 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 2299. An act making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 2002, and for other purposes.

The message also announced that the House has agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 172. Concurrent resolution recognizing and honoring the Young Men's Christian Association on the occasion of its 150th anniversary in the United States.

At 3:21 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the Speaker has signed the following enrolled bill:

S. 657. An act to authorize funding for the National 4–H Program Centennial Initiatives.

The enrolled bill was signed subsequently by the President pro tempore (Mr. BYRD).

MEASURES REFERRED

The following bill was read the first and the second times by unanimous consent, and referred as indicated:

H.R. 2299. An act making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 2002, and for other purposes; to the Committee on Appropriations.

The following concurrent resolution was read, and referred as indicated:

H. Con. Res. 172. Concurrent resolution recognizing and honoring the Young Men's Christian Association on the occasion of its 150th anniversary in the United States; to the Committee on the Judiciary.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, which were referred as indicated:

EC–2587. A communication from the Chief Financial Officer and Plan Administrator, First South Agricultural Credit Association, transmitting, pursuant to law, the annual pension plan report for calendar year 2000; to the Committee on Governmental Affairs.

EC–2588. A communication from the Assistant Attorney General, Office of Legislative Affairs, Department of Justice, transmitting, pursuant to law, the Report of the Attorney General for the period July 1 to December 31, 2000; to the Committee on Foreign Relations.

EC–2589. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Change of Official EPA Mailing Address; Additional Technical Amendments and Corrections'' (FRL6772–2) received on June 25, 2001; to the Committee on Environment and Public Works.

EC–2590. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of rule entitled ''Oil Pollution Prevention and Response; Non-Transportation-Related Facilities'' (FRL7003–1) received on June 25, 2001; to the Committee on Environment and Public Works.

EC–2591. A communication from the Counsel for Regulations, Office of Public and Indian Housing, Department of Housing and Urban Development, transmitting, pursuant to law, the report of a rule entitled ''Section 8 Homeownership Program; Pilot Program for Homeownership Assistance for Disabled Families'' (RIN2577–AC24) received on June 25, 2001; to the Committee on Banking, Housing, and Urban Affairs.

EC–2592. A communication from the Counsel for Regulations, Office of Public and Indian Housing, Department of Housing and Urban Development, transmitting, pursuant to law, the report of a rule entitled ''Voluntary Conversion of Developments from Public Housing Stock; Required Initial Assessments'' (RIN2577–AC02) received on June 25, 2001; to the Committee on Banking, Housing, and Urban Affairs.

EC–2593. A communication from the Acting Assistant General Counsel for Regulations, Special Education and Rehabilitative Services, Department of Education, transmitting, pursuant to law, the report of a rule entitled ''NIDRR—Community-Based Research Projects on Technology for Independence; Resource Centers for Community-Based Disability and Rehabilitation Research Projects on Technology for Independence; Assistive Technology Outcomes and Impacts and Assistive Technology Research Project for Individuals with Cognitive Disabilities'' received on June 21, 2001; to the Committee on Health, Education, Labor, and Pensions.

EC–2594. A communication from the Acting Assistant General Counsel for Regulations, Office of the General Counsel, Office of Postsecondary Education, Department of Education, transmitting, pursuant to law, the

report of a rule entitled ''Federal Work-Study Programs, Federal Supplemental Educational Opportunity Grant Program, and Special Leveraging Educational Assistance Partnership Program'' received on June 25, 2001; to the Committee on Health, Education, Labor, and Pensions.

EC–2595. A communication from the Railroad Retirement Board, transmitting, pursuant to law, the annual report on the financial status of the railroad unemployment insurance system for 2001; to the Committee on Health, Education, Labor, and Pensions.

EC–2596. A communication from the Director of the Policy Directives and Instructions Branch, Immigration and Naturalization Service, Department of Justice, transmitting, pursuant to law, the report of a rule entitled ''Children Born Outside the United States; Application for Certificate of Citizenship'' (RIN115–AF98) received on June 14, 2001; to the Committee on the Judiciary.

EC–2597. A communication from the Deputy Assistant Attorney General, Department of Justice, transmitting, pursuant to law, the report of a rule entitled ''Regulations Under the DNA Analysis Backlog Elimination Act of 2000'' received on June 25, 2001; to the Committee on the Judiciary.

EC–2598. A communication from the Assistant Attorney General, Office of Legislative Affairs, Department of Justice, transmitting, pursuant to law, the annual report of the Office of Police Corps and Law Enforcement Education for calendar year 2000; to the Committee on the Judiciary.

EC–2599. A communication from the Director of the Policy Directives and Instructions Branch, Immigration and Naturalization Service, Department of Justice, transmitting, pursuant to law, the report of a rule entitled ''Removing Russia from the list of countries whose citizens or nationals are ineligible for transit without visa (TWO) privileges to the United States under the TWOV program'' (RIN115–AG27) received on June 14, 2001; to the Committee on the Judiciary.

EC–2600. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Eligibility Requirements After Denial of the Earned Income Credit'' (RIN1545–AV61) received on June 22, 2001; to the Committee on Finance.

EC–2601. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Removal of the Federal Reserve Banks as Federal Depositories'' (RIN1545–AY10) received on June 25, 2001; to the Committee on Finance.

EC–2602. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Bureau of Labor Statistics Price Indexes for Department Stores—May 2001'' (Rev. Rul. 2001–35) received on June 26, 2001; to the Committee on Finance.

EC–2603. A communication from the Chief of the Regulations Division, Bureau of Alcohol, Tobacco and Firearms, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Recodification of Regulations on Tobacco Products and Cigarette Papers and Tubes'' (RIN1515–AC41) received on June 26, 2001; to the Committee on Finance.

EC–2604. A communication from the Chief of the Regulations Division, Bureau of Alcohol, Tobacco and Firearms, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Diamond Mountain District Viticultural Area'' (RIN1512–AA07) received on June 26, 2001; to the Committee on Finance.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. BYRD, from the Committee on Appropriations:

Special Report entitled ''Revised Allocation To Subcommittees Of Budget Totals for Fiscal Year 2002'' (Rept. No. 107–35).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. HARKIN (for himself, Mr. WELLSTONE, Mr. KENNEDY, Mr. SARBANES, Mr. AKAKA, Mr. BINGAMAN, Mr. DODD, Mrs. MURRAY, Mr. LEAHY, Ms. MIKULSKI, Mr. FEINGOLD, Mr. KERRY, Mr. LEVIN, Mr. BAUCUS, Mr. ROCKEFELLER, and Mrs. BOXER):

S. 1107. A bill to amend the National Labor Relations Act and the Railway Labor Act to prevent discrimination based on participation in labor disputes; to the Committee on Health, Education, Labor, and Pensions.

By Ms. SNOWE (for herself and Ms. COLLINS):

S. 1108. A bill to authorize the transfer and conveyance of real property at the Naval Security Group Activity, Winter Harbor, Maine, and for other purposes; to the Committee on Armed Services.

By Mr. COCHRAN (for himself and Mrs. LINCOLN):

S. 1109. A bill to amend the Internal Revenue Code of 1986 to clarify the excise tax exemptions for aerial applicators of fertilizers or other substances; to the Committee on Finance.

By Mr. ENZI:

S. 1110. A bill to require that the area of a zip code number shall be located entirely within a State, and for other purposes; to the Committee on Governmental Affairs.

By Mr. CRAIG (for himself, Mr. CONRAD, Mr. ALLARD, Mr. BAUCUS, Mr. BINGAMAN, Mr. BURNS, Ms. COLLINS, Mr. CRAPO, Mr. DASCHLE, Mr. DAYTON, Mr. DORGAN, Mr. ENZI, Mr. GRAMM, Mr. GRASSLEY, Mr. HAGEL, Mr. HELMS, Mrs. HUTCHISON, Mr. JEFFORDS, Mr. JOHNSON, Mr. KENNEDY, Mr. KERRY, Mr. LEAHY, Mr. LUGAR, Ms. MIKULSKI, Mrs. MURRAY, Mr. NELSON of Nebraska, Mr. REED, Mr. ROBERTS, Mr. SARBANES, Mr. SMITH of New Hampshire, Mr. SMITH of Oregon, Mr. THOMAS, and Mr. WELLSTONE):

S. 1111. A bill to amend the Consolidated Farm and Rural Development Act to authorize the National Rural Development Partnership, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. DURBIN (for himself, Mr. CHAFEE, Mrs. FEINSTEIN, Mr. BINGAMAN, Mr. AKAKA, Mr. KERRY, Mr. SARBANES, Mr. JOHNSON, and Mr. INOUYE):

S. 1112. A bill to provide Federal Perkins Loan cancellation for public defenders; to the Committee on Health, Education, Labor, and Pensions.

By Mr. SPECTER:

S. 1113. A bill to amend section 1562 of title 38, United States Code, to increase the amount of Medal of Honor Roll special pension, to provide for an annual adjustment in the amount of that special pension, and for other purposes; to the Committee on Veterans' Affairs.

By Mr. SPECTER:

S. 1114. A bill to amend title 38, United States Code, to increase the amount of educational benefits for veterans under the Montgomery GI Bill; to the Committee on Veterans' Affairs.

By Mr. KENNEDY (for himself, Mr. STEVENS, Mr. INOUYE, Mrs. HUTCHISON, and Mr. CORZINE):

S. 1115. A bill to amend the Public Health Service Act with respect to making progress toward the goal of eliminating tuberculosis, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. INOUYE (for himself, Mr. STEVENS, Mr. KENNEDY, Mrs. HUTCHISON, and Mr. CORZINE):

S. 1116. A bill to amend the Foreign Assistance Act of 1961 to provide increased foreign assistance for tuberculosis prevention, treatment, and control; to the Committee on Foreign Relations.

By Ms. LANDRIEU:

S. 1117. A bill to establish the policy of the United States for reducing the number of nuclear warheads in the United States and Russian arsenals, for reducing the number of nuclear weapons of those two nations that are on high alert, and for expanding and accelerating programs to prevent diversion and proliferation of Russian nuclear weapons, fissile materials, and nuclear expertise; to the Committee on Foreign Relations.

ADDITIONAL COSPONSORS

S. 88

At the request of Mr. ROCKEFELLER, the name of the Senator from Colorado (Mr. CAMPBELL) was added as a cosponsor of S. 88, a bill to amend the Internal Revenue Code of 1986 to provide an incentive to ensure that all Americans gain timely and equitable access to the Internet over current and future generations of broadband capability.

S. 381

At the request of Mr. ALLARD, the name of the Senator from Arkansas (Mr. HUTCHINSON) was added as a cosponsor of S. 381, a bill to amend the Uniformed and Overseas Citizens Absentee Voting Act, the Soldiers' and Sailors' Civil Relief Act of 1940, and title 10, United States Code, to maximize the access of uniformed services voters and recently separated uniformed services voters to the polls, to ensure that each vote cast by such a voter is duly counted, and for other purposes.

S. 409

At the request of Mrs. HUTCHISON, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. 409, a bill to amend title 38, United States Code, to clarify the standards for compensation for Persian Gulf veterans suffering from certain undiagnosed illnesses, and for other purposes.

S. 460

At the request of Mr. WELLSTONE, the name of the Senator from Nevada (Mr. REID) was added as a cosponsor of S. 460, a bill to provide for fairness and accuracy in high stakes educational decisions for students.

S. 466

At the request of Mr. HAGEL, the name of the Senator from Arkansas

(Mrs. LINCOLN) was added as a cosponsor of S. 466, a bill to amend the Individuals with Disabilities Education Act to fully fund 40 percent of the average per pupil expenditure for programs under part B of such Act.

S. 556

At the request of Mr. JEFFORDS, the name of the Senator from Delaware (Mr. CARPER) was added as a cosponsor of S. 556, a bill to amend the Clean Air Act to reduce emissions from electric powerplants, and for other purposes.

S. 561

At the request of Mr. JOHNSON, his name was added as a cosponsor of S. 561, a bill to provide that the same health insurance premium conversion arrangements afforded to Federal employees be made available to Federal annuitants and members and retired members of the uniformed services.

S. 570

At the request of Mr. BIDEN, the name of the Senator from Rhode Island (Mr. CHAFEE) was added as a cosponsor of S. 570, a bill to establish a permanent Violence Against Women Office at the Department of Justice.

S. 582

At the request of Mr. GRAHAM, the names of the Senator from Massachusetts (Mr. KERRY), the Senator from Michigan (Mr. LEVIN), and the Senator from Connecticut (Mr. DODD) were added as cosponsors of S. 582, a bill to amend titles XIX and XXI of the Social Security Act to provide States with the option to cover certain legal immigrants under the medicaid and State children's health insurance program.

S. 677

At the request of Mr. BREAUX, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 677, a bill to amend the Internal Revenue Code of 1986 to repeal the required use of certain principal repayments on mortgage subsidy bond financing to redeem bonds, to modify the purchase price limitation under mortgage subsidy bond rules based on median family income, and for other purposes.

At the request of Mr. HATCH, the name of the Senator from Arkansas (Mr. HUTCHINSON) was added as a cosponsor of S. 677, supra.

At the request of Mr. SMITH of New Hampshire, his name was added as a cosponsor of S. 677, supra.

S. 718

At the request of Mr. MCCAIN, the name of the Senator from Ohio (Mr. VOINOVICH) was added as a cosponsor of S. 718, a bill to direct the National Institute of Standards and Technology to establish a program to support research and training in methods of detecting the use of performance-enhancing drugs by athletes, and for other purposes.

S. 830

At the request of Mr. CHAFEE, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 830, a bill to amend the Public Health Service Act to authorize the Director of the National Institute of Environmental Health Sciences to make grants for the development and operation of research centers regarding environmental factors that may be related to the etiology of breast cancer.

S. 839

At the request of Mrs. HUTCHISON, the name of the Senator from Maryland (Mr. SARBANES) was added as a cosponsor of S. 839, a bill to amend title XVIII of the Social Security Act to increase the amount of payment for inpatient hospital services under the medicare program and to freeze the reduction in payments to hospitals for indirect costs of medical education.

S. 847

At the request of Mr. DAYTON, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 847, a bill to impose tariff-rate quotas on certain casein and milk protein concentrates.

S. 860

At the request of Mr. GRASSLEY, the name of the Senator from Florida (Mr. GRAHAM) was added as a cosponsor of S. 860, a bill to amend the Internal Revenue Code of 1986 to provide for the treatment of certain expenses of rural letter carriers.

S. 866

At the request of Mr. REID, the name of the Senator from Arkansas (Mr. HUTCHINSON) was added as a cosponsor of S. 866, a bill to amend the Public Health Service Act to provide for a national media campaign to reduce and prevent underage drinking in the United States.

S. 906

At the request of Mr. ENZI, the name of the Senator from Alaska (Mr. STEVENS) was added as a cosponsor of S. 906, a bill to provide for protection of gun owner privacy and ownership rights, and for other purposes.

S. 920

At the request of Mr. BREAUX, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 920, a bill to amend the Internal Revenue Code of 1986 to provide a credit against income tax to individuals who rehabilitate historic homes or who are the first purchasers of rehabilitated historic homes for use as a principal residence.

