The following-named officer for reappointment to the grade of lieutenant general in the U.S. Air Force while assigned to a position of importance and responsibility under title 10, United States Code, section 601:

To be lieutenant general

Lt. Gen. Lester L. Lyles, 000–00–0000.

The following-named officer for appointment to the grade of lieutenant general in the U.S. Air Force while assigned to a position of importance and responsibility under title 10, United States Code, section 601:

To be lieutenant general

Maj. Gen. Patrick K. Gamble, 000–00–0000.

The following-named officer for appointment to the grade of lieutenant general in the U.S. Air Force while assigned to a position of importance and responsibility under title 10, United States Code, section 601:

To be lieutenant general

Maj. Gen. Roger G. DeKok, 000–00–0000.

The following-named officer for reappointment to the grade of lieutenant general while assigned to a position of importance and responsibility under title 10, United States Code, section 601:

To be lieutenant general

Lt. Gen. Charles T. Robertson, 000–00–0000, U.S. Air Force.

The following-named officers for appointment in the Reserve of the Air Force, to the grade indicated, under the provisions of title 10, United States Code, sections 8373, 8374, 12201, and 12212:

To be major general

Brig. Gen. Keith D. Bjerke, 000–00–0000, Air National Guard.
Brig. Gen. Edmond W. Boenisch, Jr., 000–00–0000, Air National Guard.
Brig. Gen. Stewart R. Byrne, 000–00–0000, Air National Guard.
Brig. Gen. John H. Fenimore V, 000–00–0000, Air National Guard.
Brig. Gen. Johnny J. Hobbs, 000–00–0000, Air National Guard.
Brig. Gen. Stephen G. Kearney, 000–00–0000, Air National Guard.
Brig. Gen. William B. Lynch, 000–00–0000, Air National Guard.

To be brigadier general

Col. Brian E. Barents, 000–00–0000, Air National Guard.
Col. George P. Christakos, 000–00–0000, Air National Guard.
Col. Walter C. Corish, Jr., 000–00–0000, Air National Guard.
Col. Fred E. Ellis, 000–00–0000, Air National Guard.
Col. Frederick D. Feinstein, 000–00–0000, Air National Guard.
Col. William P. Gralow, 000–00–0000, Air National Guard.
Col. Douglas E. Henneman, 000–00–0000, Air National Guard.
Col. Edward R. Jayne II, 000–00–0000, Air National Guard.
Col. Raymond T. Klosowski, 000–00–0000, Air National Guard.
Col. Fred N. Larson, 000–00–0000, Air National Guard.
Col. Bruce W. Maclane, 000–00–0000, Air National Guard.
Col. Ronald W. Mielke, 000–00–0000, Air National Guard.
Col. Frank A. Mitolo, 000–00–0000.
Col. Frank D. Rezac, 000–00–0000.
Col. John P. Silliman, Jr., 000–00–0000.
Col. George E. Wilson III, 000–00–0000.

The following-named officer for reappointment to the grade of admiral in the U.S. Navy while assigned to a position of importance and responsibility under title 10, United States Code, sections 601 and 5033:

CHIEF OF NAVAL OPERATIONS

To be admiral

Adm. Jay L. Johnson, 000–00–0000.

The following-named officer for appointment to the grade of general in the U.S. Air Force while assigned to a position of importance and responsibility under title 10 United States Code, section 601:

To be general

Lt. Gen. Howell M. Estes III, 000–00–0000.

The following U.S. Army National Guard officer for promotion in the Reserve of the Army to the grade indicated under title 10, United States Code, sections 3385, 3392 and 12203(a):

To be major general

Brig. Gen. Gerald A. Rudisill, Jr., 000–00–0000.

The following-named officer for promotion in the Regular Air Force of the United States to the grade indicated under title 10, United States Code, section 624:

To be brigadier general

Col. Garry R. Trexler, 000–00–0000.

*Everett Alverez, Jr., of Maryland, to be a Member of the Board of Regents of the Uniformed Services University of the Health Sciences for a term expiring May 1, 1999.

*Alberto Aleman Zubieta, a citizen of the Republic of Panama, to be Administrator of the Panama Canal Commission

The following named officer for appointment to the grade of lieutenant general in the U.S. Army while assigned to a position of importance and responsibility under title 10, United States Code, section 601(a):

To be lieutenant general

Maj. Gen. Eric K. Shinseki, 000–00–0000.

The following-named officer for appointment to the grade of vice admiral in the U.S. Navy while assigned to a position of importance and responsibility under title 10 United States Code, section 601:

To be vice admiral

Rear Adm. (Selectee) Lyle G. Bien, 000–00–0000.

(The above nominations were reported with the recommendation that they be confirmed.)

Mr. THURMOND. Mr. President, for the Committee on Armed Services, I report favorably the attached listing of nominations. Those identified with a double asterisk (**) are to lie on the Secretary's desk for the information of any Senator, since these names have already appeared in the RECORDS of May 17, 1996, June 3, 18, and July 9, 11, 1996, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar, that these nominations lie at the Secretary's desk for the information of Senators.

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

(The nominations ordered to lie on the Secretary's desk were printed in the RECORDS of May 17, 1996, June 3, 18, and July 9, 11, 1996, at the end of the Senate proceedings.)

**In the Air Force there are 31 promotions to the grade of lieutenant colonel (list begins with Gregory O. Allen) (Reference No. 1132).

**In the Navy there are 170 promotions to the grade of captain (list begins with William S. Adsit) (Reference No. 1133).

**In the Navy there are 304 promotions to the grade of captain (list begins with Johnny P. Albus) (Reference No. 1134).

**In the Air Force there are 2,525 promotions to the grade of lieutenant colonel and below (list begins with Derrick K. Anderson) (Reference No. 1135).

In the Navy there are 317 promotions to the grade of captain (list begins with Michael P. Agor)

**In the Army there is 1 promotion to the grade of lieutenant colonel (Wayne E. Anderson) (Reference No. 1165).

**In the Air Force there are 13 promotions to the grade of colonel and below (list begins with Stephen D. Chiabotti) (Reference No. 1188).

**In the Marine Corps there are 2 promotions to the grade of lieutenant colonel and below (list begins with Richard L. West) (Reference No. 1189).

**In the Navy there are 10 appointments to the grade of ensign (list begins with Anthony L. Evangelista) (Reference No. 1190).

**In the Marine Corps there is 1 posthumous appointment to the grade of lieutenant colonel (John J. Canney) (Reference No. 1195).

**In the Army there are 200 promotions to the grade of lieutenant colonel (list begins with Ann L. Bagley) (Reference No. 1196).

**In the Army there are 423 promotions to the grade of major (list begins with James W. Baik) (Reference No. 1197).

Total: 3,742.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. WYDEN (for himself, Ms. SNOWE, and Mrs. BOXER):

S. 2004. A bill to modify certain provisions of the Health Care Quality Improvement Act of 1986; to the Committee on Labor and Human Resources.

By Mr. WYDEN:

S. 2005. A bill to prohibit the restriction of certain types of medical communications between a health care provider and a patient; to the Committee on Labor and Human Resources.

By Mr. HATCH (for himself, Mr. BIDEN, Mr. THURMOND, and Mr. GRASSLEY):

S. 2006. A bill to clarify the intent of Congress with respect to the Federal carjacking prohibition; read the first time.

By Mr. BIDEN (for himself, Mr. HATCH, Mr. LEAHY, Mr. KOHL, Mr. GRASSLEY, Mrs. BOXER, Ms. MIKULSKI, and Ms. MOSELEY-BRAUN):

S. 2007. A bill to clarify the intent of Congress with respect to the Federal carjacking prohibition; read the first time.

By Mr. DASCHLE (for himself, Mr. ROCKEFELLER, Mr. KERRY, Mr. WELLSTONE, Ms. MIKULSKI, Mr. BYRD, Mr. DODD, Mr. CONRAD, Mr. INOUYE, Mr. PELL, Mr. SIMON, Mr. FEINGOLD, Mr. BREAUX, Mrs. BOXER, Mr. DORGAN, Mrs. FEINSTEIN, Mr. GLENN, Mr. HARKIN, Mr. ROBB, and Mr. KENNEDY):

S. 2008. A bill to amend title 38, United States Code, to provide benefits for certain children of Vietnam veterans who are born with spina bifida, and for other purposes; to the Committee on Veterans' Affairs.

By Mr. ASHCROFT:

S.J. Res. 58. A joint resolution proposing an amendment to the Constitution of the United States relative to granting power to the States to propose constitutional amendments; to the Committee on the Judiciary.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. WYDEN (for himself, Ms. SNOWE, and Mrs. BOXER):

S. 2004. A bill to modify certain provisions of the Health Care Quality Improvement Act of 1986; to the Committee on Labor and Human Resources.

By Mr. WYDEN:

S. 2005. A bill to prohibit the restriction of certain types of medical communications between a health care provider and a patient; to the Committee on Labor and Human Resources.

THE PATIENT COMMUNICATIONS PROTECTION ACT OF 1996

Mr. WYDEN. Mr. President, I rise today to introduce two new bills which I believe will help more fully inform patients and consumers about the health care choices they face, and safeguard the most critical relationship between care giver and patient.

