By Ms. SNOWE:

S. 2599. A bill to amend title 38, United States Code, to establish a presumption of service-connection for certain veterans with Hepatitis C, and for other purposes; to the Committee on Veterans Affairs.

By Mr. HATCH:

S. 2600. A bill to amend section 402 of the Controlled Substances Act to reform the civil remedy provisions relating to record-keeping violations; to the Committee on the Judiciary.

By Mr. KYL:

S. 2601. A bill to provide block grant options for certain education funding; to the Committee on Labor and Human Resources.

S. 2602. A bill to amend the Internal Revenue Code of 1986 to allow a credit against income tax for expenses of attending elementary and secondary schools and for contributions to charitable organizations which provide scholarships for children to attend such schools; to the Committee on Finance.

By Mr. BAUCUS (for himself, Mr. DASCHLE, Mr. INOUYE, Mr. BINGAMAN, Mr. JOHNSON, and Mr. CONRAD):

S. 2603. A bill to promote access to health care services in rural areas; to the Committee on Finance.

By Mr. TORRICELLI:

S. 2604. A bill to provide demonstration grants to local educational agencies to enable the agencies to extend time for learning and the length of the school year; to the Committee on Labor and Human Resources.

By Mr. TORRICELLI (for himself and Mr. LAUTENBERG):

S. 2605. A bill to amend the Public Health Service Act to provide for the establishment of a national program of traumatic brain injury and spinal cord injury registries; to the Committee on Labor and Human Resources.

By Mr. ASHCROFT:

S. 2606. A bill to amend the Agricultural Trade Act of 1978 to require the President to report to Congress on any selective embargo on agricultural commodities, to provide a termination date for the embargo, to provide greater assurances for contract sanctity, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. DEWINE (for himself, Mr. ROCKEFELLER, Ms. LANDRIEU, and Mr. CHAFEE):

S. 2607. A bill to improve the administrative efficiency and effectiveness of the Nation's abuse and neglect courts and the quality and availability of training for judges, attorneys, and volunteers working in such courts, and for other purposes consistent with the Adoption and Safe Families Act of 1997; to the Committee on Finance.

By Mr. KYL (by request):

S. 2608. A bill to approve a mutual settlement of the Water Rights of the Gila River Indian Community and the United States, on behalf of the Community and the Allottees, and Phelps Dodge Corporation, and for other purposes; to the Committee on Indian Affairs.

By Mr. BENNETT (for himself and Mr. MACK):

S. 2609. A bill to ensure confidentiality with respect to medical records and health care-related information, and for other purposes; to the Committee on Labor and Human Resources.

By Mr. LIEBERMAN (for himself, Mr. DODD, Mr. KERRY, Mr. LAUTENBERG, and Mr. TORRICELLI):

S. 2610. A bill to amend the Clean Air to repeal the grandfather status for electric utility units; to the Committee on Environment and Public Works.

By Mr. ROTH (for himself, Mr. LIEBERMAN, and Mr. MACK):

S. 2611. A bill to amend title XVIII of the Social Security Act to enable medicare beneficiaries to remain enrolled in their chosen medicare health plan; to the Committee on the Judiciary.

By Mr. FORD:

S. 2612. A bill to provide that Tennessee may not impose sales taxes on any goods or services purchased by a resident of Kentucky at Fort Campbell, nor obtain reimbursement for any unemployment compensation claim made by a resident of Tennessee relating to work performed at Fort Campbell; to the Committee on Governmental Affairs.

By Mr. KERREY:

S. 2613. A bill to accelerate the percentage of health insurance costs deductible by self-employed individuals through the use of revenues resulting from an estate tax technical correction; to the Committee on Finance.

By Mr. COATS:

S. 2614. A bill to amend chapter 96 of title 18, United States Code, to enhance the protection of first amendment rights; to the Committee on the Judiciary.