S. 926

At the request of Mr. HARKIN, the names of the Senator from Vermont (Mr. LEAHY), the Senator from Kentucky (Mr. MCCONNELL), the Senator from Wisconsin (Mr. FEINGOLD), the Senator from New Jersey (Mr. TORRICELLI), the Senator from Minnesota (Mr. DAYTON), and the Senator from New Jersey (Mr. CORZINE) were added as cosponsors of S. 926, a bill to prohibit the importation of any article that is produced, manufactured, or grown in Burma.

S. RES. 117

At the request of Mrs. CLINTON, the name of the Senator from Delaware (Mr. BIDEN) was added as a cosponsor of S. Res. 117, a resolution honoring John J. Downing, Brian Fahey, and Harry Ford, who lost their lives in the course of duty as firefighters.

S. CON. RES. 9

At the request of Mr. HARKIN, the names of the Senator from New Jersey (Mr. CORZINE), the Senator from Illinois (Mr. DURBIN), and the Senator from Florida (Mr. NELSON) were added as cosponsors of S. Con. Res. 9, a concurrent resolution condemning the violence in East Timor and urging the establishment of an international war crimes tribunal for prosecuting crimes against humanity that occurred during that conflict.

S. CON. RES. 34

At the request of Mr. CAMPBELL, the name of the Senator from Pennsylvania (Mr. SANTORUM) was added as a cosponsor of S. Con. Res. 34, a concurrent resolution congratulating the Baltic nations of Estonia, Latvia, and Lithuania on the tenth anniversary of the reestablishment of their full independence.

S. CON. RES. 53

At the request of Mr. HAGEL, the names of the Senator from Wisconsin (Mr. KOHL), the Senator from Maryland (Ms. MIKULSKI), and the Senator from New Jersey (Mr. CORZINE) were added as cosponsors of S. Con. Res. 53, concurrent resolution encouraging the development of strategies to reduce hunger and poverty, and to promote free market economies and democratic institutions, in sub-Saharan Africa.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. HARKIN (for himself Mr. WELLSTONE, Mr KENNEDY, Mr. SARBANES, Mr. AKAKA, Mr. BINGAMAN, Mr. DODD, Mrs MURRAY, Mr. LEAHY, Ms. MIKULSKI, Mr. FEINGOLD, Mr. KERRY, Mr. LEVIN, Mr. BAUCUS, Mr. ROCKEFELLER and Mrs. BOXER).

S. 1107. A bill to amend the National Labor Relations Act and the Railway Labor Act to prevent discrimination based on participation in labor disputes; to the Committee on Health, Education, Labor, and Pensions.

Mr. HARKIN. Mr. President, I, along with 15 of my colleagues are introducing a bill today that addresses an issue we haven't talked enough about in the Senate in recent years—but it's a critically important issue that we cannot continue to ignore.

I'm talking about workers' rights—specifically the erosion of a worker's fundamental right to strike, to protect that right.

Today, we are introducing the Workplace Fairness Act. This may sound familiar to many of my colleagues here in the Senate. It was a bill my good friend and former colleague Senator Howard Metzenbaum from Ohio introduced in the 102nd and 103rd congress.

The Workplace Fairness Act would amend the National Labor Relations

Act and the Railway Labor Act by prohibiting employers from hiring permanent replacement workers during a strike. It would also make it an unfair labor practice for an employer to refuse to allow a striking worker who has made an unconditional offer to return to go back to work.

Why do we need this legislation?

Because right now, a right to strike is a right to be permanently replaced—to lose your job. Every cut-rate, cut-throat employer knows they can break a union if they are willing to play hardball and ruin the lives of the people who have made their company what it is. In my own state of Iowa—Titan Tire Company out of Des Moines, is trying to drive out the union workers with permanent replacements—the union has been on strike for three years now.

Over the past two decades, workers' right to strike has too often been undermined by the destructive practice of hiring permanent replacement workers. Since the 1980s, permanent replacements have been used again and again to break unions and to shift the balance between workers and management.

Titan Tire just outside is just one of many examples.

On May 1, 1998, the 650 members of the United Steelworkers of America, Local 164, who work in Des Moines Titan Tire plant, were forced into an Unfair Labor Practice Strike.

During the contract negotiations preceding this strike, Titan International Inc. President and CEO, Morry Taylor, attempted to eliminate pension and medical benefits and illegally move jobs and equipment out of the plant. He also forced employees to work excessive mandatory overtime, sometimes working people as many as 26 days in a row without a day off.

Well, the membership decided that Titan's final offer was impossible to accept, and they voted to strike. Two months later, in July, 1998, Titan began hiring permanent replacement workers.

During the past three years, approximately 500 permanent replacement workers have been hired at the Des Moines plant. And little or no progress has been made toward reaching a fair settlement. In fact on April 30, 2000, the day before the second anniversary of the Titan strike, Morrie Taylor predicted that the strike would never be settled.

Workers deserve better than this. Workers aren't disposable assets that can be thrown away when labor disputes arise.

When we considered this legislation in 1994, the Senate labor and Human Resources Committee heard poignant testimony about the emotional and financial hardships caused by hiring permanent replacement workers. We heard about workers losing their homes; going without health insurance because of the high costs of COBRA coverage; feeling useless when they were permanently replaced after years of loyal service.

The right to strike—which we all know is a last resort since no worker takes the financial risk of a strike lightly—is fundamental to preserving workers' rights to bargain for better wages and better working conditions. Without the right to strike, workers forgo their fair share of bargaining power.

Permanent striker replacement not only affects the workers who were replaced. It affects other workers in competing companies. When one employer in an industry breaks a union, hires permanent replacements, and cuts salaries and benefits, it affects all the other companies in the industry. Now they either have to find a way to compete with the low-wages and shoddy benefits of a cut-rate, cut-throat business—or they have to follow suit.

Also, workers faced with being replaced are forced to make a choice. They can either stay with the union and fight for their jobs, or they can cross the picket line to avoid losing the jobs they've held for ten or twenty or thirty years.

Is this a free choice, as some of our colleagues would suggest? Or is this blackmail that takes away the rights and the dignity of the workers of this country? What does it mean to tell workers, ''you have the right to strike''—when we allow them to be summarily fired for exercising that right?

In reality, there is no legal right to strike today. And because there is no legal right to strike, there is no legal right to bargain collectively. And since there is no legal right to bargain collectively, there is no level playing field between workers and management.

In other words, Management gets to say that you must bargain on their terms—or find some other place to work. If you're permanently replaced, that means you're out of work; you lose all your pension rights; you lose your seniority; you lose your job forever.

How did this happen? We've got to go back to the 1930's for the answer.

In response to widespread worker abuses—and union busting—Congress passed the National Labor Relations Act—the Wagner Act—in 1935 and it was signed into law by President Roosevelt. The Wagner Act guarantees workers the right to organize and bargain collectively and strike if necessary. It makes it illegal for companies to interfere with these rights. In fact, it specifies the right to strike and states: 'Nothing in this act—except as specifically provided herein—shall be construed so as to interfere with or impede or diminish in any way the right to strike.'

In 1938, the Supreme Court dealt the Wagner Act a mortal blow in the case National Labor Relations Board (NLRB) versus Mackay Radio and Telegraph Co. In that case, the Court said that Mackay Radio could hire permanent replacement workers for those engaged in an economic strike.

There are two types of strikes: economic and unfair labor practices. Employers must rehire employees in unfair labor practice strikes. The NLRB determines if the strike is economic or based on unfair labor practices. Unions cannot know in advance whether NLRB will rule that their employer has engaged in unfair labor practices. So any employee participating in a strike runs a risk of permanently losing his or her job.

What's interesting is that following the Court's ruling, companies did not take advantage of this loophole until the 1980s. Before then, they recognized that doing that would upset this level playing field. For almost 40 years, management rarely hired permanent replacements.

That began to change in the 1980s. Since then, hiring permanent replacements has become a routine practice to break unions and shift the balance between workers and management.

Again, the Workplace Fairness Act would restore the fundamental principle of fair labor-management relations—the right of workers to strike without having to fear losing their jobs.

Permanent striker replacement keeps us from moving forward as a nation into an era of high-wage, high-skilled, highly productive jobs in the global marketplace. Without the right to strike, workers' rights will continue to erode. The result will be fewer incentives and less motivation to produce good work, and companies will also suffer with less quality in their products.

Obviously, this legislation won't be adopted this year. But we are introducing it today to signal my intent on raising it and other fundamental labor law reforms in the next session of Congress. It's time for us to level the playing field for hard-working Americans.

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

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

S. 1107

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

SECTION 1. PREVENTION OF DISCRIMINATION DURING AND AT THE CONCLUSION OF LABOR DISPUTES.

Section 8(a) of the National Labor Relations Act (29 U.S.C. 158(a)) is amended—

(1) by striking the period at the end of paragraph (5) and inserting ''; or''; and

(2) by adding at the end thereof the following new paragraph:

''(6)(i) to offer, or to grant, the status of a permanent replacement employee to an individual for performing bargaining unit work for the employer during a labor dispute; or

''(ii) to otherwise offer, or grant, an individual any employment preference based on the fact that such individual was employed, or indicated a willingness to be employed, during a labor dispute over an individual who—

''(A) was an employee of the employer at the commencement of the dispute;

''(B) has exercised the right to join, to assist, or to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection through the labor organization involved in the dispute; and

''(C) is working for, or has unconditionally offered to return to work for, the employer.''.

SEC. 2. PREVENTION OF DISCRIMINATION DURING AND AT THE CONCLUSION OF RAILWAY LABOR DISPUTES.

Paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152) is amended—

(1) by inserting ''(a)'' after ''Fourth.''; and

(2) by adding at the end the following:

''(b) No carrier, or officer or agent of the carrier, shall—

''(1) offer, or grant, the status of a permanent replacement employee to an individual for performing work in a craft or class for the carrier during a dispute involving the craft or class; or

''(2) otherwise offer, or grant, an individual any employment preference based on the fact that such individual was employed, or indicated a willingness to be employed, during a dispute over an individual who—

''(A) was an employee of the carrier at the commencement of the dispute;

''(B) has exercised the right to join, to organize, to assist in organizing, or to bargain collectively through the labor organization involved in the dispute; and

''(C) is working for, or has unconditionally offered to return to work for, the carrier.''.

Mr. WELLSTONE. Mr. President, I am pleased to join my good friend Senator HARKIN as an original cosponsor of the Workplace Fairness Act of 2001. This measure, along with the ''Right to Organize Act of 2001,'' which I introduced yesterday, are two of the most important pieces of legislation that will come before the Senate this year.

Together, these measures strengthen workers' rights to organize, to join a union, and to advocate for fair collective bargaining and fair agreements. Together, these measures produce the basic platform for healthy economies, healthy communities, and healthy families.

Specifically, the Striker Replacement Act is designed to combat an unfair labor practice which strikes at the very heart of the collective bargaining process in this country: the permanent replacement of striking workers. The goal of this Act is to restore the labor-management balance in today's workplace by preventing the fundamental right to strike from being transformed into a right to be fired.

The record shows that permanent replacement of striking workers has been used increasingly over the years. Private sector employers, emboldened by the Reagan Administration's permanent replacement of striking Federal employees in the early 1980's, began to use the permanent replacement of striking workers as a means of abrogating collective bargaining agreements and bringing in new hires often screened for their anti-union biases.

The process is fairly simple: require major and unreasonable concessions of a union; force them to strike; permanently replace them with workers unsympathetic to the union; and move to decertify the union. This should be called what it is: outright union busting. And it should not be tolerated.

The purpose of the Railway Labor Act and the National Labor Relations Act was to respond to the persistent—and sometimes violent—denial by certain employers of the right to organize and bargain collectively. The resulting strikes and other forms of industrial unrest in the 1930's were held by the courts to have severely burdened free and open commerce across the country. As a result, the Railway Labor Act and the National Labor Relations Act were passed, guided by two fundamental principles: 1. Employees have a right to pursue their interests collectively without fear of employer reprisals, and 2. Questions about representation must be separated from substantive issues in dispute. Government-supervised procedure should be established to ensure fair representation; while collective bargaining should be the forum for settling the remaining substantive disputes.

This system and these principles are sound. Workers have a right to organize without being retaliated against for exercising that right. And they have a right to negotiate wages, benefits, and other items through collective bargaining.

But these principles only work if the right to strike, in the words of the National Labor Relations Act, is not ''interfered with or impeded or diminished in any way.'' In 1938, the Supreme Court in the Mackay Radio case cut a huge swath through these guiding principles by creating the striker replacement doctrine. Under this doctrine, affirmed in subsequent decisions, such as Belknap v. Hale (1983) and TWA v. IFFA (1989), even though it is unlawful to fire a striking worker, it is not unlawful to permanently replace him or her.

The distinction between firing and permanent replacement, is ludicrous—and it is untenable. The central practical reality—as any man or woman who has exercised his or her right to strike and has paid the consequences can tell you—in either case, whether it is called a firing or a permanent replacement—the employee loses their job because he or she has exercised the right to strike. That's the reality. That's the harsh reality.

The measure we are introducing today is a simple one. It does two things: 1. It amends the National Labor Relations Act and the Railway Labor Act to prohibit employers from hiring permanent replacement workers during a strike, or giving employment preference to cross over employees, and 2. It makes it an unfair labor practice for an employer to refuse to allow a striking worker to return to work if that worker has unconditionally offered to return to work.

It's that simple. These are fundamental protections. These are protections that are part of the basic compact with the American worker created by the National Labor Relations Act and the Railway Labor Act. It is long past time that workers seeking to better their lives, their families, and their communities are given access to a collective bargaining process that is fair and even-handed. It is long past time that workers be allowed to advocate for reasonable terms and conditions of their employment without fear of devastating retribution.

Finally, this measure not only meets the needs of workers, their families, and their communities, it also serves the interest of our nation in a global economy. As others have pointed out, if we are to remain strong and competitive as a nation, we must develop a highly motivated and skilled workforce and we must create stable worker-employer relationships that are based on mutual respect and a mutual commitment to a joint economic enterprise. This will only happen if we level the playing field and support a just, sound, and effective collective bargaining process.

This measure, the Workplace Fairness Act, is one key to achieving these goals. I urge my colleagues to join me in supporting this legislation.

By Ms. SNOWE (for herself and Ms. COLLINS):

S. 1108. A bill to authorize the transfer and conveyance of real property at the Naval Security Group Activity, Winter Harbor, Maine, and for other purposes; to the Committee on Armed Services.

Ms. SNOWE. Mr. President. I rise today with my colleague from Maine to introduce legislation facilitating the land conveyance at Winter Harbor, ME.

First, may I note that this bill is the product of countless hours of hard work and deliberation by the communities it affects—Winter Harbor and Gouldsboro—the State of Maine, and the Maine Delegation. I would like to thank those involved: Chairmen Stan Torrey and Tom Mayor and members of the Gouldsboro and Winter Harbor Base Reuse Committees; Jean Marshall, the Defense Conversion Coordinator for Eastern Maine Development; Linda Pagels and Roger Barto, Town Managers for Gouldsboro and Winter Harbor; and Commander Edwin Williamson, Commanding Officer of Naval Security Group Activity Winter Harbor, for their efforts in crafting legislation that all concerned can support.