The first bill, which I introduce with my colleagues Senator SNOWE and Senator BOXER, is the Health Care Quality Improvements Act of 1996. It amends and improves the 1986 public law which created the national practitioner databank, an informational resource maintained by the Department of Health and Human Services which is a compendium of State disciplinary actions and civil malpractice case judgments against caregivers. As of this year, some 86,000 caregivers are listed in this taxpayer-supported databank. Currently, this informational resource is accessible only by hospitals, insurance plans, and State boards of medicine and health care licensing. The legislation introduced by Senator SNOWE and me, today, would for the first time allow public access to critically important databank records. Caregivers who have had at least three reportable incidents in their files would have their entire databank records opened to the public. This legislation also would create an Internet site on the World Wide Web allowing easier access for publicly accessible information.

The second bill, the Patient Communications Protection Act of 1996, would make illegal provisions in some contracts between caregivers and health plans which restrict communications between caregivers and their patients. Too often, I believe, these contract provisions limit the free and necessary communications of information to patients regarding their medical condition and all possible modalities of treatment. This legislation, while upholding the right of plans to work with physicians to improve the overall quality of care within a health plan, clearly restricts plans from impeding the free flow of medical information between State-licensed caregivers and patient.

The Health Care Quality Improvements Act is endorsed by a number of groups including Families USA, Consumer Action, the National Association of Health Data Organizations, and the United Seniors Health Cooperative.

The Patient Communications Protection Act is supported by the Oregon Medical Association, the American Association of Retired Persons, the Center for Patient Advocacy, Citizen Action, the Consumers Union, and the American College of Emergency Physicians.

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

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

S. 2004

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 ''Health Care Quality Improvement Act Amendments of 1996''.

SEC. 2. STANDARDS FOR PROFESSIONAL REVIEW ACTIONS.

Section 412(a) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11112(a)) is amended in the matter after and below paragraph (4) by adding at the end the following sentence: ''A motion for summary judgment that such standards have been met shall be granted unless, considering the evidence in the light most favorable to the opposing party, a reasonable finder of fact could conclude that the presumption has been so rebutted. The decision on such a motion may be appealed as of right, without regard to whether the motion is granted or denied, and the courts of appeals (other than the United States Court of Appeals for the Federal Circuit) have jurisdiction of appeals from such decisions of the district courts.''.

SEC. 3. REQUIRING REPORTS ON MEDICAL MALPRACTICE DATA.

(a) IN GENERAL.—Section 421 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131) is amended—

(1) by striking subsections (a) and (b);

(2) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(3) by inserting before subsection (d) (as so redesignated) the following subsections:

''(a) IN GENERAL.—

''(1) REQUIREMENT OF REPORTING.—Subject to the subsequent provisions of this subsection, each person or entity which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report, in accordance with section 424, information respecting the payment and circumstances thereof.

''(2) PAYMENTS BY PRACTITIONERS.—The persons to whom the requirement of paragraph (1) applies include a physician or other licenses healthcare practitioner who makes a payment described in such paragraph and whose acts or omissions are the basis of the action or claim involved. The preceding sentence is subject to paragraph (3).

''(3) REFIND OF FEES.—With respect to a physician or other licensed health care practitioner whose acts or omissions are the basis of an action or claim described in paragraph (1), the requirement of such paragraph shall not apply to a payment described in such paragraph if—

''(A) the payment is made by the physician or practitioner as a refund of fees for the health services involved, and

''(B) the payment does not exceed the amount of the original charge for the health services.

''(4) DEFINITION OF ENTITY AND PERSON.—For purposes of this section, the term 'entity' includes the Federal Government, any State or local government, and any insurance company or other private entity; and the term 'person' includes Federal officers and employees.

''(b) INFORMATION TO BE REPORTED.—The information to be reported under subsection (a) by a person or entity regarding a payment and an action or claim includes the following:

''(1)(A) The name of each physician or other licensed health care practitioner whose acts or omissions were the basis of the action or claim; and (to the extent authorized under title II of the Social Security Act) the social security account number assigned to the physician or practitioner.

''(B) The medical field of the physician or practitioner, including as applicable the medical specialty.

''(C) The date on which the physician or practitioner was first licensed in the medical field involved, and the number of years the physician or practitioner has been practicing in such field.

''(D) If the physician or practitioner could not be identified for purposes of subparagraph (A)—

''(i) a statement of such fact and an explanation of the inability to make the identification, and

''(ii) the name of the hospital or other health services organization (as defined in section 431) for whose benefit the payment was made.

''(2) The amount of the payment.

''(3) The name (if known) of any hospital or other health services organization with which the physician or practitioner is affiliated or associated.

''(4)(A) A statement that describes the acts or omissions and injuries or illnesses upon which the action or claim was based, that specifies whether an action was filed, and if an action was filed, that specifies whether the action was a class action.

''(B) A statement by the physician or practitioner regarding the action or claim, if the physician or practitioner elects to make such a statement.

''(C) If the payment was made without the consent of the physician or practitioner, a statement specifying such fact and the reasons underlying the decision to make the payment without such consent.

''(5) Such other information as the Secretary determines is required for appropriate interpretation of information reported under this section.

''(c) CERTAIN REPORTING CRITERIA; NOTICE TO PRACTITIONERS.—

''(1) REPORTING CRITERIA.—The establishing criteria under section 424(a) for reports under this section, the Secretary shall establish criteria regarding statements under subsection (b)(4). Such criteria shall include—

''(A) criteria regarding the length of each of the statements,

''(B) criteria regarding the notice required by paragraph (2) of this subsection, and

''(C) such other criteria as the Secretary determines to be appropriate.

''(2) NOTICE OF OPPORTUNITY TO MAKE STATEMENT.—In the case of an entity that prepares a report under subsection (a)(1) regarding a payment and an action or claim, the entity shall notify any physician or practitioner identified under subsection (b)(1)(A) of the opportunity to make a statement under subsection (b)(4)(B). Criteria under paragraph (1)(B) of this subsection shall include criteria regarding the date by which the reporting entity is to provide the notice and the date by which the physician or practitioner is to submit the statement to the entity.''.

(b) DEFINITION OF HEALTH SERVICES ORGANIZATION.—Section 431 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151) is amended—

(1) by redesignating paragraphs (5) through (14) as paragraphs (6) through (15), respectively; and

(2) by inserting after paragraph (4) the following paragraph:

''(5) The term 'health services organization' means an entity that, directly or through contracts, provides health services. Such term includes hospitals; health maintenance organizations and other health plans; and health care entities (as defined in paragraph (4)).''.

(c) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—The Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.) is amended—

(A) in section 411(a)(1), in the matter preceding subparagraph (A), by striking ''431(9)'' and inserting ''431(10)'';

(B) in section 421(d) (as redesignated by subsection (a)(2) of this section), by inserting ''person or'' before ''entity'';

(C) in section 422(a)(2)(A), by inserting before the comma at the end the following: '', and (to the extent authorized under title II of the Social Security Act) the social security account number assigned to the physician''; and

(D) in section 423(a)(3)(A), by inserting before the comma at the end the following: '', and (to the extent authorized under title II of the Social Security Act) the social security account number assigned to the physician or practitioner''.

(2) APPLICABILITY OF REQUIREMENTS TO FEDERAL ENTITIES.—

(A) Section 432 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11152) is amended—

(i) by striking subsection (b); and

(ii) by redesignating subsection (c) as subsection (b).

(B) Section 432 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11133) is amended by adding at the end the following subsection:

''(e) APPLICABILITY TO FEDERAL FACILITIES AND PHYSICIANS.—

''(1) IN GENERAL.—Subsection (a) applies to Federal health facilities (including hospitals) and actions by such facilities regarding the competence or professional conduct of Federal physicians to the same extent and in the same manner as such subsection applies to health care entities and professional review actions.

''(2) RELEVANT BOARD OF MEDICAL EXAMINERS.—For purposes of paragraph (1), the Board of Medical Examiners to which a Federal health facility is to report is the Board of Medical Examiners of the State within which the facility is located.''.

(C) Section 425 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11135) is amended by adding at the end the following subsection:

''(d) APPLICABILITY TO FEDERAL HOSPITALS.—This section applies to Federal hospitals to the same extent and in the same manner as such subsection applies to other hospitals.''.

SEC. 4. REPORTING OF SANCTIONS TAKEN BY BOARDS OF MEDICAL EXAMINERS.

Section 422(a) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11132(a)) is amended—

(1) in paragraph (1)(A), by striking ''which revokes or suspends'' and inserting ''which denies, revokes, or suspends''; and

(2) in paragraph (2)—

(A) in subparagraph (B), by striking ''(if known)'' and all that follows and inserting ''for the action described in paragraph (1)(A) that was taken with respect to the physician or, if known, for the surrender of the license,'';

(B) by redesignating subparagraph (C) as subparagraph (E); and

(C) by inserting after subparagraph (B) the following subparagraphs:

''(C) the medical field of the physician, if known, including as applicable the medical specialty,

''(D) the date on which the physician was first licensed in the medical field, and the number of years the physician has been practicing in such field, if known, and''.

SEC. 5. REPORTING OF CERTAIN PROFESSIONAL REVIEW ACTIONS TAKEN BY HEALTH CARE ENTITIES.

Section 423(a)(3) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11133(a)(3)) is amended—

(1) in subparagraph (B), by striking ''and'' after ''surrender,'';

(2) by redesignating subparagraph (C) a subparagraph (E); and

(3) by inserting after subparagraph (B) the following subparagraphs:

''(C) the medical field of the physician, if known, including as applicable the medical specialty,

''(D) the date on which the physician was first licensed in the medical field, and the number of years the physician has been practicing in such field, if known, and''.