By Mr. MURKOWSKI:

S. 2615. A bill to study options to improve and enhance the protection, management, and interpretation of the significant natural and other resources of certain units of the National Park System in northwest Alaska, to implement a pilot program to better accomplish the purposes for which those units were established by providing greater involvement by Alaska Native communities, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. ROTH (for himself and Mr. MOYNIHAN):

S. 2616. A bill to amend title XVIII of the Social Security Act to make revisions in the per beneficiary and per visit payment limits on payment for health services under the medicare program; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

By Mr. THOMAS (for himself, Mr. KERRY, Mr. SMITH of Oregon, Mr. LIEBERMAN, and Mr. GRAMS):

S. Res. 294. A resolution expressing the sense of the Senate with respect to developments in Malaysia and the arrest of Dato Seri Anwar Ibrahim; to the Committee on Foreign Relations.

By Mr. COATS (for himself, Mr. MCCAIN, and Mr. COVERDELL):

S. Res. 295. A bill to express the sense of the Senate concerning the development of effective methods for eliminating the use of heroin; to the Committee on Labor and Human Resources.

By Mr. KERREY:

S. Res. 296. A resolution expressing the sense of the Senate that, on completion of construction of a World War II Memorial in Area I of the District of Columbia and its environs, Congress should provide funding for the maintenance, security, and custodial and long-term care of the memorial by the National Park Service; considered and agreed to.

By Mr. LOTT (for himself and Mr. DASCHLE):

S. Res. 297. A resolution authorizing testimony and representation of former and current Senate employees and representation of Senator Craig in Student Loan Fund of Idaho, Inc. v. Riley, et al; considered and agreed to.

By Mr. ABRAHAM:

S. Res. 298. A resolution condemning the terror, vengeance, and human rights abuses against the civilian population of Sierra Leone; to the Committee on Foreign Relations.

By Mr. DURBIN (for himself and Mr. MACK):

S. Con. Res. 127. A concurrent resolution recognizing the 50th anniversary of the National Institute of Allergy and Infectious Diseases, and for other purposes; to the Committee on the Judiciary.

By Mr. LEAHY (for himself, Mr. DODD, Mrs. FEINSTEIN, Mr. KERRY, Mrs. MURRAY, Mr. DURBIN, Mr. BINGAMAN, Mr. FEINGOLD, Mr. HARKIN, Mr. BUMPERS, Mr. WELLSTONE, Mr. JEFFORDS, Mrs. BOXER, Mr. KENNEDY, Mr. WYDEN, and Ms. MIKULSKI):

S. Con. Res. 128. A concurrent resolution expressing the sense of Congress regarding measures to achieve a peaceful resolution of the conflict in the state of Chiapas, Mexico, and for other purposes; to the Committee on Foreign Relations.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. TORRICELLI (for himself, Mr. LEAHY, Mr. DEWINE, and Mr. JEFFORDS):

S. 2596. A bill to amend the Federal Agriculture Improvement and Reform Act of 1996 to improve the farmland protection program; to the Committee on Agriculture, Nutrition, and Forestry.

FARMLAND PROTECTION LEGISLATION

● Mr. TORRICELLI. Mr. President, today I introduce legislation which will assist in the critical effort to preserve our nation's most vulnerable farmland. I want to first acknowledge Senator LEAHY's decisive leadership on this issue, and recognize him as the author of the original legislation establishing the Farmland Protection Program in the 1996 Farm Bill. He has been a tireless advocate for this important issue, and I look forward to working closely with him in the future to protect more of our Nation's open spaces.

We have heard a lot during the last decade about the dissolution and destruction of the American Family Farm. Indeed, the family farm is under serious threat of extinction. Today, there are 1,925,300 farms in the United States, the lowest number of farms in our Nation since before the Civil War. The U.S. is losing two acres of our best farmland to development every minute of every day. In my State, New Jersey, we have lost 6,000 farms, or 40 percent of our total, since 1959. This reduction has serious implications for the environment, the economy and our food supply.

The threat comes partially from an anachronistic and unfair inheritance tax that threatens the generational continuity of the family farm and partially from the fact that much of America's farmland is near major cities. As our cities sprawl into neighboring rural areas, our farms are in danger of becoming subdivisions or shopping malls.