The Navy has been a strong and supportive presence in the Winter Harbor region since the establishment of their facility over 80 years ago. What started as one man's patriotic efforts in World War I to establish a radio station for transatlantic communications developed into a complex network of sophisticated equipment that became Winter Harbor Naval Security Group Activity. Throughout the two World Wars and subsequent Cold War, the men and women stationed at Winter Harbor provided invaluable services in our Nation's defense.

Maine and the Navy have always had a special relationship, and that relationship extended to Winter Harbor. The base and community embraced one another and developed a good neighbor relationship seldom seen between a military installation and the surrounding community. For both sides, it was truly a win-win situation. The sailors and their families enjoyed the hospitality of Maine while the towns of Winter harbor and Gouldsboro economically benefited from the Navy's presence.

Unfortunately, the advent of new technology has made the equipment and mission of Winter Harbor obsolete. With the announcement that the Winter Harbor Naval Activity would close in June 2002, the communities began the laborious process of planning for life without the good neighbors of Winter Harbor NSGA.

With this base closing, Maine will lose an economic base it has depended on for over 80 years. At its high point, Winter Harbor had approximately 250 sailors, 140 civilian employees, and their family members in residence and the base became an economic focal point for the region with an estimated $11 to $15 million being contributed to the local economy on an annual basis.

To offset this impending loss, the towns applied for and received a small Economic Development Administration Defense Conversion Planning Grant in the amount of $200,000. While these funds proved crucial to the start of the reuse process, many needs still remain unmet. This legislation is intended to address some of those needs and to minimize the financial consequences of the base closure.

The towns of Winter Harbor and Gouldsboro are not looking for charity. As you will see, this legislation's intent is to reimburse the towns for infrastructure improvements made at the Navy's behest and to provide the means for the region to restore its economic viability.

As I mentioned earlier, the Maine Delegation has been working with the local communities, the State, Navy, and National Park Service to develop a comprehensive plan for reuse of the property and facilities. The primary facilities at Winter Harbor are located on a beautiful and breathtaking portion of the Maine coastline known as Schoodic Point. Once the base closes, this legislation dictates that the Schoodic Point property will shift to the Department of the Interior's jurisdiction for inclusion in Acadia National Park.

In preparation for this property transfer, the National Park Service has initiated a plan to establish a Research and Education Center at the site. This center will host educational programs and private and public research facilities, becoming a source for meaningful employment and economic generation for the communities. However, the National Park Service effort will not be achieved overnight and, like all programs, requires adequate funding.

As such, this legislation was drafted to include financial provisions to ease and expedite this transition as well as to reimburse the community for local services and infrastructure improvements.

In closing, I would like to thank all of those in the local communities, the State of Maine, the Navy, and the National Park Service and, of course, my colleagues from the Maine Delegation for their assistance in crafting this legislation. I urge my colleagues to support this initiative and allow the good people of Winter Harbor and Gouldsboro to make the most of this unique base reuse opportunity.

I ask unanimous consent the text of the bill be printed in the RECORD.

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

S. 1108

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

SECTION 1. LAND TRANSFER AND CONVEYANCE, NAVAL SECURITY GROUP ACTIVITY, WINTER HARBOR, MAINE.

(a) TRANSFER OF JURISDICTION OF SCHOODIC POINT PROPERTY AUTHORIZED.—(1) The Secretary of the Navy may transfer, without consideration, to the Secretary of the Interior administrative jurisdiction of a parcel of real property, including any improvements thereon and appurtenances thereto, consisting of approximately 26 acres as generally depicted as Tract 15–116 on the map entitled ''Acadia National Park Schoodic Point Area'', numbered 123/80,418 and dated May 2001. The map shall be on file and available for inspection in the appropriate offices of the National Park Service.

(2) The transfer authorized by this subsection shall occur, if at all, concurrently with the reversion of administrative jurisdiction of a parcel of real property consisting of approximately 71 acres, as depicted as Tract 15–115 on the map referred to in paragraph (1), from the Secretary of the Navy to the Secretary of the Interior as authorized by Public Law 80–260 (61 Stat. 519) and to be executed on or about June 30, 2002.

(b) CONVEYANCE OF COREA AND WINTER HARBOR PROPERTIES AUTHORIZED.—The Secretary of the Navy may convey, without consideration, to the State of Maine, any political subdivision of the State of Maine, or any tax-supported agency in the State of Maine, all right, title, and interest of the United States in and to any of the parcels of real property, including any improvements thereon and appurtenances thereto, consisting of approximately 485 acres and comprising the former facilities of the Naval Security Group Activity, Winter Harbor, Maine, located in Hancock County, Maine, except for the real property described in subsection (a)(1).

(c) TRANSFER OF PERSONAL PROPERTY.—The Secretary of the Navy shall transfer, without consideration, to the Secretary of the Interior in the case of the real property transferred under subsection (a), or to any recipient of such real property in the case of real property conveyed under subsection (b), any or all personal property associated with such real property so transferred or conveyed, including—

(1) the ambulances and any fire trucks or other firefighting equipment; and

(2) any personal property required to continue the maintenance of the infrastructure of such real property, including the generators and an uninterrupted power supply in building 154 at the Corea site.

(d) MAINTENANCE OF PROPERTY PENDING CONVEYANCE.—The Secretary of the Navy shall maintain any real property, including any improvements thereon, appurtenances thereto, and supporting infrastructure, to be conveyed under subsection (b) in accordance with the protection and maintenance standards specified in section 101–47.4913 of title 41, Code of Federal Regulations, until the earlier of—

(1) the date of the conveyance of such real property under subsection (b); or

(2) September 30, 2003.

(e) INTERIM LEASE.—(1) Until such time as any parcel of real property to be conveyed under subsection (b) is conveyed by deed under that subsection, the Secretary of the Navy may lease such parcel to any person or entity determined by the Secretary to be an appropriate lessee of such parcel.

(2) The amount of rent for a lease under paragraph (1) shall be the amount determined by the Secretary to be appropriate, and may be an amount less than the fair market value of the lease.

(3) Notwithstanding any other provision of law, the Secretary shall credit any amount received for a lease of real property under paragraph (1) to the appropriation or account providing funds for the operation and maintenance of such property or for the procurement of utility services for such property. Amounts so credited shall be merged with funds in the appropriation or account to which credited, and shall be available for the same purposes, and subject to the same conditions and limitations, as the funds with which merged.

(f) REIMBURSEMENT FOR ENVIRONMENTAL AND OTHER ASSESSMENTS.—(1) The Secretary of the Navy may require each recipient of real property conveyed under subsection (b) to reimburse the Secretary for the costs incurred by the Secretary for any environmental assessment, study, or analysis carried out by the Secretary with respect to such property before completing the conveyance under that subsection.

(2) The amount of any reimbursement required under paragraph (1) shall be determined by the Secretary, but may not exceed the cost of the assessment, study, or analysis for which reimbursement is required.

(3) Section 2695(c) of title 10, United States Code, shall apply to any amount received by the Secretary under this subsection.

(g) DESCRIPTION OF PROPERTY.—The exact acreage and legal description of the real property transferred under subsection (a), and each parcel of real property conveyed under subsection (b), shall be determined by a survey satisfactory to the Secretary of the Navy. The cost of any survey under the preceding sentence for real property conveyed under subsection (b) shall be borne by the recipient of the real property.

(h) ADDITIONAL TERMS AND CONDITIONS.—The Secretary of the Navy may require such additional terms and conditions in connection with any conveyance under subsection (b), and any lease under subsection (e), as the Secretary considers appropriate to protect the interests of the United States.

SEC. 2. TRANSFER OF FUNDS TO DEPARTMENT OF THE INTERIOR.

The Secretary of Defense shall transfer to the Secretary of the Interior amounts as follows:

(1) $5,000,000 for purposes of capital investments for the development of a research and education center at Acadia National Park, Maine.

(2) $1,400,000 for purposes of operation and maintenance activities at Acadia National Park Maine.

SEC. 3. FINANCIAL ASSISTANCE.

(a) GRANT ASSISTANCE FOR TOWN OF WINTER HARBOR.—(1) The Secretary of the Navy

shall, by grant, provide financial assistance to the Town of Winter Harbor, Maine (in this subsection referred to as the ''Town''), in each of fiscal years 2002, 2003, and 2004, for the purpose of reimbursing the Town for costs incurred in making improvements to the water and sewer systems of the Town for the benefit of the Naval Security Group Activity, Winter Harbor, Maine, located in Hancock County, Maine.

(2) The amount of the grant under paragraph (1) in fiscal year 2002 shall be $68,000.

(3) The amount of the grant under paragraph (1) in each of fiscal years 2003 and 2004 shall be the amount, not to exceed $68,000, jointly determined by the Secretary and the Town to be appropriate to reimburse the Town as described in that paragraph in the applicable fiscal year.

(b) GRANT ASSISTANCE FOR SCHOOL ADMINISTRATIVE DISTRICT.—(1) The Secretary shall, by grant, provide financial assistance to the School Administrative District (SAD) operating Sumner High School, Sullivan, Maine.

(2) The purpose of the grant is to offset the loss of impact aid under title VIII of the Elementary and Secondary Education Act of 1965 that the local educational agency experienced for fiscal years 2000 and 2001 as a result of the closure of the Naval Security Group Activity, Winter Harbor, Maine.

(3) The amount of the grant under paragraph (1) shall be $86,000.

SEC. 4. AUTHORIZATIONS OF APPROPRIATIONS.

(a) TRANSFERS OF FUNDS TO DEPARTMENT OF INTERIOR.—There is hereby authorized to be appropriated for the Department of Defense for fiscal year 2002, $6,400,000 for purposes of the transfers of funds required by section 2.

(b) GRANTS.—There is hereby authorized to be appropriated for the Department of the Navy for purposes of the grants required by section 3, amounts as follows:

(1) For fiscal year 2002, $154,000.

(2) For each of fiscal years 2003 and 2004, such amounts as may be necessary.

(c) SUPPLEMENT NOT SUPPLANT.—The amounts authorized to be appropriated by this section for the Department of Defense, or for the Department of the Navy, for a fiscal year are in addition to any other amounts authorized to be appropriated for such Department for such fiscal year under any other provision of law.

(d) AVAILABILITY.—Amounts authorized to be appropriated by this section for a fiscal year shall remain available until expended, without fiscal year limitation.

Ms. COLLINS. Mr. President, I am pleased to be joining my distinguished colleague, Senator SNOWE, today in introducing this legislation, the Naval Security Group Activity at Winter Harbor Conveyance Act. This conveyance legislation will authorize the transfer of land, which has been under the control of the Naval Security Group for some seventy plus years back to the Department of the Interior, and to the State, ultimately to be put to good use by our local communities.

Over the past seven decades, the Navy has performed a key national security mission called Classic Wizard at Winter Harbor. The Navy has played a significant role in the economic development of the local communities as Maine residents and Navy personnel have supported this mission. As the requirement for the Classic Wizard mission at Winter Harbor is coming to an end, and as technology advances, this naval activity will be ending its ties to the base in the summer of 2002.

While the Navy will be missed, it has worked hand-in-hand with me and the other members of the Maine delegation, the Department of Interior, National Park Service, and our local communities in creating a viable economic development and reuse plan for the naval base and its associated property.

As part of its reuse plan for the site, the National Park Service has proposed developing a research and education center at the Schoodic Point. The center would accommodate and promote a variety of research activities including wildlife genetics and serve as a base for permanent and visiting scientists to conduct interdisciplinary research.

I worked with the National Park Service in the development of its proposal, and I have offered to help make the concept a reality. Maine Governor Angus King shares my support for the proposed research and learning center and has expressed the State's willingness to work as a partner in the effort to establish a wildlife genetics laboratory at the center. We believe that such a laboratory would generate good jobs and promote the region's economy. The work done at Schoodic Point also would compliment the world class research underway at other area facilities in the area such as The Jackson Laboratory, the Mount Desert Island Biological Laboratory, and the University of Maine's Cooperative Aquaculture Research Center.

The National Park Service's proposed reuse of the peninsula also includes an educational component that would promote the public's understanding of the important natural and cultural resources that are a part of our national park system. Moreover, those who have visited Schoodic would agree that the remarkably beautiful 100 acres are worthy of being a part of Acadia National Park, one of our Nation's greatest natural treasures.

It is important for the Federal Government to lend a hand to communities that are struggling to cope with the adverse effects of a base closure. Our legislation, which was developed in consultation with the local communities, the State, the Department of the Interior and the Navy, provides the options and opportunities that the region needs to move beyond the loss of the Naval Security Group Activity at Winter Harbor. I will work to secure approval of this bill by the Senate Armed Services committee and the full Senate.

By Mr. ENZI:

S. 1110. A bill to require that the area of a zip code number shall be located entirely within a State, and for other purposes; to the Committee on Governmental Affairs.

Mr. ENZI. Mr. President, I rise to announce the introduction of a bill that would help preserve the identity of American communities that have struggled with the United States Postal Service to acquire their own, individual zip codes. The bill would do this by prohibiting the Postal Service from extending zip codes across State boundaries.

This bill was introduced in response to concerns raised by the community of Alta, WY. Alta is a small, rural town situated next to the Wyoming-Idaho border at the western base of the Grand Teton Mountains. Because of treacherous travel conditions to the east of Alta, the Postal Service made the decision to serve Alta residents out of the post office in neighboring Driggs, ID. Alta is isolated from other parts of Wyoming and it simply would be too dangerous to require the Postal Service to cross the Teton mountain range in the winter to deliver mail to Alta. In providing this service, however, the post office has not provided Alta residents their own zip code at the Driggs post office, but has required them to use the Driggs zip code even though Alta residents live in an entirely different State.

While this may not seem like a big deal on its face, there are a number of technical complications that arise in the lives of Alta residents because the Postal Service has not been willing to extend the courtesy of an Alta zip code.

By requiring Alta residents to use the Driggs zip code, the Postal Service has created a lot of confusion for Alta residents who attempt to conduct business with mail order companies. What sales tax do they pay? Idaho or Wyoming? Although the Postal Service maintains that zip codes are not used to identify specific locations, other companies use zip codes as an important location code that is necessary to adequately conduct their business. Sales tax is often programmed by zip code, so are car insurance rates, life insurance, homeowner's insurance, even our Federal and State income taxes use zip codes as an indicator of when and where to pay taxes.

The requirements of this bill will not be onerous for the Postal Service to implement. It will not require the service to build new facilities or even to change its method of operations. All it will do is require the Postal Service to identify those communities whose mail service crosses State boundaries and to assign them the necessary identification number that they need to provide the rest of the world a clear and concise description of where they live and who they are.

I urge my colleagues to support this most important legislation.