SEC. 6. FORM OF REPORTING.

Section 424 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11134) is amended by adding at the end the following subsection:

''(d) ADDITIONAL REQUIREMENTS.—Not later than 30 days after the effective date for this subsection under section 11 of the Health Care Quality Improvement Act Amendments of 1996, the information reported under sections 421, 422(a), and 423(b) shall be available (to persons and entities authorized in this Act to receive the information) in accordance with the following:

''(1) The methods of organizing the information shall include organizing by medical field (and as applicable by medical specialty).

''(2) With respect to medical malpractice actions reported under section 421(b)(4)(A), the methods of organizing shall specify whether the action was a class action.''.

SEC. 7. DUTY TO OBTAIN INFORMATION.

Part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) is amended by inserting after section 425 the following section:

''SEC. 425A. DUTY OF BOARDS OF MEDICAL EXAMINERS TO OBTAIN INFORMATION.

''(a) IN GENERAL.—Effective 2 years after the date of the enactment of the Health Care Quality Improvement Act Amendments of 1996, it is the duty of each Board of Medical Examiners to request from the Secretary (or the agency designated under section 424(b)) information reported under this part concerning a physician—

''(1) at the time the physician submits the initial application for a physician's license in the State involved, and

''(2) at each time the physician submits an application to continue in effect the license, subject to subsection (d).

A Board of Medical Examiners may request information reported under this part concerning a physician at other times.

''(b) FAILURE TO OBTAIN INFORMATION.—With respect to an action for mandamus or other cause of action against a Board of Medical Examiners, a Board which does not request information respecting a physician as required under subsection (a) is presumed to have knowledge of any information reported under this part to the Secretary with respect to the physician.

''(c) RELIANCE ON INFORMATION PROVIDED.—With respect to a cause of action against a Board of Medical Examiners, each Board of Medical Examiners may rely upon information provided to the Board under this title, unless the Board has knowledge that the information provided was false.

''(d) STATE OPTION REGARDING CONTINUATION OF LICENSES.—

''(1) ESTABLISHMENT OF ELECTRONIC SYSTEM FOR TRANSMISSION OF DATA.—After consultation with the States, the Secretary shall establish a system for electronically transmitting information under this part to States that elect to install equipment necessary for participation in the system. The system shall possess the capability to receive transmissions of data from such States.

''(2) STATE OPTION REGARDING ELECTRONIC SYSTEM.—With respect to compliance with subsection (a)(2) (relating to applications to continue in effect physicians' licenses), if a State is participating in the system under paragraph (1) and provides the Board of Medical Examiners of the State with access to the system, the Board may elect, in lieu of complying with subsection (a)(2), to comply with paragraph (3) of this subsection.

''(3) DESCRIPTION OF OPTION.—For purposes of paragraph (2), a Board of Medical Examiners is complying with this paragraph if—

''(A) through the system under paragraph (1), the Board annually transmits to the Secretary (or the agency designated under section 424(b)) data identifying all individuals who hold a valid physician's license issued by the Board, without regard to whether the licenses are expiring, and

''(B) after receiving from the Secretary (or such agency) a list of physicians under paragraph (4)(B), the Board complies with paragraph (5).

''(4) IDENTIFICATION BY SECRETARY OF RELEVANT PHYSICIANS.—After receiving data under paragraph (3)(A) from a Board of Medical Examiners, the Secretary (or the agency designated under section 424(b)) shall—

''(A) from among the physicians identified through the data, determine which of such physicians has been the subject of information reported under this part, and the State in which the incidents involved occurred, and

''(B) provide to the Board, through the system under paragraph (1), a list of the physicians who have been such subjects, which list specifies for each physician the States in which the incidents involved occurred.

''(5) REQUEST BY STATE OF INFORMATION ON RELEVANT PHYSICIANS.—For purposes of paragraph (3)(B), a Board of Medical Examiners of a State is complying with this paragraph if, after receiving the list of physicians under paragraph (4)(B), the Board promptly—

(A) identifies which of the physicians has had, for purposes of paragraph (4), an incident in another State, and

(B) requests for the Secretary (or the agency) information reported under this part concerning each of the physicians so identified.''.

SEC. 8. ADDITIONAL PROVISIONS REGARDING ACCESS TO INFORMATION; MISCELLANEOUS PROVISIONS.

(a) ACCESS TO INFORMATION.—Section 427(a) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11137(a)) is amended to read as follows:

''(a) ACCESS REGARDING LICENSING, EMPLOYMENT, AND CLINICAL PRIVILEGES.—The Secretary (or the agency designated under section 424(b)) shall, upon request, provide information reported under this part concerning a physician or other licensed health care practitioner to—

''(1) State licensing boards, and

''(2) hospitals and other health services organizations—

''(A) that have entered (or may be entering) into an employment or affiliation relationship with the physician or practitioner, or

''(B) to which the physician or practitioner has applied for clinical privileges or appointment to the medical staff.''.

(b) FEES.—Section 427(b)(4) of the Health Care Quality Improvement Act of 1986 (42

U.S.C. 11137(b)(4)) is amended to read as follows:

''(4) FEES.—In disclosing information under subsection (a) or section 426, the Secretary may impose fees in amounts reasonably related to the costs of carrying out the duties of the Secretary regarding the information reported under this part (including the functions specified in section 424(b) with respect to the information), except that a fee may not be imposed for providing a list under section 425A(d)(4)(B) to any Board of Medical Examiners. Such fees are available to the Secretary (or, in the Secretary's discretion, to the agency designated under section 424(b)) to cover such costs. Such fees remain available until expended.''.

(c) ADDITIONAL DISCLOSURES OF INFORMATION.—Section 427 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11137) is amended by adding at the end the following subsection:

''(e) AVAILABILITY OF INFORMATION TO PUBLIC.—

''(1) IN GENERAL.—Not later than 30 days after the effective date for this subsection under section 11 of the Health Care Quality Improvement Act Amendments of 1996, and every 3 months thereafter, the Secretary shall, except as provided in paragraph (2), make available to the public all information reported under sections 421, 422(a), and 423(b). For such purpose, the information shall be published as a separate document whose principal topic is such information, and in addition the information shall be made available through the method described in paragraph (3).

''(2) LIMITATIONS.—In the case of a physician or other licensed health care practitioner with respect to whom one or more incidents have been reported under sections 421, 422(a), and 423(b), the following applies:

''(A) Information may not be made available under paragraph (1) if, subject to subparagraph (B), the aggregate number of discrete incidents reported under such sections is not more than 2.

''(B) A discrete incident reported under section 421 may not be counted under subparagraph (A) if the payment for the medical malpractice action or claim involved was less than $25,000.

''(C) If the number of discrete incidents counted under subparagraph (A) is 3 or more, the resulting availability of information under paragraph (1) with respect to such practitioner shall include information reported on all the discrete incidents that were so counted. Such availability may not include information on any incident not counted by reason of subparagraph (B).

''(D) Of the information reported under section 421, the following information may not be made available under paragraph (1) (regardless of the number of discrete incidents counted under subparagraph (A) and regardless of the amount of the payments involved):

''(i) The social security account number of the physician or practitioner.

''(ii) Information disclosing the identity of any patient involved in the incidents involved.

''(iii) With respect to information that the Secretary requires under section 421(b)(5) (if any)—

''(I) the home address of the physician or practitioner, and

''(II) the number assigned to the physician or practitioner by the Drug Enforcement Administration.

''(iv) Information not required to be reported under such section.

''(3) USE OF INTERNET.—For purposes of paragraph (1), the method described in this paragraph is to make the information involved available to the public through the telecommunications medium known as the World Wide Web of the Internet. The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall provide for the establishment of a site on such medium, and shall update the information maintained through such medium not less frequently than once every 3 months.

''(4) DISSEMINATION; FEES.—The Secretary shall disseminate each publication under paragraph (1) to public libraries without charge. In providing the publication to other entities, and in making information available under paragraph (3), the Secretary may impose a fee reasonably related to the costs of the Secretary in carrying out this subsection. Such fees are available to the Secretary (or, in the Secretary's discretion, to the agency designated under section 424(b)) to cover such costs. Such fees remain available until expended.''.

(d) CONFORMING AMENDMENTS.—Section 427 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11137) is amended—

(1) in subsection (b)(1), in the first sentence, by striking ''Information reported'' and inserting the following: ''Except for information disclosed under subsection (e), information reported''; and

(2) in the heading for the section, by striking ''**MISCELLANEOUS PROVISIONS**'' and inserting the following: ''**ADDITIONAL PROVISIONS REGARDING ACCESS TO INFORMATION; MISCELLANEOUS PROVISIONS**''.

SEC. 9. OTHER MATTERS.

The Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.) is amended—

(1) by redesignating part C as part D; and

(2) by inserting after part B the following part:

''PART C—OTHER MATTERS REGARDING IMPROVEMENT OF HEALTH CARE QUALITY

''SEC. 428. PROHIBITION AGAINST SETTLEMENT WITHOUT CONSENT OF PRACTITIONER.

''(a) PROHIBITION.—With respect to a physician or other licensed health care practitioner whose acts or omissions are the basis of a medical malpractice action or claim, an entity may not make a payment described in section 421(a)(1) without the written consent of the physician or practitioner, subject to subsection (b).