Last year I strongly supported a significant reduction in the estate tax to

keep farms in the family, preserve open space and ensure fairness in our tax code. This was an important victory for farmers across the Nation. However, we also need programs like the Farmland Protection Program to reinforce this effort. This critical initiative is designed to protect soil by encouraging landowners to limit conversion of their farmland to non-agricultural uses. It has proven so successful that demand for these grants currently outstrips availability of funds by 900 percent, and the last of its authorized funding was spent during fiscal year 1998.

The legislation I am introducing today with Senators LEAHY, DEWINE and JEFFORDS will provide authorization for additional funding, and ensure the survival of this important program. Our bill will reauthorize the program at $55 million a year through 2002, and will broaden the original legislation to allow non-profit conservation groups to hold these easements. This provision is necessary because some State governments, such as Colorado's, are barred from holding easements by their constitution. This legislation will allow non-profit groups to hold these easements in lieu of the state government and this will broaden participation in the program.

I hope my colleagues are able to support this legislation and allow us to continue building on the success of the past few years, during which we were able to protect nearly 82,000 acres on more than 230 farms.●

By Mr. TORRICELLI. (for himself and Mr. LAUTENBERG):

S. 2598. A bill to require proof of screening for lead poisoning and to ensure that children at highest risk are identified and treated; to the Committee on Finance.

CHILDREN'S LEAD PREVENTION AND INCLUSIVE TREATMENT ACT OF 1998

● Mr. TORRICELLI. Mr. President, today with my colleague from New Jersey, Senator LAUTENBERG, I introduce the ''Children's Lead Prevention and Inclusive Treatment Act of 1998.'' For almost thirty years Congress has focused attention on lead-related issues. In 1971 we first passed the Lead-based Paint Poisoning Prevention Act, and much has been done since that time to identify children with elevated lead levels, to educate parents on the dangers of lead, and to devise means of removing or controlling lead in homes. Over the last 20 years, the removal of lead from gasoline, food canning, children's toys, and other sources has seen a reduction in national population blood lead levels by over 80 percent.

Yet recent studies indicate that we are still not doing enough. While national lead levels have dropped over 80 percent, the numbers for Medicaid children, and poor children overall, are nothing short of disgraceful. Since 1992 the Health Care Financing Administration, at the behest of Congress, has required that Medicaid children be screened for elevated blood-lead levels at least twice before they reach the age of 2. But the Centers for Disease Control and Prevention estimates that nationally, 890,000 children between the ages of one and five have elevated blood lead levels and have never been tested.

Even worse, Mr. President, in a Report to Congress earlier this year, the General Accounting Office reported that almost 79 percent of Medicaid children under two years of age have never been screened! This means that as many as 206,000 Medicaid children between the ages of 1 and 2 have not been screened. Considering that in 1991 the U.S. Public Health Service called for a society-wide effort to eliminate childhood lead poisoning by the year 2011, it is quite apparent that we are not making much progress in reaching that goal.

A subsequent GAO report further identified poor and minority children as being at greatest risk of lead poisoning. GAO reported that the prevalence of elevated blood lead levels in Hispanic children aged 1 through 5 was more than twice that of white children, and for African-American children it was more than five times that of white children. Additionally, children in families below 130 percent of the Federal poverty level had a higher prevalence of elevated blood lead levels than those children above the Federal poverty level. Yet all these children continue to be the very ones falling through the cracks!

That is why, Mr. President, I am introducing this legislation. The Children's Lead PAINT Act promises to be a three-pronged attack on the lead-screening system. First, it will create a ''safety net'' through WIC and Early Start to ensure that high-risk children are screened. A parent enrolling their child in either of these programs must provide proof of screening, within 180 days of enrollment. If a child hasn't been screened, a parent can request WIC or Early Start to perform the test themselves. Additionally, if WIC or Early Start performs the test, Medicaid will be authorized to reimburse the program.

Second, we will be putting teeth into the State's screening obligation, by setting a Minimum number of Screenings a State must perform, or having it face a penalty for failure. Beginning in Fiscal Year 2000, States will be required to screen at least 50 percent of Medicaid children under age 2. This will increase 10 percent each year until it hits 90 percent, where it must remain. If States fail to meet these targets, they stand to lose one percent of their Medicaid funds.