By Mr. CRAIG (for himself, Mr. CONRAD, Mr. ALLARD, Mr. BAUCUS, Mr. BINGAMAN, Mr. BURNS, Ms. COLLINS, Mr. CRAPO, Mr. DASCHLE, Mr. DAYTON, Mr. DORGAN, Mr. ENZI, Mr. GRAMM, Mr. GRASSLEY, Mr. HAGEL, Mr. HELMS, Mrs. HUTCHISON, Mr. JEFFORDS, Mr. JOHNSON, Mr. KENNEDY, Mr. KERRY, Mr. LEAHY, Mr. LUGAR, Ms. MIKULSKI, Mrs. MURRAY, Mr. NELSON of Nebraska, Mr. REED, Mr. ROBERTS, Mr. SARBANES, Mr.

SMITH of New Hampshire, Mr. SMITH of Oregon, Mr. THOMAS, and Mr. WELLSTONE):

S. 1111. A bill to amend the Consolidated Farm and Rural Development Act to authorize the National Rural Development Partnership, and for other purposes; to the Committee on Agriculture Nutrition and Forestry.

Mr. CRAIG. Mr. President, I rise today with Senator CONRAD to introduce the National Rural Development Partnership Act of 2001—a bill to codify the National Rural Development Partnership, NRDP or the Partnership, and provided a funding source for the program, I am pleased that Senators ALLARD, BAUCUS, BINGAMAN, BURNS, COLLINS, CRAPO, DASCHLE, DAYTON, DORGAN, ENZI, GRAMM, GRASSLEY, HAGEL, HELMS, HUTCHISON, JEFFORDS, JOHNSON, KENNEDY, KERRY, LEAHY, LUGAR, MIKULSKI, MURRAY, BEN NELSON, REED, ROBERTS, SARBANES, BOB SMITH, GORDON SMITH, THOMAS, and WELLSTONE are joining us as original cosponsors.

The Partnership was established under the Bush administration in 1990, by Executive Order 12720. Although the partnership has existed for ten years, it has never been formally authorized by Congress. The current basis for the existence of the partnership is found in the Consolidated Farm and Rural Development Act of 1972 and the Rural Development Policy Act of 1980. In addition, the conference committee report on the 1996 federal farm bill created specific responsibilities and expectations for the partnership and State rural development councils, SRDCs.

The partnership is a nonpartisan interagency working group whose mission is to ''contribute to the vitality of the Nation by strengthening the ability of all rural Americans to participate in determining their futures.'' The NRDP and SRDCs do something no other entities do: facilitate collaboration among federal agencies and between Federal agencies and State, local, and tribal governments and the private and non-profit sectors to increase coordination of programs and services to rural areas. When successful, these efforts result in more efficient use of limited rural development resources and actually add value to the efforts and dollars of others.

On March 8, 2000, the Subcommittee on Forestry, Conservation, and Rural Revitalization, which I chaired, held an oversight hearing on the operations and accomplishments of the NRDP and SRDCs. The subcommittee heard from a number of witnesses, including officials of the U.S. Departments of Agriculture, Transportation, and Health and Human Services, State agencies, and private sector representatives. The hearing established the need for some legislative foundation and consistent funding. The legislation we introduced last year and are reintroducing this Congress accomplishes just that.

This legislation formally recognizes the existence and operations of the partnership, the National Rural Development Coordinating Committee, NRDCC, and SRDCs. In addition, the legislation gives specific responsibilities to each component of the Partnership and authorizes it to receive congressional appropriations.

Specifically, the bill formally establishes the NRDP and indicates it is composed of the NRDCC and SRDCs. NRDP is established for empowering and building the capacity of rural communities, encouraging participation in flexible and innovative methods of addressing the challenges of rural areas, and encouraging all those involved in the partnership to be fully engaged and to share equally in decisionmaking. This legislation also identifies the role of the Federal Government in the partnership as being that of partner, coach, and facilitator. Federal agencies are called upon to designate senior-level officials to participate in the NRDCC and to encourage field staff to participate in SRDCs. Federal agencies are also authorized to enter into cooperative agreements with, and to provide grants and other assistance to, State rural development councils, regardless of the form of legal organization of a State rural development council.

The composition of the NRDCC is specified as being one representative from each Federal agency with rural responsibilities, and governmental and non-governmental for-profit and non-profit organizations that elect to participate in the NRDCC. The legislation outlines the duties of the council as being to provide support to SRDCs; facilitate coordination among Federal agencies and between the Federal, State, local and tribal governments and private organizations; enhance the effectiveness, responsiveness, and delivery of Federal Government programs; gather and provide to Federal agencies information about the impact of government programs on rural areas; review and comment on policies, regulations, and proposed legislation; provide technical assistance to SRDCs; and develop strategies for eliminating administrative and regulatory impediments. Federal agencies do have the ability to opt out of participation in the council, but only if they can show how they can more effectively serve rural areas without participating in the partnership and council.

This legislation provides that states may participate in the partnership by entering into a memorandum of understanding with USDA to establish an SRDC. SRDCs are required to operate in a nonpartisan and nondiscriminatory manner and to reflect the diversity of the States within which they are organized. The duties of the SRDCs are to facilitate collaboration among government agencies at all levels and the private and non-profit sectors; to enhance the effectiveness, responsiveness, and delivery of Federal and State Government programs; to gather information about rural areas in its State and share it with the NRDCC and other entities; to monitor and report on policies and programs that address, or fail to address, the needs of rural areas; to facilitate the formulation of needs assessments for rural areas and participate in the development of the criteria for the distribution of Federal funds to rural areas; to provide comments to the NRDCC and others on policies, regulations, and proposed legislation; assist the NRDCC in developing strategies for reducing or eliminating impediments; to hire an executive director and support staff; and to fundraise.

As I have stated before, this legislation authorizes the partnership to receive appropriations as well as authorizing and encouraging federal agencies to make grants and provide other forms of assistance to the partnership and authorizing the partnership to accept private contributions. The SRDCs are required to provide at least a 33-percent match for funds it receives as a result of its cooperative agreement with the Federal Government.

As you know, too many parts of rural America have not shared in the boom that has brought great prosperity to urban America. We need to do more to ensure that rural citizens will have opportunities similar to those enjoyed by urban areas. To do so, we do not necessarily need new government programs. Instead, we must do a better job of coordinating the many programs available from USDA and other Federal agencies that can benefit rural communities. With the passage of this legislation, the NRDP and SRDCs will be better situated to provide that much needed coordination.

Mr. CONRAD. Mr. President, I am pleased to join Senator LARRY CRAIG and 31 of our colleagues today in the introduction of the National Rural Development Partnership Act of 2001. This bill is similar to S. 3175 which Senator CRAIG and I sponsored last year during the 106th Congress. I am pleased that so many members from both sides of the aisle have recognized the importance of this measure by agreeing to join as original cosponsors.

The National Rural Development Partnership had its origin in Executive Order 12720, issued by President George H. Bush in 1990. Through the issuance of this order, the U.S. Department of Agriculture was assigned the responsibilities of creating the partnership and providing assistance to States that wish to form rural development partnerships. The intent of the legislation is the same. At least 40 States have now formed partnership councils to coordinate rural development activities of Federal, State, local, and tribal governments with private and non-profit organizations, to address community and economic development needs, and to coordinate community and job building activities in rural areas. The funding for these activities has been voluntary from various Federal agencies, including the Departments of Health and Human Services, Labor, Transportation, Veterans, and state

agencies. The U.S. Department of Agriculture has historically provided the largest single amount.

The needs of rural America are great. The demands on the Federal budget are also great. If we are to make optimum use of hard-to-find Federal, State, local, and private resources in rural areas, it is imperative that we find ways to coordinate development activities. This legislation does that. It formally authorizes National Rural Development Councils and also authorizes appropriations for this program.

The existing partnerships are doing an outstanding job in coordinating activities to enhance the quality of life and to build jobs in areas that have historically lacked high paying opportunities. While we recognize the continuing importance of the agriculture industry in many States, especially a State like North Dakota, we recognize that, unless we diversify our economy, we will continue to see out migration from the rural areas into the already crowded metropolitan areas of our country.

Again, I am pleased to join this bipartisan effort.

By Mr. DURBIN (for himself,Mr. CHAFEE, Mrs. FEINSTEIN, Mr. BINGAMAN, Mr. AKAKA, Mr. KERRY, Mr. SARBANES, Mr. JOHNSON, and Mr. INOUYE):

S. 1112. A bill to provide Federal Perkins Loan cancellation for public defenders; to the Committee on Health, Education, Labor, and Pensions.

Mr. DURBIN. Mr. President, today I rise with Senator CHAFEE to reintroduce legislation to include full-time public defense attorneys in the Federal Perkins Loan Cancellation Forgiveness Program for law enforcement officers. This bill would provide parity to public defense attorneys and uphold the goals set forth by the Supreme Court to equalize access to legal resources. Senators FEINSTEIN, BINGAMAN, AKAKA, KERRY, SARBANES, JOHNSON, and INOUYE are original cosponsors of this bipartisan bill. Representative Tom Campbell of California introduced a companion bill in the House in the 106th Congress.

Under section 465(a)(2)(F) of the Higher Education Act of 1965, a borrower with a loan made under the Federal Perkins Loan Program is eligible to have the loan canceled for serving full-time as a law enforcement officer or correction officer in a local, State, or Federal law enforcement or corrections agency. While the rules governing borrower eligibility for law enforcement cancellation have been interpreted by the Department of Education to include prosecuting attorneys, public defenders have been excluded from the loan forgiveness program. This policy must be amended.

Like prosecutors, public defense attorneys play an integral role in our adversarial process. This judicial process is the most effective means of getting at truth and rendering justice. The United States Supreme Court in a series of cases has recognized the importance of the right to counsel in implementing the Sixth Amendment's guarantee of a fair trial and the Fourteenth Amendment's due process clause requiring counsel to be appointed for all person accused of offenses in which there is a possibility of a jail term being imposed.

Absent adequate counsel for all parties, there is a danger that the outcome maybe determined not by who has the most convincing case but by who has the most resources. The Court rightly addressed this possible miscarriage of justice by requiring counsel to be appointed for the accused. Public defenders fill this Court mandated role by representing the interests of criminally accused indigent person. they give indigent defendants sufficient resources to present an adequate defense, so that the public goal of truth and justice will govern the outcome.

The Department of Education's interpretation of the statute to include public defenders from the loan forgiveness program undermines the goals set forth by the Supreme Court to equalize access to legal resources. It creates an obvious disparity of resources between public defenders and prosecutors by encouraging talented individuals to pursue public service as prosecutors but not as defenders. The criminal justice system works best when both sides are adequately represented. The public interest is served when indigent defendants have access to talented defenders. One of the ways to facilitate this goal is by granting loan cancellation benefits to defense attorneys.

Moreover, public defense attorneys meet all the eligibility requirements of the loan forgiveness program as set forth in current Federal regulations. They belong to publicly funded public defender agencies and they are sworn officers of the court whose principal responsibilities are unique to the criminal justice system and are essential in the performance of the agencies' primary mission. In addition, like prosecuting attorneys, public defenders are law enforcement officers dedicated to upholding, protecting, and enforcing our laws. Without public defense attorneys, the adversarial process of our criminal justice system could not operate.

I urge my colleague to join me, Senator CHAFEE, Senator FEINSTEIN, Senator BINGAMAN, Senator AKAKA, Senator KERRY, Senator SARBANES, Senator JOHNSON, and Senator INOUYE in supporting the goal of equalized access to legal resources, as set forth in the Constitution and elucidated by the Supreme Court, by providing parity to public defenders and allowing them to join prosecutors in receiving loan cancellation benefits.

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

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

S. 1112

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

SECTION 1. FEDERAL PERKINS LOAN CANCELLATION FOR PUBLIC DEFENDERS.

(a) FINDINGS.—Congress makes the following findings:

(1) The Department of Education has issued clarifications that prosecuting attorneys are among the class of law enforcement officers eligible for benefits under the Federal Perkins Loan cancellation program.

(2) Like prosecutors, public defenders also meet all the eligibility requirements of the Federal Perkins Loan cancellation program as set forth in Federal regulations.

(3) Public defenders are law enforcement officers who play an integral role in our Nation's adversarial legal process. Public defenders fill the Supreme Court mandated role requiring that counsel be appointed for the accused, by representing the interests of criminally accused indigent persons.

(4) In order to encourage highly qualified attorneys to serve as public defenders, public defenders should be included with prosecutors among the class of law enforcement officers eligible to receive benefits under the Federal Perkins Loan cancellation program.

(b) AMENDMENT.—Section 465(a)(2)(F) of the Higher Education Act of 1965 (20 U.S.C. 1087ee(a)(2)(F)) is amended by inserting '', or as a full-time public defender for service to a local or State government, or to the Federal Government (directly or by a contract with a private, nonprofit organization)'' after ''agencies''.

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to—

(1) loans made under part E of title IV of the Higher Education Act of 1965, whether made before, on, or after the date of enactment of this Act; and

(2) service as a public defender that is provided on or after the date of enactment of this Act.

(d) CONSTRUCTION.—Nothing in this section or the amendment made by this section shall be construed to authorize the refunding of any repayment of a loan.

By Mr. SPECTER:

S. 1113. A bill to amend section 1562 of title 38, United States Code, to increase the amount of Medal of Honor Roll special pension, to provide for an annual adjustment in the amount of that special pension, and for other purposes; to the Committee on Veterans' Affairs.

Mr. SPECTER. Mr. President, I have sought recognition at this time to comment on legislation that I have introduced today to increase the special pension that is available to Medal of Honor recipients, and to provide for automatic adjustments in that special pension to reflect annual increases in the cost of living. When the Congress enacted the Medal of Honor pension, it stated, in the 1916 Senate Report, Report No. 240, 64th Congress, accompanying enactment, that the special pension was then necessary to serve as a ''recognition of superior claims on the gratitude of the country,'' and to ''reward . . . in a modest way startling deeds of individual daring and audacious heroism in the face of mortal danger when war is on.'' The legislation that I have introduced today has the same two purposes: to recognize, and to reward, the ''startling deeds of

individual daring and audacious heroism'' to which every Medal of Honor recipient can lay claim.

No one can question that Medal of Honor recipients deserve the Nation's respect and gratitude. And no one could question a limited government pension is a proper sign of that respect and gratitude. I am concerned that some of the 149 surviving Medal of Honor recipients, there are only 149 such people among us, may struggle to make financial ends meet, notwithstanding the availability of the pension. The current $600 monthly amount is simply too small, in my estimation, to afford a minimum standard of living for our Nation's heroes given their expenses.

In 1997, the Congressional Medal of Honor Society suggested that the Medal of Honor pension level be set at $1,000 per month and that the level of the pension be adjusted thereafter on an annual basis to reflect increases in the annual cost of living. At that time, the Senate Committee on Veterans' Affairs, which I then had the privilege of chairing, succeeded in securing an increase in the pension from $400 to $600 per month, but we were not successful in persuading the House to approve an ''indexation'' feature. I believe a compelling argument could be made then, and still can be made now, to grant the entire increase suggested by the Congressional Medal of Honor Society and to approve the indexing of the benefit. I am pleased to offer legislation to that effect today.