''(b) EXCEPTIONS.—Subsection (a) shall not apply with respect to a payment by an entity regarding an action or claim, subject to subsection (c)—

''(1) if the payment is made in satisfaction of a judgment in a court of competent jurisdiction,

''(2) if, with respect to the action or claim, the physician or other licensed health care practitioner involved enters a process of alternative dispute resolution, and the process has been concluded or any of the individuals involved has terminated participation in the process,

''(3)(A) the entity delivers directly, or makes a reasonable effort to deliver through the mail, a written notice to the physician or practitioner involved providing the information specified in subsection (c), and

''(B) a 30-day period elapses, at the conclusion of which the entity has a reasonable belief that the physician or practitioner does not object to the payment.

''(c) CRITERIA REGARDING NOTICE.—For purposes of subsection (b)(3) regarding a written notice to a physician or practitioner—

''(1) the notice shall be considered to have been delivered if the notice was delivered to the home or business address of the physician or practitioner, and to the attorney (if any) representing the physician or practitioner in the action or claim involved,

''(2) the notice shall be considered to have been delivered directly if the notice was delivered personally by the entity involved or by an agent of the entity,

''(3) the entity shall be considered to have made a reasonable effort to deliver the notice through the mail if the entity provided the notice through certified mail, with return receipt requested,

''(4) the information specified in this paragraph for the notice is that the entity intends to make the payment involved; that the physician or practitioner has a legal right to prohibit the payment; and that such right expires in 30 days, with a specification of the date on which the right expires, and

''(5) the 30-day period begins on the date on which the notice is delivered directly to the physician or practitioner, or on the seventh day after the date on which the notice is posted, as the case may be.

''(d) CIVIL MONEY PENALTY.—An entity that makes a payment in violation of subsection (a) shall be subject to a civil money penalty of not more than $10,000 for each such payment involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act are imposed and collected under that section.

''SEC. 429. EMPLOYMENT TERMINATION OF PHYSICIAN.

''(a) REQUIREMENT OF ADEQUATE NOTICE AND HEARING.—

''(1) IN GENERAL.—A health services organization may not terminate the employment of a physician, and may not terminate a contract with a physician for the provision of health services, unless adequate notice and hearing procedures have been afforded the physician involved.

''(2) APPLICABILITY.—Section 412(a)(3) applies in lieu of paragraph (1) in the case of an employment termination that is a professional review action. (With respect to the preceding sentence, paragraph (1) does apply to an employment termination that is an action described in subparagraph (A) of section 431(10) or in the other subparagraphs of such section.)

''(b) SAFE HARBOR.—

''(1) IN GENERAL.—A health services organization is deemed to have met the adequate notice and hearing requirement of subsection (a) with respect to the employment of, or a contract of, a physician if the conditions described in paragraphs (2) through (4) are met (or are waived voluntarily by the physician).

''(2) NOTICE OF PROPOSED ACTION.—Conditions under paragraph (1) are that the physician involved has been given notice stating—

''(A)(i) that the health services organization proposes to take action to terminate the employment or contract,

''(ii) reasons for the proposed action,

''(B)(i) that the physician has the right to request a hearing on the proposed action,

''(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

''(C) a summary of the rights in the hearing under paragraph (4).

''(3) NOTICE OF HEARING.—Conditions under paragraph (1) are that, if a hearing is requested on a timely basis under paragraph (2)(B), the physician involved must be given notice stating—

''(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

''(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the health services organization.

''(4) CONDUCT OF HEARING AND NOTICE.—Conditions under paragraph (1) are that, if a hearing is requested on a timely basis under paragraph (2)(B)—

''(A) subject to subparagraph (B), the hearing shall be held (as determined by the health services organization)—

''(i) before arbitrator mutually acceptable to the physician involved and the health services organization,

''(ii) before a hearing officer who is appointed by the organization and who is not in direct economic competition with the physician, or

''(iii) before a panel of individuals who are appointed by the organization and are not in direct economic competition with the physician,

''(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear,

''(C) in the hearing the physician has the right—

''(i) to representation by an attorney or other person of the physician's choice,

''(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

''(iii) to call, examine, and cross-examine witnesses,

''(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

''(v) to submit a written statement at the close of the hearing, and

''(D) upon completion of the hearing, the physician has the right—

''(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

''(ii) to receive a written decision of the health services organization, including a statement of the basis for the decision.

''(c) RULE OF CONSTRUCTION.—A health services organization's failure to meet the conditions described in paragraphs (2) through (4) of subsection (b) shall not, in itself, constitute failure to meet the standards of subsection (a).''.

SEC. 10. DEFINITIONS.

Section 431(6) of the Health Care Quality Improvement Act of 1986, as redesignated by section 3(b)(1) of this Act, is amended by inserting before the period the following: ''(except that such term means an institution described in such paragraph (1) (without regard to such paragraph (7)) if, under applicable State or local law, the institution is permitted to operate without being licensed or otherwise approved as a hospital)''.

SEC. 11. EFFECTIVE DATES.

(a) INCORPORATION OF TEXT OF AMENDMENTS.—The amendments described in this Act are made upon the date of the enactment of this Act.

(b) SUBSTANTIVE EFFECT.—Except as provided in subsection (c)(1) and subsection (d), and except as otherwise provided in this Act—

(1) the amendments made by this Act take effect upon the expiration of the 1-year period beginning on the date of the enactment of this Act; and

(2) prior to the expiration of such period, the Health Care Quality Improvement Act of 1986, as in effect on the day before such date of enactment, continues in effect.

(c) REGULATIONS.—

(1) IN GENERAL.—With respect to the amendments made by this Act, the Secretary of Health and Human Services may issue regulations pursuant to such amendments before the expiration of the period specified in subsection (b)(1), and may otherwise take appropriate action before the expiration of such period to prepare for the responsibilities of the Secretary to the amendments.

(2) ABSENCE OF FINAL RULE.—The final rule for purposes of paragraph (1) may not take effect before the expiration of the period specified in subsection (b)(1), and the absence of such a rule upon such expiration does not affect the provisions of subsection (b).

(d) TRANSITIONAL PROVISIONS REGARDING MALPRACTICE PAYMENTS BY PERSONS.—With respect to the reporting of information under section 421 of the Health Care Quality Improvement Act of 1986, the following applies:

(1) The requirement of reporting by persons under section 421(a)(1) of such Act (as amended by section 3(a) of this Act) takes effect 180 days after the date of the enactment of this Act.

(2) The requirement of reporting by persons applies to payments under such section 421(a)(1) made before, on, or after such date of enactment.

(3)(A) The information received by the Secretary of Health and Human Services on or before August 27, 1993, pursuant to regulations requiring reports from persons (in addition to reports from entities) shall be maintained in the same manner as the information was maintained prior to such date, and shall be available in accordance with the regulations in effect under such Act prior to such date (which regulations remain in effect unless a provision of this Act takes effect pursuant to this section and requires otherwise).

(B) Subparagraph (A) takes effect on the date of the enactment of this Act.

S. 2005

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

SECTION 1. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the ''Patient Communications Protection Act of 1996''.

(b) FINDINGS.—Congress finds the following:

(1) Patients need access to all relevant information to make appropriate decisions, with their physicians, about their health care.

(2) Restrictions on the ability of physicians to provide full disclosure of all relevant information to patients making health care decisions violate the principles of informed consent and practitioner ethical standards.

(3) The offering and operation of health plans affect commerce among the States. Health care providers located in one State serve patients who reside in other States as well as that State. In order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in one State as well as those operating among the several States.

SEC. 2. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) IN GENERAL.—

(1) PROHIBITION OF CERTAIN PROVISIONS.—Subject to paragraph (2), an entity offering a health plan (as defined in subsection (d)(2)) may not include any provision that prohibits or restricts any medical communication (as defined in subsection (b)) as part of—

(A) a written contract or agreement with a health care provider,

(B) a written statement to such a provider, or

(C) an oral communication to such a provider.

''(2) CONSTRUCTION.—Nothing in this section shall be construed as preventing an entity from exercising mutually agreed upon terms and conditions not inconsistent with paragraph (1), including terms or conditions requiring caregivers to participate in, and cooperate with, all programs, policies, and procedure developed or operated by the person, corporation, partnership, association, or other organization to ensure, review, or improve the quality of health care.

(3) NULLIFICATION.—Any provision described in paragraph (1) is null and void.

(b) MEDICAL COMMUNICATION DEFINED.—In this section, the term ''medical communication'' means a communication made by a health care provider with a patient of the provider (or the guardian or legal representative of such patient) with respect to the patient's physician or mental condition or treatment options.

(c) ENFORCEMENT THROUGH IMPOSITION OF CIVIL MONEY PENALTY.—

(1) IN GENERAL.—Any entity that violates paragraph (1) of subsection (a) shall be subject to a civil money penalty of up to $15,000 for each violation. No such penalty shall be imposed solely on the basis of an oral communication unless the communication is part of a pattern or practice of such communications and the violation is demonstrated by a preponderance of the evidence.

(2) PROCEDURES.—The provisions of subsections (c) through (l) of section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) shall apply to civil money penalties under paragraph (1) in the same manner as they apply to a penalty or proceeding under section 1128A(a) to a penalty or proceeding under section 1128A(a) of such Act.

(d) DEFINITIONS.—For purposes of this section:

(1) HEALTH CARE PROVIDER.—The term ''health care provider'' means anyone licensed under State law to provide health care services, including a practitioner such as a nurse anesthetist or chiropractor who is so licensed.