Finally, Mr. President, we will require any Health Care Provider that signs a State Medicaid contract to agree in that contract to comply with the screening requirements, and to provide follow-up services to children who test positive. Although States have been required to perform these screenings, they are not a mandatory requirement of Medicaid health care contracts. Thus, there is no statutory obligation on the part of physicians to perform the tests. This will ensure that doctors perform the tests and that if a child does test positive that an environmental assessment will be done at their home and that follow-up testing and evaluations will be conducted.

I am especially pleased that I have been joined in this fight by two highly regarded national advocacy groups. The Alliance to End Childhood Lead Poisoning, a non-profit public interest organization exclusively dedicated to the elimination of childhood lead poisoning, has publicly endorsed the Lead PAINT Act. Similarly, the Coalition to End Childhood Lead Poisoning, a non-profit parents and victims organization dedicated to educating the public on the dangers of lead poisoning and as well as to eradicating this disease, has also publicly endorsed this legislation.

Mr. President, although we have made great progress in lead poison prevention techniques, first, by banning lead-based paint in homes and more recently by strengthening our home testing system, the GAO report makes it very clear that we are failing to identify those children with lead already in their bodies. It is time we demand accountability. Our children deserve no less.

I look forward to working with my colleagues on this legislation and this issue. I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2598

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 ''Children's Lead Prevention and Inclusive Treatment Act of 1998'' or the ''Children's Lead PAInT Act''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds that—

(1) lead poisoning remains a serious environmental risk, especially to the health of young children;

(2) childhood lead poisoning can cause reductions in IQ, attention span, reading, and learning disabilities, and other growth and behavior problems;

(3) children under the age of 6 are at the greatest risk because of the sensitivity of their developing brains and nervous systems;

(4) poor children and minority children are at substantially higher risk of lead poisoning;

(5) it is estimated that more than 500,000 children enrolled in medicaid have harmful levels of lead in their blood;

(6) children enrolled in medicaid represent 60 percent of the 890,000 children in the United States with elevated blood lead levels;

(7) although the Health Care Financing Administration has required mandatory blood lead screenings for children enrolled in medicaid who are not less than 1 nor more than 5 years of age, approximately two-thirds of children enrolled in medicaid have not been screened or treated;

(8) the Health Care Financing Administration mandatory screening policy has not been effective, or sufficient, to properly identify and screen children enrolled in medicaid who are at risk;

(9) uniform lead screening requirements do not exist for children not enrolled in medicaid; and

(10) adequate treatment services are not uniformly available for children with elevated blood lead levels.

(b) PURPOSE.—The purpose of this Act is to create a lead screening safety net that will, through medicaid and other entitlement programs, ensure that low-income children at the highest risk of lead poisoning receive blood lead screenings and appropriate follow-up care.

SEC. 3. INCREASED LEAD POISONING SCREENINGS AND TREATMENTS UNDER THE MEDICAID PROGRAM.

(a) PENALTY FOR INSUFFICIENT INCREASES IN LEAD POISONING SCREENINGS.—

(1) PERFORMANCE IMPROVEMENT.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following:

''(x) PERFORMANCE IMPROVEMENT.—

''(1) IN GENERAL.—Notwithstanding section 1905(b), beginning with fiscal year 2000 and for each fiscal year thereafter, with respect to any State that fails to meet minimum blood lead screening rates stated in paragraph (2), the Federal medical assistance percentage determined under section 1905(b) for the State for the fiscal year shall be reduced by 1 percentage point, but only with respect to—

''(A) items and services furnished under a State plan under this title during that fiscal year;

''(B) payments made on a capitation or other risk-basis under a State plan under this title for coverage occurring during that fiscal year; and

''(C) payments under a State plan under this title that are attributable to DSH allotments for the State determined under section 1923(f) for that fiscal year.