Many Medal of Honor recipients, out of a sense of duty and patriotism, make frequent trips to provide accounts of their act of valor and, more importantly, to speak of the lessons learned in battle and the vigilance that freedom requires to this day. Countless young Americans have benefitted by the example of these most distinguished role models. Often, the expenses associated with these excursions are borne by the medal of Honor recipients themselves, men who, we must remember, emerged from, and, in most cases, returned to, the ordinary citizenry from whom America has always drawn her warriors. Testimony offered by AMVETS at a Veterans' Affairs Committee hearing on July 25, 1997, confirmed that the majority of Medal of Honor recipients live only on their social security benefits, supplemented by the Medal of Honor pension, giving them an average monthly income of only $1,600. It is unconscionable to think that we, as a country, can allow them to live so close to the poverty line.

I ask my colleagues to join with me, once again, to show our gratitude to the recipients of our Nation's highest honor. Let us show them—in this minor way—how grateful America truly is for their wonderful example.

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

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

S. 1113

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

SECTION 1. INCREASE AND ANNUAL ADJUSTMENT OF MEDAL OF HONOR ROLL SPECIAL PENSION.

(a) INCREASE IN AMOUNT.—Subsection (a) of section 1562 of title 38, United States Code, is amended by striking ''$600'' and inserting ''$1,000, as adjusted from time to time under subsection (e),''.

(b) ANNUAL ADJUSTMENT.—That section is further amended by adding at the end the following:

''(e) Effective as of December 1 each year, the Secretary shall increase the amount of monthly special pension payable under subsection (a) as of November 30 of such year by the same percentage that benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.) are increased effective December 1 of such year as a result of a determination under section 215(i) of that Act (42 U.S.C. 415(i)).''.

(c) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act, and shall apply with respect to months that begin on or after that date.

(2) The Secretary of Veterans Affairs shall not make any adjustment under subsection (e) of section 1562 of title 38, United States Code, as added by subsection (b) of this section, in 2001.

By Mr. SPECTER:

S. 1114. A bill to amend title 38, United States Code, to increase the amount of educational benefits for veterans under the Montgomery GI Bill; to the Committee on Veterans' Affairs.

Mr. SPECTER. Mr. President, I have sought recognition at this time to comment briefly on legislation that I am introducing today to increase educational benefits paid to veterans under the Montgomery GI bill, MGIB. This bill is the same as a bill, H.R. 1291, that was passed by the House, under the leadership of the chairman of the House Committee on Veterans' Affairs, Representative CHRIS SMITH, on June 19, 2001, by a vote of 416–0. I introduce the same legislation here in the Senate, and I urge my colleagues to join with me to complete the task of increasing veterans' Montgomery GI bill benefits.

This legislation, once it is fully phased in over a three year period, would increase the basic monthly benefit paid to veterans with at least three years of service who have returned to school from $650 to $1,100. With this 85 percent increase in MGIB benefits, the largest percentage increase in the history of the Montgomery GI bill, a veteran with three years of service would be able to afford the average cost of tuition, fees, books, and room and board at a four-year public college or university, and still have money left over for transportation expenses or other personal expenses. The legislation would provide greater educational freedom for veterans who are constrained by the current benefit amount; it would open up the possibility of attendance at more expensive universities. And it would promote the national security interests of the United States by providing a substantial inducement for young men and women to serve in the military.

When I became chairman of the Senate Committee on Veterans' Affairs at the start of the 105th Congress in 1997, I committed to increasing MGIB benefits which, due to budget constraints, had been woefully inadequate. I am pleased to report that that picture has changed; the basic MGIB benefit has increased by 52 percent from $427 to 650 per month, and in addition, service members now have the opportunity to ''buy-up'' an additional $150 in monthly benefits, bringing the total level of available benefits to $800 per month, an increase of 87 percent since 1997. Despite this significant progress, however, I remain concerned that the benefit usage rate among young veterans is too low, and that it may not yet be a sufficient inducement to assist the Department of Defense in recruiting high quality young men and women to serve in the military.

Of the young veterans eligible for MGIB benefits, only 57 percent choose to avail themselves of this extraordinary opportunity. According to a recent report by the Department of Veterans Affairs, VA, a significant reason for this relatively low usage rate is the inadequacy of the benefit amount. MGIB benefits have simply not kept pace with rising education costs. As a consequence, veterans who use the benefit must compromise on the educational programs they select; a low percentage of MGIB users, only 12 percent, attend private institutions, and a relatively high percentage of MGIB users, 27 percent, enroll in two-year college programs. Now I do not undervalue the role, contributions, or quality of our two-year colleges. The fact is, however, that many veterans who would choose to attend four-year institutions, even public institutions, cannot afford to do so with the current level of benefits. My legislation would move us closer to the day when the only limitation on veterans' educational choice would be their own interests and aspirations.

One of the primary purposes of the MGIB is to assist the Department of Defense, DOD with service member recruitment. When DOD asked new recruits in 1997 to list the reasons they joined the military, money for college ranked second only to ''a chance to better myself in life'' among the answers given. Even so, tight labor market and the availability of other Federal education aid have resulted in DOD difficulty in meeting recruiting goals. The Assistant Secretary of Defense for Force Management Policy reports that a benefit level ''of approximately $1,000 per month . . . would increase high-quality accessions without having a negative impact on reenlistments. . . .'' Thus, my proposed legislation, which would, in phases, increase

the monthly benefit to $1,100, is consistent with DOD's position that increased MGIB benefits are necessary for it to attract high-quality recruits.

Attracting high-quality young men and women into the military is not only in the interest of the Department of Defense, it is in the national interest of all of our citizens. The United States Commission on National Security/21st Century, chaired by our former colleagues, Senators Gary Hart and Warren Rudman, recently called on Congress to enhance national security by ''significantly enhanc[ing] the Montgomery GI Bill'' by providing a benefit that would pay for the average education costs of four-year U.S. colleges. The Commission emphasized that the ''GI bill is both a strong recruitment tool and, more importantly, a valuable institutional reward for service to the nation in uniform.'' I thank the Commission for recognizing the important role the GI bill has played, and will continue to play, in ensuring the security of our country.

I commend the chairman of the House Committee on Veterans' Affairs, Representative CHRIS SMITH, who has taken the lead on this issue in the House during this first year of his chairmanship. Under Mr. SMITH's leadership, the House did its part on June 19, 2001, by passing H.R. 1291 by a resounding vote of 416–0. I urge my Senate colleagues to join with me to complete the task here in the Senate.

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

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

S. 1114

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

SECTION 1. INCREASE IN RATES OF BASIC EDUCATIONAL ASSISTANCE UNDER MONTGOMERY GI BILL.

(a) IN GENERAL.—(1) Section 3015(a)(1) of title 38, United States Code, is amended to read as follows:

''(1) for an approved program of education pursued on a full-time basis, at the monthly rate of—

''(A) for months occurring during fiscal year 2002, $800,

''(B) for months occurring during fiscal year 2003, $950,

''(C) for months occurring during fiscal year 2004, $1,100, and

''(D) for months occurring during a subsequent fiscal year, the amount for months occurring during the previous fiscal year increased under subsection (h); or''.

(2) Section 3015(b)(1) of such title is amended to read as follows:

''(1) for an approved program of education pursued on a full-time basis, at the monthly rate of—

''(A) for months occurring during fiscal year 2002, $650,

''(B) for months occurring during fiscal year 2003, $772,

''(C) for months occurring during fiscal year 2004, $894, and

''(D) for months occurring during a subsequent fiscal year, the amount for months occurring during the previous fiscal year increased under subsection (h); or''.

(b) CPI ADJUSTMENT.—No adjustment in rates of educational assistance shall be made under section 3015(h) of title 38, United States Code, for fiscal years 2002, 2003, and 2004.

By Mr. KENNEDY (for himself, Mr. STEVENS, Mr. INOUYE, Mrs. HUTCHISON, and Mr. CORZINE):

S. 1115. A bill to amend the Public Health Service Act with respect to making progress toward the goal of eliminating tuberculosis, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. KENNEDY. Mr. President, it is a privilege to join my colleagues Senator STEVENS, Senator INOUYE, Senator HUTCHISON, and Senator CORZINE in introducing the Comprehensive Tuberculosis Elimination Act. This bipartisan legislation will provide enhanced authority and greater resources to State, local and Federal health officials to do all they can to combat this deadly infectious disease in our country.

Tuberculosis is the world's leading infectious killer. Its growth has been propelled by the global HIV epidemic, and multi-drug resistant strains have become increasingly prevalent around the world. The World Health Organization estimates that more than one-third of the world's population is infected with tuberculosis. Every year, there are 8 million new cases of active tuberculosis and 2 million deaths from tuberculosis. This disease causes more deaths among women worldwide than all other causes of maternal death combined.

These harrowing statistics illustrate the truth behind the saying that diseases know no borders. Senators INOUYE, STEVENS, and HUTCHISON and I have already introduced the Stop TB Now Act, which focuses on international tuberculosis control. The bill we are introducing today will deal with tuberculosis in our own country. Only through enactment of both of these measures can we be sure of defeating this readily treatable and preventable disease.

Today's bill is intended to fulfill the recommendations of the landmark report issued by the Institute of Medicine last year, entitled ''Ending Neglect: The Elimination of Tuberculosis in the United States.'' Our measure will create a national plan for the eradication of tuberculosis. It will enhance tuberculosis-related research, education and training through the Centers for Disease Control and Prevention. It will also expand support for vaccine research and for international tuberculosis research through the National Institutes of Health.

In the United States, tuberculosis has been going through what the Institute of Medicine calls ''recurrent cycles of neglect'' by public health authorities, ''followed by resurgence'' of the disease. In the late nineteenth century, tuberculosis was one of the leading causes of death in America. As cities swelled with waves of European immigration, millions of individuals and families were forced into overcrowded tenements and unhealthy workplaces. Many fell victim to outbreaks of deadly infectious diseases. In 1886, the leading cause of death among infants was tuberculosis, followed by infant diarrhea.

Although medical science and public health were in their infancy in those days, the need to combat tuberculosis was clear even then. In 1882, Robert Kock first isolated the organism that causes this disease, providing physicians and scientists with a microbial foundation for science-based public health action. In the early twentieth century, health advocates and physicians formed an association dedicated to fighting tuberculosis, which today is the American Lung Association. Their work helped to bring about more sanitary living conditions and workplaces for the poor, stronger public health laws, and the use of sanatoriums to treat people with tuberculosis.

In this century, the possibility of actually eradicating tuberculosis arose following the development of effective antibiotics in the 1950s. But the country failed to capitalize on scientific opportunities or undertake the kind of broad public health campaign that we undertook so successfully against polio. As a result, scientific interest and public health funding for tuberculosis control waned in the following decades. After years of decline, specific Federal funding for tuberculosis control was actually eliminated in 1972.

Our country paid the price for this complacency in the 1980s. A resurgence of cases and an alarming growth in the prevalence of drug-resistant tuberculosis strains challenged public health and shook the confidence of experts. Through great effort and difficulty, we renewed our national commitment to fighting tuberculosis. But the effort took longer than necessary, and the Nation suffered needless deaths and illness as we worked to bring the number of new tuberculosis cases to its current, all-time low.

Today, we have a historic opportunity to eradicate tuberculosis in the United States. We have a generation of public health officials who have lived through and successfully combated the recent resurgence of the disease. And we have expert recommendations from both the Federal Advisory Council for the Elimination of Tuberculosis and the Institute of Medicine to guide our efforts.

This legislation is supported by leading public health organizations, including the American Lung Association, the American Thoracic Society, the National Coalition to Eliminate Tuberculosis and RESULTS International. Its enactment can be an essential in achieving to fulfilling this important and long overdue public health goal, and I urge the Senate to approve it.

By Mr. INOUYE (for himself, Mr. STEVENS, Mr. KENNEDY, Mrs. HUTCHISON, and Mr. CORZINE):

S. 1116. A bill amend the Foreign Assistance Act of 1961 to provide increased foreign assistance for tuberculosis prevention, treatment, and control; to the Committee on Foreign Relations.

Mr. INOUYE. Mr. President, I rise today to join my colleagues, Senator STEVENS, Senator KENNEDY, Senator HUTCHISON, and Senator CORZINE, to introduce the Stop Tuberculosis Now Act of 2001, a bill that responds to the dire need of the United States and the rest of the world to stop the terrible infection that is threatening citizens in every country of the world.

Tuberculosis is the biggest killer of young women and people with AIDS in the world today, and two million people will die of tuberculosis this year alone. Although tuberculosis is preventable and treatable, last year there were more than 17,000 new cases of tuberculosis in the U.S. Among these cases were new strains of tuberculosis that are resistant to many traditional antibiotics that were very successful in the past. Due to its infectious and resistant nature, tuberculosis cannot be stopped at national borders, and virtually every international airport in the U.S. therefore is a port of entry for carriers of tuberculosis. Thus, it will be impossible to control tuberculosis in the U.S. until we control it worldwide.

Because of this dire situation, we are introducing the ''Stop Tuberculosis Now Act,'' which calls for a U.S. investment in international tuberculosis control of $200 million in 2002, with a focus on expanding the proven, low cost direct observation therapy system, DOTS, tuberculosis treatment for countries with high rates of tuberculosis infection. DOTS tuberculosis treatment involves a health worker observing and ensuring tuberculosis patients take their prescribed medication that is needed to stop a tuberculosis infection successfully. The current projection for implementing an international tuberculosis treatment program is $1 billion. The U.S. share of this program would be $200 million. This is a small price to pay in order to stop this terrible infectious disease which brings such misery and death, to the U.S. and the rest of the world.

This bill would amend the Foreign Assistance Act of 1961 and declare that a major objective of the U.S. foreign assistance program is to control tuberculosis. Congress would designate the World Health Organization and other health organizations to develop and implement a comprehensive tuberculosis control program, including expanding the use of the strategy of DOTS tuberculosis treatment method and strategies to address multi-drug resistant tuberculosis. The particular focus of this program would be in countries with the highest rates of tuberculosis infection. The program would set as goals the cure of at least 95 percent of tuberculosis cases detected and the reduction of tuberculosis related deaths by 50 percent, by December 31, 2010.

I ask unanimous consent that the test the bill be printed in the RECORD.

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

S. 1116

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Stop Tuberculosis (TB) Now Act''.

SEC. 2. FINDINGS.

Congress finds the following:

(1)(A) Tuberculosis is one of the greatest infectious causes of death of adults worldwide, killing 2,000,000 people per year—one person every 15 seconds.

(B) Globally, tuberculosis is the leading cause of death of young women and the leading cause of death of people with HIV/AIDS.

(2) An estimated 8,000,000 individuals develop active tuberculosis each year.

(3) Tuberculosis is spreading as a result of inadequate treatment and it is a disease that knows no national borders.

(4) With over 40 percent of tuberculosis cases in the United States attributable to foreign-born individuals and with the increase in international travel, commerce, and migration, elimination of tuberculosis in the United States depends on efforts to control the disease in developing countries.

(5) The threat that tuberculosis poses for Americans derives from the global spread of tuberculosis and the emergence and spread of strains of multi-drug resistant tuberculosis (MDR–TB).

(6) Up to 50,000,000 individuals may be infected with multi-drug resistant tuberculosis.

(7) In the United States, tuberculosis treatment, normally about $2,000 per patient, skyrockets to as much as $250,000 per patient to treat multi-drug resistant tuberculosis, and treatment may not even be successful.