(2) HEALTH PLAN.—The term ''health plan'' means any public or private health plan or arrangement (including an employee welfare benefit plan) which provides, or pays the cost of, health benefits, and includes an organization of health care providers that furnishes health services under a contract or agreement with such a plan.

(3) COVERAGE OF THIRD PARTY ADMINISTRATORS.—In the case of a health plan that is an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974), any third party administrator or other person with responsibility for contracts with health care providers under the plan shall be considered, for purposes of this section, to be an entity offering such health plan.

(e) NON-PREEMPTION OF STATE LAW.—A State may establish or enforce requirements with respect to the subject matter of this section, but only if such requirements are consistent with the Act and are more protective of medical communications than the requirements established under this section.

(g) EFFECTIVE DATE.—Subsection (a) shall take effect 180 days after the date of the enactment of this Act and shall apply to medical communications made on or after such date.

By Mr. HATCH (for himself, Mr. BIDEN, Mr. THURMOND, and Mr. GRASSLEY):

S. 2006. A bill to clarify the intent of Congress with respect to the Federal carjacking prohibition.

THE CARJACKING CORRECTION ACT OF 1996

Mr. HATCH. Mr. President, I rise to introduce the Carjacking Correction Act of 1996. This bill adds an important clarification to the Federal carjacking statute, which is to provide that a rape committed during a carjacking should be considered a serious bodily injury.

I am pleased to be joined in this effort by the ranking member of the Judiciary Committee, Senator BIDEN. He

has long been a leader in addressing the threat of violence against women, and our partnership in enacting the Violence Against Women Act is evidence of strong bipartisan outrage at every incident of assault or domestic violence.

This correction to the law is necessitated by the fact that at least one court has held that under the Federal carjacking statute, rape would not constitute a serious bodily injury. Few crimes are as brutal, vicious, and harmful to the victim than rape. Yet, under this interpretation, the sentencing enhancement for such injury may not be applied to a carjacker who brutally rapes his victim.

In my view, Congress should act now to clarify the law in this regard. The bill we introduce today would do this by specifically including rape as serious bodily injury under the statute.

I want to thank Representative JOHN CONYERS, the ranking member of the House Judiciary Committee, who brought this matter to my attention and is leading the effort in the House for passage of this legislation.

I urge my colleagues to support swift passage of this bill.

By Mr. DASCHLE (for himself, Mr. ROCKEFELLER, Mr. KERRY, Mr. WELLSTONE, Ms. MIKULSKI, Mr. BYRD, Mr. DODD, Mr. CONRAD, Mr. INOUYE, Mr. PELL, Mr. SIMON, Mr. FEINGOLD, Mr. BREAUX, Mrs. BOXER, Mr. DORGAN, Mrs. FEINSTEIN, Mr. GLENN, Mr. HARKIN, Mr. ROBB, and Mr. KENNEDY):

S. 2008. A bill to amend title 38, United States Code, to provide benefits for certain children of Vietnam veterans who are born with spina bifida, and for other purposes; to the Committee on Veterans Affairs.

THE AGENT ORANGE BENEFITS ACT OF 1996

Mr. DASCHLE. Mr. President, today, with 19 of my colleagues, I am introducing the Agent Orange Benefits Act of 1996. This legislation is an important step toward easing the burden of innocent, indirect victims of our country's use of agent orange during the Vietnam war. The bill would extend health care and related benefits, including a monthly monetary allowance, to Vietnam veterans' children suffering from spina bifida—a serious neural tube birth defect that requires lifelong care.

This bill is a necessary followup to the Agent Orange Act of 1991, which I coauthored with Senators KERRY and Cranston and Representative LANE EVANS and which unanimously passed the Senate. Among other things, the Agent Orange Act required the Department of Veterans Affairs [VA] to contract with the Institute of Medicine [IOM], which is part of the National Academy of Sciences [NAS], to conduct a scientific review of all evidence pertaining to exposure to agent orange and other herbicides used in Vietnam and the subsequent occurrence of disease and other health-related conditions. The law required an initial report, which was issued by NAS in 1993, followed by biennial updates for 10 years. The first update was published by NAS last March.

In accordance with the law, Vietnam veterans are not required to prove exposure to agent orange; the law presumes that all military personnel who served in Vietnam were exposed to agent orange. The Secretary is to provide presumptive disability compensation for diseases suffered by Vietnam veterans whenever he determines, based on all credible evidence, including the congressionally mandated NAS reports, that a positive association exists between exposure and the occurrence of such diseases in humans. For purposes of this law, a positive association must be found to exist whenever credible evidence for an association is equal to or outweighs the credible evidence against the association.

We have been struggling for decades to provide compensation and health care for Vietnam veterans—and, if warranted, their children—for health problems associated with exposure to agent orange. Since 1985, Vietnam veterans have been eligible for free VA health care for conditions believed to be related to exposure to agent orange. Vietnam veterans are also eligible for presumptive disability compensation for several diseases, including chloracne and various cancers, associated with exposure to agent orange or other herbicides used in Vietnam. Most recently, in response to the March NAS report, the Secretary of Veterans Affairs awarded service-connected disability compensation for prostate cancer and acute and subacute peripheral neuropathy.

An area of key concern to Vietnam veterans has been what they believe to be a high rate of birth defects in the children born to them since their service in Vietnam. The Agent Orange Act of 1991 specifically mandated that the area of reproductive disorders and birth defects be given special attention to determine whether or not compensatory action is warranted. The March NAS report showed new evidence suggesting a link between exposure to agent orange and the occurrence of spina bifida in Vietnam veterans' children. The report also noted that there is growing evidence, though not as strong as the evidence on spina bifida at this point, suggestive of an increase in other birth defects among Vietnam veterans' children.

In response to the NAS report, the Secretary of Veterans Affairs assembled an interdepartmental task force, which consulted with interested veterans' service organizations and experts in spina bifida, to review the NAS findings and make policy recommendations to the Secretary.

In May, the Secretary delivered to the President several policy recommendations based on the VA's review of the NAS report. These included recommendations to add prostate cancer and acute and subacute peripheral neuropathy to the list of presumptive diseases, and, if authority were granted, to treat spina bifida in veterans' children in the same manner. The VA does not currently have the authority to provide benefits to veterans' children. Subsequently, President Clinton announced that the administration would propose legislation to provide an appropriate remedy for Vietnam veterans' children who suffer from spina bifida. This bill reflects that effort.

Clearly, the Government's responsibility does not end once veterans return from war. Effects of combat, even those passed down through reproductive disorders, are a direct result of our decisions to place our Nation's men and women in harm's way. We have a moral responsibility to help veterans whose children suffer from spina bifida and to meet those children's health care needs.

It should be noted that spina bifida is a devastating, irreversible birth defect resulting from the failure of the spine to properly close early in pregnancy. It requires lifelong medical treatment, and the cost of caring for a child with spina bifida can be financially devastating for families. While spina bifida affects approximately one of every 1,000 newborns in the United States, a study of Vietnam veterans that was included in the NAS report showed three spina bifida cases in a group of only 792 infants of Vietnam veterans—a statistically significant result.

The Agent Orange Benefits Act of 1996 would provide health care, limited vocational rehabilitation, and a monthly stipend to Vietnam veterans' children with spina bifida based on the severity of each child's condition. It includes the provision of essential medical care and case management services to coordinate health and social services for the child.

Unfortunately, the NAS report confirmed what Vietnam veterans have long feared: the Vietnam war continues to claim innocent victims. Nothing can erase the physical and psychological wounds of the war, but, by providing limited benefits to affected children, the Agent Orange Benefits Act of 1996 will allow us to heal some of the lingering scars from Vietnam.

The NAS report also serves as a valuable reminder that the impact of any war is felt decades beyond the final shots. Just as reproductive disorders and birth defects in their children have been among Vietnam veterans' greatest health concerns, health problems in their children is of great concern to veterans who served in the Gulf war. We must be prepared to learn from the scientific effort on agent orange and apply these lessons to the effort to discover the true health effects of environmental hazards on the men and women who served in the Gulf and on their children. Based on the NAS report's findings related to spina bifida in the children of Vietnam veterans,

the VA is establishing a reproductive outcomes research center to investigate potential environmental hazards of military service. I look forward to seeing those efforts come to fruition, and I am hopeful they will help us provide answers to the many outstanding questions in this area.

I applaud the President and Secretary Jesse Brown, along with my colleagues who have been committed to this fight for years, for working together to develop a proposal that adequately addresses the needs of these children and their families, and for providing modest compensation for a wrong that can never fully be righted.

With the passage of this legislation, we can begin to fulfill our promise to these most innocent victims and their families. Vietnam veterans' families have suffered for decades and now live with the pain of knowing that their military service may have jeopardized the health and welfare of their children. The very least we can do is ease their burden by providing this limited assistance and care.

Mr. President, I ask unanimous consent that the text of the bill, a summary of the bill, a letter of support from the administration, and a table from the NAS report that explains the four-tiered classification system for agent orange-related illnesses, be printed in the RECORD.

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

S. 2008

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

SECTION 1. REFERENCES TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

SEC. 2. BENEFITS FOR THE CHILDREN OF VIETNAM VETERANS WHO ARE BORN WITH SPINA BIFIDA.