(8) Multi-drug resistant tuberculosis kills more than one-half of those individuals infected in the United States and other industrialized nations and without access to treatment it is a virtual death sentence in the developing world.

(9) There is a highly effective and inexpensive treatment for tuberculosis. Recommended by the World Health Organization as the best curative method for tuberculosis, this strategy, known as directly observed treatment, short course (DOTS), includes low-cost effective diagnosis, treatment, monitoring, and recordkeeping, as well as a reliable drug supply. A centerpiece of DOTS is observing patients to ensure that they take their medication and complete treatment.

SEC. 3. ASSISTANCE FOR TUBERCULOSIS PREVENTION, TREATMENT, AND CONTROL.

(a) ADDITIONAL PREVENTION, TREATMENT, AND CONTROL.—Section 104(c)(7)(A) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)(7)(A)) is amended—

(1) in clause (i), by adding at the end before the semicolon the following: '', by expanding the use of the strategy known as directly observed treatment, short course (DOTS) and strategies to address multi-drug resistant tuberculosis (MDR–TB) where appropriate at the local level, particularly in countries with the highest rate of tuberculosis''; and

(2) in clause (ii)—

(A) by inserting after ''the cure of at least 95 percent of the cases detected'' the following: ''by focusing efforts on the use of the directly observed treatment, short course (DOTS) strategy or other internationally accepted primary tuberculosis control strategies''; and

(B) by striking ''and the cure'' and inserting ''the cure''.

(b) FUNDING REQUIREMENT.—Section 104(c)(7) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)(7)) is amended—

(1) by redesignating subparagraph (B) as subparagraph (C); and

(2) by inserting after subparagraph (A) the following:

''(B) In carrying out this paragraph, not less than 75 percent of the amount appropriated pursuant to the authorization of appropriations under subparagraph (D) shall be used for the diagnosis and treatment of tuberculosis for at-risk and affected populations utilizing directly observed treatment, short course (DOTS) strategy or other internationally accepted primary tuberculosis control strategies developed in consultation with the World Health Organization (WHO), including funding for the Global Tuberculosis Drug Facility of WHO's Stop TB Partnership.''.

(c) ANNUAL REPORT.—Section 104(c)(7) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)(7)) is amended—

(1) by redesignating subparagraph (C) (as redesignated by this Act) as subparagraph (D); and

(2) by inserting after subparagraph (B) the following:

''(C) In conjunction with the transmission of the annual request for enactment of authorizations and appropriations for foreign assistance programs for each fiscal year, the President shall transmit to Congress a report that contains a summary of all programs, projects, and activities carried out under this paragraph for the preceding fiscal year, including a description of the extent to which such programs, projects, and activities have made progress to achieve the goals described in subparagraph (A)(ii).''.

(d) AUTHORIZATION OF APPROPRIATIONS.—Subparagraph (D) of section 104(c)(7) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)(7)), as redesignated by this Act, is amended by striking ''$60,000,000 for each of the fiscal years 2001 and 2002'' and inserting ''$60,000,000 for fiscal year 2001 and $200,000,000 for fiscal year 2002''.

By Ms. LANDRIEU:

S. 1117. A bill to establish the policy of the United States for reducing the number of nuclear warheads in the United States and Russian arsenals, for reducing the number of nuclear weapons of those two nations that are on high alert, and for expanding and accelerating programs to prevent diversion and proliferation of Russian nuclear weapons, fissile materials, and nuclear expertise; to the Committee on Foreign Relations.

Ms. LANDRIEU. Mr. President, when Winston Churchill addressed the student body at Westminister College in 1946, he declared to the United States that ''with primacy of power is also joined an awe-inspiring accountability to the future . . . you must not only feel the sense of duty done, but also the anxiety lest you fall below that level of achievement.'' Over the course of the cold war, we did not fail in our duty, nor should we in the new century.

In the same speech he laid before the whole world the rhetoric that would define the cold war. In describing the Sphere of Soviet dominance in Eastern Europe, Mr. Churchill described an Iron Curtain which the ancient capitals of Warsaw, Prague, and Budapest were

held. With the fall of communism in the early part of the last decade, the United States has had to re-shape its review of Eastern Europe. No longer do we view the countries of Poland, the Czech Republic, or Hungary as isolated adversaries, but as partners in the very alliance that carried us through the cold war. In the same way that we have looked to reforming our relationship with the countries of the old Warsaw Pact we must find new ways to view Russia. It is difficult to fathom that in the 21st century we view Russia as a declared ally on the world stage while maintaining a nuclear posture at home which treats her as an enemy. It is time that we transform our nuclear doctrine from one that reflects the thinking of the cold war to one that fits in the context of the 21st century and addresses what is perhaps the greatest threat to our security.

When President Bush met with Mr. Putin a few weeks ago, he expressed that the United States and Russia can find a ''common position'' on a ''new strategic framework''. President Bush declared that the two countries are friends and that it is time for the U.S. and Russia to act that way. In context of this historic meeting, it is time that we ''work together to address the world as it is, not as it used to be, it is important that we not only talk differently, we must also act differently.''

I rise today to introduce legislation that would direct the President to seek in his own words: '' . . . a broad strategy of active non-proliferation . . . to deny weapons of terror from those seeking to acquire them . . . and to work with allies and friends who wish to join us to defend against the harm they, WMD can inflict''

The Nuclear threat Reduction Act of 2001, NTRA, would make it the policy of the United States to reduce the number of nuclear warheads and delivery systems held by the U.S. and Russia through bilateral agreements. These reductions should fall to the lowest possible number consistent with national security. It would enable the President to reduce our nuclear stockpile while negotiating such reductions with the Russians that are transparent, predictable and verifiable. To do such a thing would be a mark of principled leadership. It would acknowledge that it is no longer necessary to maintain large stockpiles of nuclear arms by the United States and Russia and that to continue to do so would be unacceptable.

On May 23,2000 President Bush stated ''The premises of cold war targeting should no longer dictate the size of our arsenal.'' I could not agree with the President more. The current level of nuclear weapons maintained by the United States comes at a great cost to ourselves financially and poses a significant threat to our security. The level of nuclear protection that we maintain forces the Russians to keep a similarly robust force which they cannot afford. The crumbling infrastructure of the Russian Military continually raises the risk of accidental launch or greater proliferation. Indeed, the legislation being considered today would ensure that once parts of the Russian arsenal are dismantled, they will be kept safe, they will be accounted for, and they will eventually be destroyed.

The savings from reducing our nuclear arsenal are substantial. A recent CBO report estimated that $1.67 billion could be saved by retiring 50 MX Peacekeeper missiles by 2003. We could use this money to address shortfalls in our conventional capabilities. Additionally, we can devote more funds to meeting the asymmetrical threats that will face us in the future. To invest in deterrents to cyberwarfare and to augment spending on homeland defense would be the best way to transform our thinking and spending from the Cold War to the twenty-first century.

In addition to this, the Nuclear Threat Reduction Act would encourage the U.S. and Russia to take their systems off of high-alert status. In the context of the cold war, such a strategy was necessary to ensure our security, but it no longer applies to present conditions.

The Nuclear Threat Reduction Act would also embolden existing Department of State, Energy, and Defense programs that seek to contain existing nuclear weapons material and expertise in Russia. The economic situation in Russia makes it more and more likely that a rouge state will acquire the means to manufacture nuclear weapons. This could come through the distribution of nuclear material or the exodus of Russian scientists. Our former colleague Sen Nunn put it best when he said ''We dare not risk a world where a Russian scientist can take care of his children by endangering ours.'' The cost to the United States is minuscule compared to the threat of nuclear proliferation. Work on this serious issue has already been addressed by the Nunn-Lugar bill, but it is time that we further our efforts.

In January of this year, a task force headed by Howard Baker and Lloyd Cutler issued a report calling the proliferation of the Russian nuclear stockpile ''The most serious threat to national security we face today''. The Baker-Cutler Task Force strongly endorsed existing non-proliferation programs and suggested that their goals could be achieved in 8–10 years if they are fully funded. Increased support for these programs will certainly bring them more in line with the immediacy and scope of the dangers that they address.

The NTRA requires the President to formulate and submit to Congress a strategic plan to secure and neutralize Russia's nuclear weapons and weapons-usable materials over the next eight years. The plan would have to include the administrative and organizational reforms necessary to provide effective coordination of these programs and to reflect the priority that the President attaches to them. The President himself has advocated such a strategy and I call on him to implement it.

Finally, the NTRA requires the President to submit a report to Congress on the feasibility of establishing a ''debt for security'' program with Russia. Under this concept, a portion of Russia's debts to various major powers would be forgiven in exchange for a Russian commitment to devoting those funds to non-proliferation activities. If successful, such a program could significantly help Russia's secure, account for, and neutralize its weapons materials.

In closing, The Nuclear Reduction Act of 2001 would help us fulfill the duty that comes with being the world's last remaining super power. By preventing the spread of nuclear materials and technology, reducing the nuclear stockpiles of the United States and Russia, and by taking our missiles off of high-alert status, we can fulfill that duty. I ask the other Members of the Senate to join me in support of this measure.

AMENDMENTS SUBMITTED AND PROPOSED

SA 819. Mr. THOMPSON proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage.

SA 820. Mr. MCCAIN (for himself, Mr. BAYH, Mr. CARPER, and Mr. EDWARDS) proposed an amendment to the bill S. 1052, supra.

SA 821. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 822. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 823. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 824. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 825. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 826. Ms. COLLINS (for herself, Mr. NELSON, of Nebraska, Mr. ENZI, Mr. VOINOVICH, Mr. HUTCHINSON, and Mr. ROBERTS) proposed an amendment to the bill S. 1052, supra.

SA 827. Mr. DOMENICI submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 828. Mrs. HUTCHISON submitted an amendment intended to be proposed by her to the bill S. 1052, supra; which was ordered to lie on the table.

SA 829. Mr. DEWINE submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 830. Mr. BREAUX (for himself, Mr. JEFFORDS, Mr. KENNEDY, Mr. MCCAIN, and Mr. EDWARDS) proposed an amendment to the bill S. 1052, supra.

TEXT OF AMENDMENTS

SA 819. Mr. THOMPSON proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 150, strike line 17 and all that follows through page 153, line 8, and insert the following:

''(9) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—A cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102 and 103 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

''(B) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) or paragraph (10)(B), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met.

''(C) RECEIPT OF BENEFITS DURING APPEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

''(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

''(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

The court in any action commenced under this subsection shall take into account any receipt of benefits during such administrative processes or such action in determining the amount of the damages awarded.

''(D) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 103 of the Bipartisan Patient Protection Act of 2001 shall be admissible in any Federal court proceeding and shall be presented to the trier of fact.

On page 165, strike line 15 and all that follows through page 168, line 3, and insert the following:

''(4) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—A cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102, 103, and 104 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

''(B) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) unless the requirements of subparagraph (A) are met.

''(C) RECEIPT OF BENEFITS DURING APPEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

''(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

''(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

''(D) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 104 of the Bipartisan Patient Protection Act of 2001 shall be admissible in any Federal or State court proceeding and shall be presented to the trier of fact.

SA 820. Mr. MCCAIN (for himself, Mr. BAYH, Mr. CARPER, and Mr. EDWARDS) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 36 line 5, strike ''except'' and all that follows through ''(2)'' on line 8.

On page 62, between lines 10 and 11, insert the following:

(V) Compliance with the requirement of subsection (d)(1) that only medically reviewable decisions shall be the subject of independent medical review and with the requirement of subsection (d)(3) that independent medical reviewers may not require coverage for specifically excluded benefits.

On page 62, line 20, after the period insert the following: ''The Secretary, or organization, shall revoke a certification or deny a recertification with respect to an entity if there is a showing that the entity has a pattern or practice of ordering coverage for benefits that are specifically excluded under the plan or coverage.''.

On page 62, between lines 20 and 21, insert the following:

(vii) PETITION FOR DENIAL OR WITHDRAWAL.—An individual may petition the Secretary, or an organization providing the certification involves, for a denial of recertification or a withdrawal of a certification with respect to an entity under this subparagraph if there is a pattern or practice of such entity failing to meet a requirement of this section.

On page 66, between lines 10 and 11, insert the following:

(5) REPORT.—Not later than 12 months after the general effective date referred to in section 401, the General Accounting Office shall prepare and submit to the appropriate committees of Congress a report concerning—

(A) the information that is provided under paragraph (3)(D);

(B) the number of denials that have been upheld by independent medical reviewers and the number of denials that have been reversed by such reviewers; and

(C) the extent to which independent medical reviewers are requiring coverage for benefits that are specifically excluded under the plan or coverage.

SA 821. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

On page 148, between lines 23 and 24, insert the following:

''(D) EXCLUSION OF SMALL EMPLOYERS.—

''(i) IN GENERAL.—Notwithstanding any other provision of this paragraph, in addition to excluding certain physicians, other health care professionals, and certain hospitals from liability under paragraph (1), paragraph (1)(A) does not create any liability on the part of a small employer (or on the part of an employee of such an employer acting within the scope of employment).

''(ii) DEFINITION.—In clause (i), the term 'small employer' means an employer——

''(I) that, during the calendar year preceding the calendar year for which a determination under this subparagraph is being made, employed an average of at least 2 but not more than 15 employees on business days; and

''(II) maintaining the plan involved that is acting, serving, or functioning as a fiduciary, trustee or plan administrator, including——

''(aa) a small employer described in section 3(16)(B)(i) with respect to a plan maintained by a single employer; and

''(bb) one or more small employers or employee organizations described in section 3(16)(B)(iii) in the case of a multi-employer plan.

''(iii) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subparagraph:

''(I) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

''(II) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(III) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

On page 165, between lines 14 and 15, insert the following:

''(D) EXCLUSION OF SMALL EMPLOYERS.—

''(i) IN GENERAL.—Notwithstanding any other provision of this paragraph, in addition to excluding certain physicians, other health care professionals, and certain hospitals from liability under paragraph (1), paragraph (1)(A) does not create any liability on the part of a small employer (or on the part of an employee of such an employer acting within the scope of employment).

''(ii) DEFINITION.—In clause (i), the term ''small employer' means an employer—

''(I) that, during the calendar year preceding the calendar year for which a determination under this subparagraph is being made, employed an average of at least 2 but not more than 15 employees on business days; and

''(II) maintaining the plan involved that is acting, serving, or functioning as a fiduciary, trustee or plan administrator, including—

''(aa) a small employer described in section 3(16)(B)(i) with respect to a plan maintained by a single employer; and

''(bb) one or more small employers or employee organizations described in section 3(16)(B)(iii) in the case of a multi-employer plan.

''(iii) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subparagraph:

''(I) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

''(II) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(III) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.''

SA 822. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

At the end of the bill, add the following:

SEC. . TEN-YEAR EXTENSION OF MEDICARE COST CONTRACTS.

Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)), as redesignated by section 634(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–568), as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by striking ''2004'' and inserting ''2014''.

SA 823. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

At the end of the bill, add the following:

SEC. . NINE-YEAR EXTENSION OF MEDICARE COST CONTRACTS

Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)), as redesignated by section 634(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–568), as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by striking ''2004'' and inserting ''2013''.

SA 824. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

At the end of the bill, add the following:

SEC. . NINE-YEAR EXTENSION OF MEDICARE COST CONTRACTS

Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)), as redesignated by section 634(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–568), as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by striking ''2004'' and inserting ''2012''.

SA 825. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

At the end of the bill, add the following:

SEC. . SEVEN-YEAR EXTENSION OF MEDICARE COST CONTRACTS.

Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)), as redesignated by section 634(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–568), as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by striking ''2004'' and inserting ''2011''.

SA 826. Ms. COLLINS (for herself, Mr. NELSON of Nebraska, Mr. ENZI, Mr. VOINOVICH, Mr. HUTCHINSON, and Mr. ROBERTS) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

Beginning on page 122, strike line 19 and all that follows through line 16 on page 129, and insert the following:

SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) GENERAL RULE.—

(1) NO PREEMPTION.—

(A) IN GENERAL.—Subject to paragraph (2), nothing in subtitles B, C or D shall be construed to preempt or supersede any provision of State law that is enacted prior to the effective date that establishes, implements, or continues in effect any standard or requirement relating to health insurance issuers (in connection with group health insurance coverage or otherwise) and non-Federal governmental plans with respect to a patient protection requirement.

(B) NOTIFICATION.—Subparagraph (A) shall apply to a State that has, by not later than the effective date, submitted a notice to the Secretary of the existence of a State law described in such subparagraph.

(2) APPEALS.—Subtitle A shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual health insurance coverage and to non-Federal governmental plans except to the extent that such standard or requirement prevents the application of a requirement of such subtitle.

(3) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to group health plans.

(b) STATE CERTIFICATION.—

(1) IN GENERAL.—Effective beginning on the effective date, a State shall submit to the Secretary a certification that—

(A) the State has enacted one or more State laws or regulations that are consistent with the purposes of the patient protection requirements of this title, with respect to health insurance coverage that is issued in the State, including group coverage, individual coverage, and coverage under non-Federal governmental plans;

(B) the State has not enacted a law described in subparagraph (A) because of the adverse impact that such a law would have on premiums paid for health care coverage in the State and the adverse impact that such increases in premiums would have on the number of individuals in the State with health insurance coverage; or

(C) the State has not enacted a law described in subparagraph (A) because the existence of a managed care market in the State is negligible.

(2) RECEIPT AND REVIEW BY SECRETARY.—

(A) IN GENERAL.—The Secretary shall—

(i) promptly review a certification submitted under paragraph (1); and

(ii) approve the certification unless the Secretary finds that there is no rational basis for such approval.

(B) APPROVAL DEADLINES.—

(i) INITIAL REVIEW.—A certification under paragraph (1) is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification—

(I) that the certification is disapproved because there is no rational basis for the certification;

(II) with respect to a certification described in paragraph (1)(A), that the Secretary determined that the State law does not provide for patient protections that are consistent with the purposes of the patient protection requirement to which the law relates; or

(III) that specified additional information is needed.

A notice under this clause shall include an explanation of the basis for the determination of the Secretary and shall identify specific deficiencies in the State certification.

(ii) ADDITIONAL INFORMATION.—With respect to a State that has been notified by the Secretary under clause (i)(III) that specified additional information is needed, the Secretary shall make a determination with respect to such certification within 60 days after the date on which such specified additional information is received by the Secretary.

(C) APPROVAL FOR FAILURE TO MEET DEADLINE.—If the Secretary fails to meet the deadline applicable under subparagraph (B) with respect to a State certification, the certification shall be deemed to be approved.

(D) STATE CHALLENGE.—A State that has a certification disapproved by the Secretary under subparagraph (A) may challenge such disapproval in the appropriate United States district court.

(3) CERTIFICATION OF ALL OR SELECTIVE PROTECTIONS.—A certification under this subsection may be submitted with respect to all patient protection requirements or selective requirements.

(4) TERMINATION OF CERTIFICATION.—

(A) IN GENERAL.—The Secretary, not more frequently than once every 5 years, may request that a State with respect to which a certification has been approved under this subsection, submit an assurance to the Secretary that with respect to a certification, the assurances contained in the certification are still applicable with respect to the State.

(B) TERMINATION.—If a State fails to submit an assurance to the Secretary under subparagraph (A) within the 60-day period beginning on the date on which the Secretary makes a request for such an assurance, the certification applicable to the State under this section shall terminate.

(5) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a State from submitting more than one certification under paragraph (1).

(c) EFFECT OF CERTIFICATION.—

(1) IN GENERAL.—A State that has submitted—

(A) a notice under subsection (a)(1)(B); or

(B) a certification that has been approved by the Secretary under subsection (b);

with respect to all of the patient protection requirements shall be eligible to receive a grant under subsection (d).

(2) EFFECT OF TERMINATION.—A State that has a certification terminated under subsection (b)(4) shall not be eligible to receive grant funds under subsection (d) until such time as the State has a new certification in effect.

(3) RULE OF CONSTRUCTION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), nothing in this Act shall be construed to apply any patient protection requirement in a State unless the State enacts a State law with respect to such application.

(B) SELF-INSURED PLANS.—Notwithstanding this section, the patient protection requirements of this Act shall apply to self-insured group health plans as provided for under section 714 of the Employee Retirement Income Security Act.

(d) PATIENT QUALITY ENHANCEMENT GRANTS.—

(1) IN GENERAL.—Beginning on the effective date, the Secretary shall award grants to eligible States to enable such States to carry out activities to promote high quality health care.

(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, a State shall—

(A) be a State described in subsection (c)(1); and

(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(3) USE OF FUNDS.—A State may use amounts awarded under a grant under this subsection to carry out activities to promote increased health care quality, educate consumers on health care products, provide health care coverage, improve patient safety, carry out enforcement activities with respect to compliance with State patient protection laws, and carry out other activities determined appropriate by the Secretary.

(4) FORMULA.—The Secretary shall determine the amount of each grant based on the population of the State relative to other eligible States.

(5) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $500,000,000 for fiscal year 2002, and such sums as may be necessary for each subsequent fiscal year.

(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a State with a certification that has been approved under subsection (b) from amending or otherwise modifying State laws or regulations that the approval was based upon.

(f) LIMITATION ON DELEGATION OF FUNCTIONS.—The Secretary may not delegate the duties and authority provided to the Secretary under this section to the Center for Medicare and Medicaid Services.

(g) NONAPPLICABILITY OF PROVISIONS.—Nothing in this section shall be construed to apply the patient protection requirements to States except as specifically provided for in this section.

(h) DEFINITIONS.—In this section:

(1) EFFECTIVE DATE.—The term ''effective date'' means October 1, 2002.

(2) PATIENT PROTECTION REQUIREMENT.—The term ''patient protection requirement'' means any one or more of the following requirements:

(A) Section 111 (relating to consumer choice option) with respect to non-Federal governmental plans only.

(B) Section 112 (relating to choice of health care professional).

(C) Section 113 (relating to access to emergency care).

(D) Section 114 (relating to timely access to specialists).

(E) Section 115 (relating to patient access to obstetric and gynecological care).

(F) Section 116 (relating to access to pediatric care).

(G) Section 117 (relating to continuity of care), but only insofar as a replacement issuer assumes the obligation for continuity of care.

(H) Section 118 (relating to access to needed prescription drugs).

(I) Section 119 (relating to coverage for individuals participating in approved clinical trials).

(J) Section 120 (relating to required coverage for minimum hospital stays).

(K) Section 121 (relating to access to information).

(L) A prohibition under—

(i) section 131 (relating to prohibition of interference with certain medical communications);

(ii) section 132 (relating to prohibition of discrimination against providers based on licensure); and

(iii) section 133 (relating to prohibition against improper incentive arrangements.)

(M) Section 134 (relating to the payment of claims).

(N) Section 135 (relating to protection for patient advocacy).

(3) STATE, STATE LAW.—The terms ''State'' and ''State law'' shall have the meanings given such terms in section 2723(d) of the Public Health Service Act (42 U.S.C. 300gg-23(d)).

SA 827. Mr. DOMENICI submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

At the appropriate place in title V, insert the following:

SEC. . RADIATION EXPOSURE COMPENSATION ACT.

(a) IN GENERAL.—Section 3(e) of the Radiation Exposure Compensation Act (42 U.S.C. 2210 note) is amended—

(1) in the subsection heading by striking the first 2 words and inserting ''INDEFINITE''; and

(2) by striking ''authorized to be''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 2001.

SA 828. Mrs. HUTCHISON submitted an amendment intended to be proposed by her to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

Beginning on page 98, strike line 2 and all that follows through line 21 on page 109, and insert the following:

SEC. 121. PATIENT ACCESS TO INFORMATION.

(a) REQUIREMENT.—

(1) DISCLOSURE.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer that provides coverage in connection with health insurance coverage, shall provide for the disclosure to participants, beneficiaries, and enrollees—

(i) of the information described in subsection (b) at the time of the initial enrollment of the participant, beneficiary, or enrollee under the plan or coverage;

(ii) of such information on an annual basis—

(I) in conjunction with the election period of the plan or coverage if the plan or coverage has such an election period; or

(II) in the case of a plan or coverage that does not have an election period, in conjunction with the beginning of the plan or coverage year;

(iii) of information relating to any material reduction to the benefits or information described in such subsection or subsection (c), in the form of a notice provided not later than 30 days before the date on which the reduction takes effect; and

(iv) of information relating to the disenrollment of a participant, beneficiary, or enrollee or relating to the plan or issuer otherwise reducing coverage or benefits as described in clause (iii), in the form of a notice provided not later than 30 days before the date on which the disenrollment or reduction takes effect.

(B) PARTICIPANTS, BENEFICIARIES, AND ENROLLEES.—The disclosure required under subparagraph (A) shall be provided—

(i) jointly to each participant, beneficiary, and enrollee who reside at the same address; or

(ii) in the case of a beneficiary or enrollee who does not reside at the same address as the participant or another enrollee, separately to the participant or other enrollees and such beneficiary or enrollee.

(2) PROVISION OF INFORMATION.—Information shall be provided to participants, beneficiaries, and enrollees under this section at the last known address maintained by the plan or issuer with respect to such participants, beneficiaries, or enrollees, to the extent that such information is provided to participants, beneficiaries, or enrollees via the United States Postal Service or other private delivery service.

(b) REQUIRED INFORMATION.—The informational materials to be distributed under this section shall include for each option available under the group health plan or health insurance coverage the following:

(1) BENEFITS.—A description of the covered benefits, including—

(A) any in- and out-of-network benefits;

(B) specific preventive services covered under the plan or coverage if such services are covered;

(C) any specific exclusions or express limitations of benefits described in section 104(b)(3)(C);

(D) any other benefit limitations, including any annual or lifetime benefit limits and any monetary limits or limits on the number of visits, days, or services, and any specific coverage exclusions; and

(E) any definition of medical necessity used in making coverage determinations by the plan, issuer, or claims administrator.

(2) COST SHARING.—A description of any cost-sharing requirements, including—

(A) any premiums, deductibles, coinsurance, copayment amounts, and liability for balance billing, for which the participant, beneficiary, or enrollee will be responsible under each option available under the plan;

(B) any maximum out-of-pocket expense for which the participant, beneficiary, or enrollee may be liable;

(C) any cost-sharing requirements for out-of-network benefits or services received from nonparticipating providers; and

(D) any additional cost-sharing or charges for benefits and services that are furnished without meeting applicable plan or coverage requirements, such as prior authorization or precertification.

(3) COMPENSATION METHODS.—A summary description by category of the applicable methods (such as capitation, fee-for-service, salary, bundled payments, per diem, or a combination thereof) used for compensating

prospective or treating health care professionals (including primary care providers and specialists) and facilities in connection with the provision of health care under the plan or coverage.

(c) ADDITIONAL INFORMATION.—The informational materials to be provided upon the request of a participant, beneficiary, or enrollee, as provided for under subsection (d), shall include for each option available under a group health plan or health insurance coverage the following:

(1) SERVICE AREA.—A description of the plan or issuer's service area, including the provision of any out-of-area coverage.

(2) PARTICIPATING PROVIDERS.—A directory of participating providers (to the extent a plan or issuer provides coverage through a network of providers) that includes, at a minimum, the name, address, and telephone number of each participating provider, and information about how to inquire whether a participating provider is currently accepting new patients, and the State licensure status of the providers and participating health care facilities, and, if available, the education, training, specialty qualifications or certifications of such professionals.

(3) CHOICE OF PRIMARY CARE PROVIDER.—A description of any requirements and procedures to be used by participants, beneficiaries, and enrollees in selecting, accessing, or changing their primary care provider, including providers both within and outside of the network (if the plan or issuer permits out-of-network services), and the right to select a pediatrician as a primary care provider under section 116 for a participant, beneficiary, or enrollee who is a child if such section applies.

(4) PREAUTHORIZATION REQUIREMENTS.—A description of the requirements and procedures to be used to obtain preauthorization for health services, if such preauthorization is required.

(5) EXPERIMENTAL AND INVESTIGATIONAL TREATMENTS.—A description of the process for determining whether a particular item, service, or treatment is considered experimental or investigational, and the circumstances under which such treatments are covered by the plan or issuer.

(6) SPECIALTY CARE.—A description of the requirements and procedures to be used by participants, beneficiaries, and enrollees in accessing specialty care and obtaining referrals to participating and nonparticipating specialists, including any limitations on choice of health care professionals referred to in section 112(b)(2) and the right to timely access to specialists care under section 114 if such section applies.

(7) CLINICAL TRIALS.—A description of the circumstances and conditions under which participation in clinical trials is covered under the terms and conditions of the plan or coverage, and the right to obtain coverage for approved clinical trials under section 119 if such section applies.

(8) PRESCRIPTION DRUGS.—To the extent the plan or issuer provides coverage for prescription drugs, a statement of whether such coverage is limited to drugs included in a formulary, a description of any provisions and cost-sharing required for obtaining on- and off-formulary medications, and a description of the rights of participants, beneficiaries, and enrollees in obtaining access to access to prescription drugs under section 118 if such section applies.

(9) EMERGENCY SERVICES.—A summary of the rules and procedures for accessing emergency services, including the right of a participant, beneficiary, or enrollee to obtain emergency services under the prudent layperson standard under section 113, if such section applies, and any educational information that the plan or issuer may provide regarding the appropriate use of emergency services.

(10) CLAIMS AND APPEALS.—A description of the plan or issuer's rules and procedures pertaining to claims and appeals, a description of the rights (including deadlines for exercising rights) of participants, beneficiaries, and enrollees under subtitle A in obtaining covered benefits, filing a claim for benefits, and appealing coverage decisions internally and externally (including telephone numbers and mailing addresses of the appropriate authority), and a description of any additional legal rights and remedies available under section 502 of the Employee Retirement Income Security Act of 1974 and applicable State law.

(11) ADVANCE DIRECTIVES AND ORGAN DONATION.—A description of procedures for advance directives and organ donation decisions if the plan or issuer maintains such procedures.