(a) SHORT TITLE.—This section may be cited as the ''Agent Orange Benefits Act of 1996.''

(b) ESTABLISHMENT OF NEW CHAPTER 18.—Part II is amended by inserting after chapter 17 the following new chapter:

''CHAPTER 18—BENEFITS FOR THE CHILDREN OF VIETNAM VETERANS WHO ARE BORN WITH SPINA BIFIDA

SEC. ''1801. PURPOSE.

''The purpose of this chapter is to provide for the special needs of certain children of Vietnam veterans who were born with the birth defect spina bifida, possibly as the result of the exposure of one or both parents to herbicides during active service in the Republic of Vietnam during the Vietnam era, through the provision of health care, vocational training, and monetary benefits.

''SEC. 1802. DEFINITIONS.

''For the purposes of this chapter—

''(1) The term 'child' means a natural child of a Vietnam veteran, regardless of age or marital status, who was conceived after the date on which the veteran first entered the Republic of Vietnam during the Vietnam era.

''(2) The term 'Vietnam veteran' means a veteran who, during active military, naval, or air service, served in the Republic of Vietnam during the Vietnam era.

''(3) The term 'spina bifida' means all forms of spina bifida other than spina bifida occulta.

''SEC. 1803. HEALTH CARE.

''(a) In accordance with regulations the Secretary shall prescribe, the Secretary shall provide such health care under this chapter as the Secretary determines is needed to a child of a Vietnam veteran who is suffering from spina bifida, for any disability associated with such condition.

''(b) The Secretary may provide health care under this section directly or by contract or other arrangement with a health care provider.

''(c) For the purposes of this section—

''(1) the term 'health care' means home care, hospital care, nursing home care, outpatient care, preventive care, habilitative and rehabilitative care, case management, and respite care, and includes the training of appropriate members of a child's family or household in the care of the child and provision of such pharmaceuticals, supplies, equipment, devices, appliances, assistive technology, direct transportation costs to and from approved sources of health care authorized under this section, and other materials as the Secretary determines to be necessary.

''(2) the term 'health care provider' includes, but is not limited to, specialized spina bifida clinics, health-care plans, insurers, organizations, institutions, or any other entity or individual who furnishes health care services that the Secretary determines are covered under this section.

''(3) the term 'home care' means outpatient care, habilitative and rehabilitative care, preventive health services, and health-related services furnished to an individual in the individual's home or other place of residence.

''(4) the term 'hospital care' means care and treatment for a disability furnished to an individual who has been admitted to a hospital as a patient.

''(5) the term 'nursing home care' means care and treatment for a disability furnished to an individual who has been admitted to a nursing home as a resident.

''(6) the term 'outpatient care' means care and treatment of a disability, and preventive health services, furnished to an individual other than hospital care or nursing home care.

''(7) the term 'preventive care' means care and treatment furnished to prevent disability or illness, including periodic examinations, immunizations, patient health education, and such other services as the Secretary determines are necessary to provide effective and economical preventive health care.

''(8) the term 'habilitative and rehabilitative care' means such professional, counseling, and guidance services and treatment programs (other than vocational training under section 1804 of this title) as are necessary to develop, maintain, or restore, to the maximum extent, the functioning of a disabled person.

''(9) the term 'respite care' means care furnished on a intermittent basis in a Department facility for a limited period to an individual who resides primarily in a private residence when such care will help the individual to continue residing in such private residence.

''SEC. 1804. VOCATIONAL TRAINING.

''(a) Pursuant to such regulations as the Secretary may prescribe, the Secretary may provide vocational training under this section to a child of a Vietnam veteran who is suffering from spina bifida if the Secretary determines that the achievement of a vocational goal by such child is reasonably feasible.

''(b)(1) If a child elects to pursue a program of vocational training under this section, the program shall be designed in consultation with the child in order to meet the child's individual needs and shall be set forth in an individualized written plan of vocational rehabilitation.

''(2)(A) Subject to subparagraph (B) of this paragraph, a vocational training program under this subsection shall consist of such vocationally oriented services and assistance, including such placement and postplacement services and personal and work adjustment training, as the Secretary determines are necessary to enable the child to prepare for and participate in vocational training or employment.

''(B) A vocational training program under this subsection—

''(i) may not exceed 24 months unless, based on a determination by the Secretary that an extension is necessary in order for the child to achieve a vocational goal identified (before the end of the first 24 months of such program) in the written plan formulated for the child, the Secretary grants an extension for a period not to exceed 24 months;

''(ii) may not include the provision of any loan or subsistence allowance or any automobile adaptive equipment; and

''(iii) may include a program of education at an institution of higher learning only in a case in which the Secretary determines that the program involved is predominantly vocational in content.

''(c)(1) A child who is pursuing a program of vocational training under this section who is also eligible for assistance under a program under chapter 35 of this title may not receive assistance under both of such programs concurrently but shall elect (in such form and manner as the Secretary may prescribe) under which program to receive assistance.

''(2) The aggregate period for which a child may receive assistance under this section and chapter 35 of this title may not exceed 48 months (or the part-time equivalent thereof).

''SEC. 1805. MONETARY ALLOWANCE.

''(a) The Secretary shall pay a monthly allowance under this chapter to any child of a Vietnam veteran for disability resulting from spina bifida suffered by such child.

''(b) The amount of the allowance paid under this section shall be based on the degree of disability suffered by a child as determined in accordance with such schedule for rating disabilities resulting from spina bifida as the Secretary may prescribe. The Secretary shall, in prescribing the rating schedule for the purposes of this section, establish three levels of disability upon which the amount of the allowance provided by this section shall be based. The allowance shall be $200 per month for the lowest level of disability prescribed, $700 per month for the intermediate level of disability prescribed, and $1,200 per month for the highest level of disability prescribed.

''(c)(1) Whenever there is an increase in benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.) as a result of a determination under section

215(i) of such Act (42 U.S.C. 415(i)), the Secretary shall, effective on the date of such increase in benefit amounts, increase each rate of allowance under this section, as such rates were in effect immediately prior to the date of such increase in benefits payable under title II of the Social Security Act, by the same percentage as the percentage by which such benefit amounts are increased.

''(2) Whenever there is an increase in the rates of the allowance payable under this section, the Secretary shall publish such rates in the Federal Register.

''(3) Whenever such rates are so increased, the Secretary may round such rates in such manner as the Secretary considers equitable and appropriate for ease of administration.

''(d) Notwithstanding any other provision of law, receipt by a child of an allowance under this section shall not impair, infringe, or otherwise affect the right of such child to receive any other benefit to which the child may otherwise be entitled under any law administered by the Secretary, nor shall such receipt impair, infringe, or otherwise affect the right of any individual to receive any benefit to which he or she is entitled under any law administered by the Secretary that is based on the child's relationship to such individual.

''(e) Notwithstanding any other provision of law, the allowance paid to a child under this section shall not be considered income or resources in determining eligibility for or the amount of benefits under any Federal or federally assisted program.

''SEC. 1806. EFFECTIVE DATE OF AWARDS.

''Effective date for an award for benefits under this chapter shall be fixed in accordance with the facts found, but shall not be earlier than the date of receipt of application therefor.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective on October 1, 1996.

(d) CLERICAL AMENDMENT.—The tables of chapters before part I and at the beginning of part II are each amended by inserting after the item referring to chapter 17 the following new item:

''18. Benefits for children of Vietnam veterans who are born with spina bifida ..... 1801''.

SEC. 3. CLARIFICATION OF ENTITLEMENT FOR BENEFITS FOR DISABILITY RESULTING FROM TREATMENT OR VOCATIONAL SERVICES PROVIDED BY DEPARTMENT OF VETERANS AFFAIRS.

(a) Section 1151 is amended—

(1) by striking out the first sentence and inserting in lieu thereof the following:

''(a) Compensation under this chapter and dependency and indemnity compensation under chapter 13 of this title shall be awarded for qualifying additional disability to or death of a veteran in the same manner as if such additional disability or death were service-connected. For purposes of this section, additional disability or death is qualifying only if it was not the result of the veteran's willful misconduct and—

''(1) it was caused by hospital care, medical or surgical treatment, or examination furnished the veteran under any law administered by the Secretary, either by a Department employee or in a Department facility as defined in section 1701(3)(A) of this title, where the additional disability or death proximately resulted—

''(A) from carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault on the part of the Department in furnishing the hospital care, medical or surgical treatment, or examination; or

''(B) from an event not reasonably foreseeable; or

''(2) it was incurred as a proximate result of the provision of training and rehabilitation services by the Secretary (including by a service-provider used by the Secretary for such purpose under section 3115 of this title) as part of an approved rehabilitation program under chapter 31 of this title.''; and

(2) in the second sentence—

(A) by redesignating that sentence as subsection (b);

(B) by striking out '', aggravation,'' both places it appears; and

(C) by striking out ''sentence'' and substituting in lieu thereof ''subsection''.

(b) The amendments made by subsection (a) shall govern all administrative and judicial determinations of eligibility for benefits under section 1151 of title 38, United States Code, made with respect to claims filed on or after the date of enactment of this Act, including those based on original applications and applications seeking to reopen, revise, reconsider, or otherwise readjudicate on any basis claims for benefits under section 1151 of that title or predecessor provisions of law.