(12) INFORMATION ON PLANS AND ISSUERS.—The name, mailing address, and telephone number or numbers of the plan administrator and the issuer to be used by participants, beneficiaries, and enrollees seeking information about plan or coverage benefits and services, payment of a claim, or authorization for services and treatment. Notice of whether the benefits under the plan or coverage are provided under a contract or policy of insurance issued by an issuer, or whether benefits are provided directly by the plan sponsor who bears the insurance risk.

(13) TRANSLATION SERVICES.—A summary description of any translation or interpretation services (including the availability of printed information in languages other than English, audio tapes, or information in Braille) that are available for non-English speakers and participants, beneficiaries, and enrollees with communication disabilities and a description of how to access these items or services.

(14) ACCREDITATION INFORMATION.—Any information that is made public by accrediting organizations in the process of accreditation if the plan or issuer is accredited, or any additional quality indicators (such as the results of enrollee satisfaction surveys) that the plan or issuer makes public or makes available to participants, beneficiaries, and enrollees.

(15) NOTICE OF REQUIREMENTS.—A description of any rights of participants, beneficiaries, and enrollees that are established by the Bipartisan Patient Protection Act (excluding those described in paragraphs (1) through (14)) if such sections apply. The description required under this paragraph may be combined with the notices of the type described in sections 711(d), 713(b), or 606(a)(1) of the Employee Retirement Income Security Act of 1974 and with any other notice provision that the appropriate Secretary determines may be combined, so long as such combination does not result in any reduction in the information that would otherwise be provided to the recipient.

(16) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, timeframes, and appeals rights) under any utilization review program under sections 101 and 102, including any drug formulary program under section 118.

(17) EXTERNAL APPEALS INFORMATION.—Aggregate information on the number and outcomes of external medical reviews, relative to the sample size (such as the number of covered lives) under the plan or under the coverage of the issuer.

(d) MANNER OF DISCLOSURE.—

(1) IN GENERAL.—The information described in this section shall be disclosed in an accessible medium and format that is calculated to be understood by a participant or enrollee.

(2) ADDITIONAL INFORMATION.—The information described in subsection (c) shall be made available and easily accessible, without cost, to participants, beneficiaries, or enrollees upon request. Such information shall be made available in writing and by electronic means (including the Internet) and in any other manner determined appropriate by the Secretary.

(e) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a group health plan, or a health insurance issuer in connection with health insurance coverage, from—

(1) distributing any other additional information determined by the plan or issuer to be important or necessary in assisting participants, beneficiaries, and enrollees in the selection of a health plan or health insurance coverage; and

(2) complying with the provisions of this section by providing information in brochures, through the Internet or other electronic media, or through other similar means, so long as—

(A) the disclosure of such information in such form is in accordance with requirements as the appropriate Secretary may impose, and

(B) in connection with any such disclosure of information through the Internet or other electronic media—

(i) the recipient has affirmatively consented to the disclosure of such information in such form,

(ii) the recipient is capable of accessing the information so disclosed on the recipient's individual workstation or at the recipient's home,

(iii) the recipient retains an ongoing right to receive paper disclosure of such information and receives, in advance of any attempt at disclosure of such information to him or her through the Internet or other electronic media, notice in printed form of such ongoing right and of the proper software required to view information so disclosed, and

(iv) the plan administrator appropriately ensures that the intended recipient is receiving the information so disclosed and provides the information in printed form if the information is not received.

SA 829. Mr. DEWINE submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

On page 171, between lines 14 and 15, insert the following:

SEC. 303. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 302, is further amended by adding at the end the following:

''(o) LIMITATION ON CLASS ACTION LITIGATION.—

''(1) IN GENERAL.—Any claim or cause of action that is maintained under this section in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of claimants is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such

class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.''.

''(2) EFFECTIVE DATE.—This subsection shall apply to all civil actions that are filed on or after the date of enactment of the Bipartisan Patients' Bill of Rights Act of 2001.''.

SA 830. Mr. BREAUX (for himself, Mr. JEFFORDS, Mr. KENNEDY, Mr. MCCAIN, and Mr. EDWARDS) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

Beginning on page 122, strike line 19 and all that follows through line 5 on page 128, and insert the following:

SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this title.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(3) CONSTRUCTION.—In applying this section, a State law that provides for equal access to, and availability of, all categories of licensed health care providers and services shall not be treated as preventing the application of any requirement of this title.

(b) APPLICATION OF SUBSTANTIALLY COMPLIANT STATE LAWS.—

(1) IN GENERAL.—In the case of a State law that imposes, with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan, a requirement that substantially complies (within the meaning of subsection (c)) with a patient protection requirement (as defined in paragraph (3)) and does not prevent the application of other requirements under this Act (except in the case of other substantially compliant requirements), in applying the requirements of this title under section 2707 and 2753 (as applicable) of the Public Health Service Act (as added by title II), subject to subsection (a)(2)—

(A) the State law shall not be treated as being superseded under subsection (a); and

(B) the State law shall apply instead of the patient protection requirement otherwise applicable with respect to health insurance coverage and non-Federal governmental plans.

(2) LIMITATION.—In the case of a group health plan covered under title I of the Employee Retirement Income Security Act of 1974, paragraph (1) shall be construed to apply only with respect to the health insurance coverage (if any) offered in connection with the plan.

(3) DEFINITIONS.—In this section:

(A) PATIENT PROTECTION REQUIREMENT.—The term ''patient protection requirement'' means a requirement under this title, and includes (as a single requirement) a group or related set of requirements under a section or similar unit under this title.

(B) SUBSTANTIALLY COMPLIANT.—The terms ''substantially compliant'', substantially complies'', or ''substantial compliance'' with respect to a State law, mean that the State law has the same or similar features as the patient protection requirements and has a similar effect.

(c) DETERMINATIONS OF SUBSTANTIAL COMPLIANCE.—

(1) CERTIFICATION BY STATES.—A State may submit to the Secretary a certification that a State law provides for patient protections that are at least substantially compliant with one or more patient protection requirements. Such certification shall be accompanied by such information as may be required to permit the Secretary to make the determination described in paragraph (2)(A).

(2) REVIEW.—

(A) IN GENERAL.—The Secretary shall promptly review a certification submitted under paragraph (1) with respect to a State law to determine if the State law substantially complies with the patient protection requirement (or requirements) to which the law relates.

(B) APPROVAL DEADLINES.—

(i) INITIAL REVIEW.—Such a certification is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification, that the certification is disapproved (and the reasons for disapproval) or that specified additional information is needed to make the determination described in subparagraph (A).

(ii) ADDITIONAL INFORMATION.—With respect to a State that has been notified by the Secretary under clause (i) that specified additional information is needed to make the determination described in subparagraph (A), the Secretary shall make the determination within 60 days after the date on which such specified additional information is received by the Secretary.

(3) APPROVAL.—

(A) IN GENERAL.—The Secretary shall approve a certification under paragraph (1) unless—

(i) the State fails to provide sufficient information to enable the Secretary to make a determination under paragraph (2)(A); or

(ii) the Secretary determines that the State law involved does not provide for patient protections that substantially comply with the patient protection requirement (or requirements) to which the law relates.

(B) STATE CHALLENGE.—A State that has a certification disapproved by the Secretary under subparagraph (A) may challenge such disapproval in the appropriate United States district court.

(C) DEFERENCE TO STATES.—With respect to a certification submitted under paragraph (1), the Secretary shall give deference to the State's interpretation of the State law involved and the compliance of the law with a patient protection requirement.

(D) PUBLIC NOTIFICATION.—The Secretary shall—

(i) provide a State with a notice of the determination to approve or disapprove a certification under this paragraph;

(ii) promptly publish in the Federal Register a notice that a State has submitted a certification under paragraph (1);

(iii) promptly publish in the Federal Register the notice described in clause (i) with respect to the State; and

(iv) annually publish the status of all States with respect to certifications.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the certification (and approval of certification) of a State law under this subsection solely because it provides for greater protections for patients than those protections otherwise required to establish substantial compliance.

(5) PETITIONS.—

(A) PETITION PROCESS.—Effective on the date on which the provisions of this Act become effective, as provided for in section 401, a group health plan, health insurance issuer, participant, beneficiary, or enrollee may submit a petition to the Secretary for an advisory opinion as to whether or not a standard or requirement under a State law applicable to the plan, issuer, participant, beneficiary, or enrollee that is not the subject of a certification under this subsection, is superseded under subsection (a)(1) because such standard or requirement prevents the application of a requirement of this title.

(B) OPINION.—The Secretary shall issue an advisory opinion with respect to a petition submitted under subparagraph (A) within the 60-day period beginning on the date on which such petition is submitted.

(d) DEFINITIONS.—For purposes of this section:

(1) STATE LAW.—The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term ''State'' includes a State, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

On page 132, between lines 11 and 12, insert the following:

SEC. 203. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.) is amended by adding at the end the following:

''SEC. 2793. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

''(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary's authority under this title to enforce the requirements applicable under title I of the Bipartisan Patient Protection Act with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan.

''(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

On page 137, lines 3 and 4, strike ''EQUIVALENT'' and insert ''COMPLIANT''.

On page 137, lines 9 and 10, strike ''is substantially equivalent'' and insert ''substantially complies''.

On page 137, line 11, strike ''to'' and insert ''with''.

On page 173, between lines 4 and 5, insert the following:

SEC. 304. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191 et seq.) is amended by adding at the end the following new section:

"SEC. 735. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

''(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary's authority under this title to enforce the requirements applicable under title I of the Bipartisan Patient Protection Act with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan.

''(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Wednesday, June 27, 2001 at 10 a.m., in open session to consider the nominations of Dionel M. Aviles to be Assistant Secretary of the Navy (Financial Management and Comptroller); Reginald Jude Brown to be Assistant Secretary of the Army (Manpower and Reserve Affairs); Steven A. Cambone to be Deputy under Secretary of Defense for Policy; Michael Montelongo to be Assistant Secretary of the Air Force (Financial Management and Comptroller); and John J. Young, Jr. to be Assistant Secretary of the Navy (Research, Development and Acquisition).

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Wednesday, June 27 at 9:30 a.m. to conduct a hearing. The committee will consider the nominations of Vicky A. Bailey to be an Assistant Secretary of Energy (International Affairs and Domestic Policy), Frances P. Mainella to be Director of the National Park Service, and John Walton Keys, III, to be Commissioner of the Bureau of Reclamation.

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

COMMITTEE ON FINANCE

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session of the Senate on Wednesday, June 27, 2001 to hear testimony on ''Prescription for Fraud: Consultants Selling Doctors Bad Billing Advice.''

The PRESIDING OFFICER. Without objection, it is ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 27, 2001 at 9:45 a.m. to hold a nomination hearing as follows:

Nominees: Mr. Clark T. Randt, Jr., of Connecticut, to be Ambassador to the People's Republic of China.

Mr. Douglas Allan Hartwick, of Washington, to be Ambassador to the Lao People's Democratic Republic.

Charles J. Swindells, of Oregon, to be Ambassador to New Zealand, and to serve concurrently and without additional compensation as Ambassador to Samoa to be introduced by Hon. GORDON SMITH.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 27, 2001 at approximately 11:15 a.m. to hold a nomination hearing as follows:

Nominees: Mr. Pierre-Richard Prosper, of California, to be Ambassador at Large for War Crimes Issues.

Mr. William A. Eaton, of Virginia, to be Assistant Secretary of State (Administration).

General Francis Xavier Taylor, of Maryland, to be Coordinator for Counterterrorism, with the rank of Ambassador at Large to be introduced by Hon. PAUL S. SARBANES.

Mr. Clark Kent Ervin, of Texas, to be Inspector General, Department of State to be introduced by Hon. PHIL GRAMM.

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

COMMITTEE ON THE JUDICIARY

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a markup on ''Protecting the Innocent: Ensuring Competent Counsel in Death Penalty Cases'' on Wednesday, June 27, 2001 at 10:00 a.m., in SD226. No witness list is available yet.

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

COMMITTEE ON RULES AND ADMINISTRATION

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Rules and Administration be authorized to meet during the session of the Senate on Wednesday, June 27, 2001, at 10:30 a.m., to receive testimony from the U.S. Commission on Civil Rights regarding its latest report on the November 2000 election and from other witnesses on election reform in general.

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

SELECT COMMITTEE ON INTELLIGENCE

Mr. DORGAN. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Wednesday, June 27, 2001 at 2:30 p.m., to hold a hearing on intelligence matters.

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

SUBCOMMITTEE ON ECONOMIC POLICY

Mr. DORGAN. Mr. President, I ask unanimous consent that the Subcommittee on Economic Policy of the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 27, 2001 to conduct a hearing on ''The Reauthorization of the Defense Production Act.''

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

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT, RESTRUCTURING AND THE DISTRICT OF COLUMBIA

Mr. DORGAN. Mr. President, I ask unanimous consent that the Subcommittee on Oversight of Government Management, Restructuring and the District of Columbia of the Committee on Governmental Affairs be authorized to meet on Wednesday, June 27, 2001 at 10:00 a.m., for a hearing to examine ''Finding a Cure to Keep Nurses on the Job: The Federal Government's Role in Retaining Nurses for Delivery of Federally Funded Health Care Services.''

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

ORDERS FOR THURSDAY, JUNE 28, 2001

Mr. REID. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until the hour of 9:15 a.m. on Thursday, June 28. I further ask consent that on Thursday, immediately following the prayer and the pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of the Patients' Bill of Rights.

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

PROGRAM

Mr. REID. Mr. President, tomorrow the Senate will convene at 9:15 a.m. and resume consideration of the Patients' Bill of Rights. There will be 30 minutes of debate on the Collins and Breaux amendments regarding scope, with two rollcall votes beginning at approximately 9:45 a.m. Additional rollcall votes will occur throughout the day and into the evening.

The majority leader has told me it is his hope that we will complete this bill tomorrow rather than on Friday or Saturday. We have made great progress today. The minority manager, Senator GREGG, has done very good work. We have our managers—Senator MCCAIN, Senator KENNEDY, and Senator EDWARDS—who have done outstanding work. We have really made great headway. So the light at the end of the tunnel is there. It is up to us whether we take that opportunity to finish this.

Then there is the supplemental appropriations bill which needs to be

done, and also the organizing resolution.

ADJOURNMENT UNTIL 9:15 A.M. TOMORROW

Mr. REID. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 7:18 p.m., adjourned until Thursday, June 28, 2001, at 9:15 a.m.

NOMINATIONS

Executive nominations received by the Senate June 27, 2001:

NATIONAL TRANSPORTATION SAFETY BOARD

JOHN ARTHUR HAMMERSCHMIDT, OF ARKANSAS, TO BE A MEMBER OF THE NATIONAL TRANSPORTATION SAFETY BOARD FOR THE REMAINDER OF THE TERM EXPIRING DECEMBER 31, 2002, VICE JAMES E. HALL, RESIGNED.

DEPARTMENT OF VETERANS AFFAIRS

CLAUDE M. KICKLIGHTER, OF GEORGIA, TO BE AN ASSISTANT SECRETARY OF VETERANS AFFAIRS (POLICY AND PLANNING), VICE DENNIS M. DUFFY, RESIGNED.