AGENT ORANGE BENEFITS FOR VIETNAM VETERANS' CHILDREN SUFFERING FROM SPINA BIFIDA

The Agent Orange Act of 1996 would extend health care and related benefits, including a monthly monetary allowance, to Vietnam veterans' children suffering from spina bifida—a serious neural tube birth defect that requires life-long care—provided the children were conceived after the veterans began their service in Vietnam.

BACKGROUND

A March National Academy of Sciences (NAS) report cited new evidence that supports a link between exposure to Agent Orange and the occurrence of spina bifida in children of veterans who served in Vietnam. This report was required by the Agent Orange Act of 1991.

Since 1985, Vietnam veterans have been eligible for free VA health care for conditions believed to be related to exposure to Agent Orange. Veterans' disability compensation for several Agent Orange-related illnesses—including non-Hodgkin's lymphoma, soft-tissue sarcoma, Hodgkin's disease, chloracne, respiratory cancers, and multiple myeloma—has been awarded as a result of either congressional or VA action, some of which was based on a 1993 NAS report. Earlier this year, Secretary Brown and the President, in response to the March NAS report, extended service-connected benefits to veterans suffering from prostate cancer and acute and sub-acute peripheral neuropathy.

Reproductive disorders and birth defects in their children have been among veterans' greatest Agent Orange-related health concerns. This legislation is necessary because, while the VA has recommended that spina bifida in veterans' offspring be service-connected, the VA does not currently have the authority to extend health care or other benefits to children of veterans.

COST

CBO has not yet provided an estimate for this proposal. However, costs would be offset by overturning the *Gardner* case, which would limit the VA's liability for non-malpractice-related injuries occurring in VA facilities. This non-controversial provision was included in Democratic and Republican budget proposals for FY 96. Excess savings would be directed to deficit reduction.

ROLE OF THE NATIONAL ACADEMY OF SCIENCES

The Agent Orange Act of 1991 directed the VA to contract with the National Academy of Sciences to conduct for 10 years biennial, comprehensive evaluations of the scientific and medical information regarding the health effects of exposure to Agent Orange and other herbicides used in Vietnam.

The first report, ''Veterans and Agent Orange: Health Effects of Herbicides Used in Vietnam,'' was published in 1993. It created the following categories to classify the level of association between certain health conditions and exposure to Agent Orange: Category I (''sufficient evidence of an association''); category II (''limited/suggestive evidence of an association''); category III (''inadequate/insufficient evidence to determine whether an association exists''); category IV (''limited/suggestive evidence of NO association'').

Following the 1993 report, the VA began to compensate Vietnam veterans suffering from three diseases in categories I and II that had not been service-connected through previous congressional or administrative action: porphyria cutanea tarda, respiratory cancers, and multiple myeloma.

The 1996 update, which was issued in March, confirmed many of the findings in the 1993 report, and found new evidence to link spina bifida in veterans' children with exposure to Agent Orange. The NAS panel placed ''spina bifida in offspring'' in category II, supporting a connection between birth defects and military service. The NAS report currently places birth defects other than spina bifida in category III.

After reviewing the NAS report and other information, the VA has recommended that all remaining conditions in categories I and II, including spina bifida, be service-connected.

THE SECRETARY OF VETERANS AFFAIRS,
Washington, DC, July 5, 1996.

Hon. CHRISTOPHER S. (KIT) BOND,
Chairman, Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: I am pleased to share with you a copy of legislation we provided earlier today to Senator Daschle. This legislation, the ''Agent Orange Benefits Act of 1996,'' would provide benefits to certain children of Vietnam veterans who are born with the birth defect spinal bifida. Enacting this legislation is a Presidential priority.

Under Public Law 102–4, and with the benefit of a National Academy of Sciences report, I determined that a positive association exists between the exposure of Vietnam veterans to herbicides (such as a Agent Orange) and spinal bifida in their children. In approving this determination, the President promised to submit ''an appropriate remedy'' for these veterans' children. This legislation fulfills that commitment. It provides for health care, vocational training, and monthly monetary allowance for these children.

As set forth in the legislation, the Administration proposes to offset the costs associated with these new benefits with a savings proposal that would effectively reverse the U.S. Supreme Court decision in Gardner v. Brown which held that monthly VA disability compensation must be paid for any additional disability or death attributable to VA medical treatment even if VA was not negligent in providing that care.

Enactment of this legislation is a top Presidential priority. I strongly urge the Senate to include it in the earliest appropriate legislative vehicle.

Thank you for your assistance in ensuring prompt and immediate action on this important legislation.

The Office of Management and Budget has advised that there is no objection from the standpoint of the Administration's program to the presentation of this letter.

Sincerely,

JESSE BROWN.

EXECUTIVE SUMMARY

TABLE 1–1—UPDATED SUMMARY OF FINDINGS IN OCCUPATIONAL, ENVIRONMENTAL, AND VETERANS STUDIES REGARDING THE ASSOCIATION BETWEEN SPECIFIC HEALTH PROBLEMS AND EXPOSURE TO HERBICIDES

Sufficient evidence of an association

Evidence is sufficient to conclude that there is a positive association. That is, a positive association has been observed between herbicides and the outcome in studies in which chance, bias, and confounding could be ruled out with reasonable confidence. For example, if several small studies that are free from bias and confounding show an association that is consistent in magnitude and direction, there may be sufficient evidence for an association. There is sufficient evidence of an association between exposure to herbicides and the following health outcomes: Soft-tissue sarcoma; Non-Hodgkin's lymphoma; Hodgkin's disease; Chlorance.

Limited/suggestive evidence of an association

Evidence is suggestive of an association between herbicides and the outcome but is limited because chance, bias, and confounding could not be ruled out with confidence. For example, at least one high-quality study shows a positive association, but the results of other studies are inconsistent. There is limited/suggestive evidence of an association between exposure to herbicides and the following health outcomes: Respiratory cancers (lung, larynx, trachea); Prostate cancer; Multiple myeloma; Acute and subacute peripheral neuropathy (new disease category); Spina bifida (new disease category); Porphyria cutanea tarda (category change in 1996).

Inadequate/insufficient evidence to determine whether an association exists

The available studies are of insufficient quality, consistency, or statistical power to permit a conclusion regarding the presence or absence of an association. For example, studies fail to control for confounding, have inadequate exposure assessment, or fail to address latency. There is inadequate or insufficient evidence to determine whether an association exists between exposure to herbicides and the following health outcomes: Hepatobiliary cancers; Nasal/nasopharyngeal cancer; Bone cancer; Female reproductive cancers (cervical, uterine, ovarian); Breast cancer; Renal cancer; Testicular cancer; Leukemia; spontaneous abortion; Birth defects (other than spina bifida); Neonatal/infant death and stillbirths; Low birthweight; Childhood cancer in offspring; Abnormal sperm parameters and infertility; cognitive and neuropsychiatric disorders; Motor/coordination dysfunction; Chronic peripheral nervous system disorders; Metabolic and digestive disorders (diabetes, changes in liver enzymes, lipid abnormalities, ulcers); Immune system disorders (immune suppression and autoimmunity); Circulatory disorders; Respiratory disorders; Skin cancer (category change in 1996).

Limited/suggestive evidence of no association

Several adequate studies, covering the full range of levels of exposure that human beings are known to encounter, are mutually consistent in not showing a positive association between exposure to herbicides and the outcome at any level of exposure. A conclusion of ''no association'' is inevitably limited to the conditions, level of exposure, and length of observation covered by the available studies. In addition, the possibility of a very small elevation in risk at the levels of exposure studied can never be excluded. There is limited/suggestive evidence of no association between exposure to herbicides and the following health outcomes: Gastrointestinal tumors (stomach cancer, pancreatic cancer, colon cancer, rectal cancer); Bladder cancer; Brain tumors.

Note: ''Herbicides'' refers to the major herbicides used in Vietnam: 2,4–D (2,4-dichlorophenoxyacetic acid); 2,4,5-T (2,4,5-trichlorophenoxyacetic acid) and its contaminant TCDD (2,3,7,8-tetrachlorodibenzo-*p*-dioxin); cacodylic acid; and picloram. The evidence regarding association is drawn from occupational and other studies in which subjects were exposed to a variety of herbicides and herbicide components.

Mr. BYRD. Mr. President, I am proud to cosponsor the legislation introduced by the able Democratic leader, Senator DASCHLE, which provides health care and assistance to the children of Vietnam veterans who suffer from spina bifida. This legislation provides the needed authority for the Department of Veterans Affairs to treat these children for their service-connected disabilities arising from their father's exposure to agent orange during the Vietnam conflict. This is an unprecedented but appropriate action, since scientific research is now sufficiently sophisticated to allow us to understand the effects of toxic exposures on ourselves and on future generations.

As a result of the Agent Orange Act of 1991, the Department of Veterans Affairs and the National Academy of Sciences have at regular intervals reviewed the ongoing research on Agent Orange exposure. The report update issued this spring found ''limited/suggestive evidence'' linking the birth defect spina bifida to agent orange exposure. The report notes that all three epidemiologic studies reviewed suggest an association between herbicide exposure and increased risk of spina bifida in offspring. It further notes that in contrast to most other diseases, for which the strongest data have been from occupationally exposed workers, these studies focused on Vietnam veterans. All the studies were judged to be of relatively high quality, although they did suffer from some methodologic limitations.

On the basis of this finding, Secretary Jesse Brown recommended that a service connection be granted to Vietnam veterans' children with spina bifida. It is the right decision, and I applaud him for it. The research and the legislation are long overdue for families that have been struggling for some twenty years. Some one has observed that ''procrastination is the thief of time.'' These children and their families have already lost time, lost long years of doubt and wondering, of financial hardship that they bore alone because the government procrastinated in investigating and acknowledging its role in this tragedy. The legislation introduced today by Senator DASCHLE attempts to correct that injustice, and I commend him for it. The poet Edward Young (1683–1796) has said: ''Be wise today; 'tis madness to defer.'' Support this legislation, take responsibility for the tragic aftermath of our involvement in Vietnam, and take care of these children.

Mr. KERRY. Mr. President, I am pleased to join my distinguished colleague from South Dakota, Senator DASCHLE, in cosponsoring the Agent Orange Benefits Act of 1996. This bill takes another crucial step forward in repaying our debt to those who have served their country and are still suffering as a result of their service in Vietnam many years ago. In May, President Clinton announced that legislation would be proposed to aid Vietnam veterans' children who suffer from the disease spina bifida. This bill fulfills that commitment by recognizing and accepting natural responsibility for one of the serious health care needs of veterans' families that stem from the tragic effects of agent orange.

Senator DASCHLE and I and many others have worked for the past decade to try to bring to a fair and just resolution the questions surrounding agent orange and the effects it has had on the men and women who faithfully served this country. I know that there is still controversy about the effects of agent orange. There may always be controversy, just as there may always be controversy about the Vietnam war itself. But we must set aside the controversy—or put it behind us—to enable suffering children to receive the care and treatment they need when that suffering can be followed back to a service person's exposure to agent orange.

After years of hard work, I believe we have reached an acceptable consensus on the effects of agent orange through numerous studies—and independent scientific reviews of the many studies—which have been made on the effects of this dangerous chemical that contains deadly dioxin. I might add that it has been 30 years since agent orange was sprayed in Vietnam and we must stop debating over the bias of each individual analyzing the information. As I said back in May of 1988, ''It is offensive to veterans to tell them that there is not enough 'scientific evidence' to justify compensation * * * The evidence is in their own bodies, and even worse, in the bodies of their children.''

We have made great strides in reaching a consensus in some areas of health care for Vietnam veterans. Since 1985, Vietnam veterans have been eligible for free health care from the Veterans Administration for conditions that are related to exposure to agent orange. Veterans' disability compensation has been awarded to veterans affected by several agent orange-related illnesses including non-Hodgkins lymphoma, soft tissue sarcoma, Hodgkin's disease, chloracne, respiratory cancers, multiple myeloma, and, most recently, prostate cancer and acute and subacute peripheral neuropathy.

Today, Mr. President, we are addressing a particularly heinous effect of agent orange—an effect that unfortunately will carry the legacy of the Vietnam war to yet another generation. The bill we are introducing today would extend health care and related

benefits to children of Vietnam veterans who suffer from spina bifida, a serious neural tube birth defect that requires life-long care—provided, of course, the children were conceived after the veterans began their service in Vietnam.

The National Academy of Sciences released a report in March of this year, citing new evidence supporting the link between exposure to agent orange and the occurrence of spina bifida in children of veterans who served in Vietnam. This report, Mr. President, warrants our action.

Both the President and the Secretary of Veterans Affairs, Jesse Brown, have asked that spina bifida in veterans' offspring be considered service connected. However, the VA currently does not have the authority to extend the health care and other related benefits to these children that they so greatly need. This bill will grant the VA the necessary authority to finally start providing needed care to these children who are suffering.

Mr. President, these are children whose misery stems from physical damage caused to one of their parents who was fighting for this country in Vietnam. We should do no less than provide them with the care and treatment they need. We must not make some of the children of our Vietnam veterans the last victims of the Vietnam war. I urge my colleagues to support this bill.

By Mr. ASHCROFT:

S.J. Res. 58. A joint resolution proposing an amendment to the Constitution of the United States relative to granting power to the States to propose constitutional amendments; to the Committee on the Judiciary.

STATE-INITIATED CONSTITUTIONAL AMENDMENT JOINT RESOLUTION

Mr. ASHCROFT. Mr. President, I rise this afternoon to talk about first principles, about fundamental truths, about a battle that helped give birth to a nation. The amendment I have sent to the desk represents an effort to restore the federal system conceived by the Framers over two centuries ago by giving the States the capacity to initiate constitutional reforms.

In considering my remarks earlier this morning, I was reminded of a trip my family and I made several years ago when I was Governor of the State of Missouri. In 1989, we were extended an opportunity to visit the site where the Continental Army, led by Gen. Atemas Ward, fought to seize Bunker Hill on the Charlestown peninsula.

It was a moving experience. One cannot help but recall the monument, dedicated by Daniel Webster, that stands as a tribute to the lives that were lost. I recommend the trip to both Members and the viewing audience alike.

I must confess, however, that the expansive field you will find fails to fully capture the raw carnage that visited Bunker Hill in June of 1775. Close to 2,000 lives were lost in less than 2 hours. And, while General Howe's regulars were masters of the peninsula at the end of the day, the casualties they sustained were more than twice that of the American militia.

Historians, Mr. President, have come to record Bunker Hill as a bloody if indecisive contest, an early salvo in a conflict which Dr. Jonathan Rossie has characterized as a ''glorious cause.'' Glorious, if warfare can be called that, because the issue that animated the colonists that day was freedom, for themselves and generations yet to come; God, courage, and posterity were their invisible allies.

And as I reflect on those events, I cannot help but wonder what has become of the first principles for which our forefathers fought? What has become of the fundamental truths that compelled those great patriots up that hill, bayonets flashing, voices shouting ''push on, push on.''

For that battle outside of Boston helped give birth to a nation, a constitutional republic that was the first of its kind. A system where, as Madison suggested in ''Federalist'' No. 46, ''the federal and state governments are in fact but different agents of the people, constituted with different powers, and designed for different purposes.''

Unfortunately, Mr. President, Madison's vision is being lost. Judicial activism, Federal intervention, and past constitutional reforms have led to a gradual erosion of State power. In particular, the passage of the 16th and 17th amendments have had a disastrous effect on the capacity of the States to check Federal expansion. The former, establishing the income tax, gave the central government a virtually unlimited spending power, while the latter, providing for the direct election of Senators, worked to undermine the Senate's contemplated role as the protector of State autonomy.

One of the single, greatest challenges we face as a country and as a Congress, is addressing the constitutional imbalance that has arisen from the convergence of these trends. Allowing the States to initiate amendments on issues ranging from a balanced budget to congressional term limits would do just that.

The operation of the proposed amendment is as simple as its intent is clear. Whenever two-thirds of the States propose an amendment, in identical terms, it is submitted to the Congress for review. If two-thirds of both Houses fail to disapprove the amendment during the session in which it is received, the proposal is then forwarded to the States for ratification by three-fourths of the legislatures thereof.

If adopted, the proposed amendment would have tremendous value on several different fronts. First, it would force the cold corridors of power on the Potomac to respond to the will of the people—no more mandates, no more deficits, no more careerist in the Congress. Similarly, the amendment would allow the States to once again share the constitutional agenda of the Nation. And finally, it would provide a potential for addressing the problems of federalism in a context which could conceivably augment State power.

In Gregory versus Ashcroft, Justice O'Connor opined that ''in the tension between Federal and State power lies the promise of liberty.'' And so it does. I believe reconstituting the federal system of which Madison wrote must become conservatives' new glorious cause. This amendment is a measured, moderate step toward achieving that end. For these reasons, Mr. President, I beg its adoption.

ADDITIONAL COSPONSORS

S. 334

At the request of Mr. MCCONNELL, the name of the Senator from Oklahoma [Mr. INHOFE] was added as a cosponsor of S. 334, a bill to amend title I of the Omnibus Crime Control and Safe Streets Act of 1968 to encourage States to enact a Law Enforcement Officers' Bill of Rights, to provide standards and protection for the conduct of internal police investigations, and for other purposes.

S. 729

At the request of Mr. BAUCUS, the name of the Senator from Minnesota [Mr. GRAMS] was added as a cosponsor of S. 729, a bill to provide off-budget treatment for the Highway Trust Fund, the Airport and Airway Trust Fund, the Inland Waterways Trust Fund, and the Harbor Maintenance Trust Fund, and for other purposes.

S. 1744

At the request of Mr. INOUYE, the name of the Senator from West Virginia [Mr. ROCKEFELLER] was added as a cosponsor of S. 1744, a bill to permit duty free treatment for certain structures, parts, and components used in the Gemini Telescope Project.

S. 1838

At the request of Mr. FAIRCLOTH, the name of the Senator from Oklahoma [Mr. INHOFE] was added as a cosponsor of S. 1838, a bill to require the Secretary of the Treasury to mint and issue coins in commemoration of the centennial anniversary of the first manned flight of Orville and Wilbur Wright in Kitty Hawk, North Carolina, on December 17, 1903.

S. 1873

At the request of Mr. INHOFE, the name of the Senator from Montana [Mr. BURNS] was added as a cosponsor of S. 1873, a bill to amend the National Environmental Education Act to extend the programs under the Act, and for other purposes.

S. 1885

At the request of Mr. INHOFE, the names of the Senator from Tennessee [Mr. FRIST] and the Senator from Hawaii [Mr. INOUYE] were added as cosponsors of S. 1885, a bill to limit the liability of certain nonprofit organizations that are providers of prosthetic devices, and for other purposes.