''(2) MINIMUM BLOOD LEAD SCREENING RATES.—The minimum acceptable percentages of 2-year-old medicaid-enrolled children who have received at least 1 blood lead screening test are—

''(A) 50 percent in fiscal year 2000;

''(B) 60 percent in fiscal year 2001;

''(C) 70 percent in fiscal year 2002;

''(D) 80 percent in fiscal year 2003; and

''(E) 90 percent in each fiscal year after fiscal year 2003.

''(3) MODIFICATION OR WAIVER.—The Secretary may modify or waive the application of paragraph (1) in the case of a State that the Secretary determines has performed during a fiscal year such a significant number of lead blood level assessments that the State reasonably cannot be expected to achieve the minimum blood lead screening rates established by paragraph (2).''.

(2) REPORTING REQUIREMENT.—Section 1902(a)(43)(D) of the Social Security Act (42 U.S.C. 1396a(a)(43)(D)) is amended—

(A) in clause (iii), by striking ''and'' at the end;

(B) in clause (iv), by striking the semicolon and inserting '', and''; and

(C) by adding at the end the following:

''(v) the number of children who are not more than 2 years of age and enrolled in the medicaid program and the number and results of lead blood level assessments performed by the State, along with demographic and identifying information that is consistent with the recommendations of the Centers for Disease Control and Prevention with respect to lead surveillance;''.

(b) MANDATORY SCREENING REQUIREMENTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (65), by striking the period and inserting ''; and''; and

(2) by adding at the end the following:

''(66) provide that each contract entered into between the State and an entity (including a health insuring organization and a medicaid managed care organization) that is responsible for the provision (directly or through arrangements with providers of services) of medical assistance under the State plan shall provide for—

''(A) compliance with mandatory screening requirements for lead blood level assessments (as appropriate for age and risk factors) that are commensurate with guidelines and mandates issued by the Secretary through the Administrator of the Health Care Financing Administration; and

''(B) coverage of appropriate qualified lead treatment services, as prescribed by the Centers for Disease Control and Prevention guidelines, for children with elevated levels of lead in their blood.''.

(c) REIMBURSEMENT FOR TREATMENT OF CHILDREN WITH ELEVATED BLOOD LEAD LEVELS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) in paragraph (26), by striking ''and'' at the end;

(B) by redesignating paragraph (27) as paragraph (28); and

(C) by inserting after paragraph (26) the following:

''(27) qualified lead treatment services (as defined in subsection (v);''; and

(2) by adding at the end the following:

''(v)(1) The term 'qualified lead treatment services' means all appropriate and medically necessary services that are provided by a qualified provider, as determined by the State, to treat a child described in paragraph (2), including—

''(A) environmental investigations to determine the source of a child's lead exposure, including the costs of qualified and trained professionals (including health professionals and lead professionals certified by the State or the Environmental Protection Agency) to conduct such investigations and the costs of laboratory testing of substances suspected of being significant pathways for lead exposure (such as lead dust, paint chips, bare soil, and water);

''(B) professional case management services to coordinate access to such services; and

''(C) emergency measures to reduce or eliminate lead hazards to a child, if required (as recommended by the Centers for Disease Control and Prevention).

''(2) For purposes of paragraph (1), a child described in this paragraph is a child who—

''(A) has attained 6 months of age but has not attained 73 months of age; and

''(B) has been identified as having a blood lead level that equals or exceeds 20 micrograms per deciliter (or persistently equals or exceeds 15 micrograms per deciliter).''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section apply on and after October 1, 1998.

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of this section solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

SEC. 4. LEAD POISONING SCREENING FOR SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN.

Section 17(d) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(d)) is amended by adding at the end the following:

''(4) LEAD POISONING SCREENING.—

''(A) IN GENERAL.—Subject to subparagraph (B), for an infant or child to be eligible to participate in the program under this section, a member of the family of the infant or child shall provide proof to the State agency, not later than 180 days after enrollment of the infant or child in the program and periodically thereafter (as determined by the State agency), that the infant or child has received a blood lead test for lead poisoning using an assessment that is appropriate for age and risk factors.

''(B) WAIVERS.—A State agency or local agency may waive the requirement of subparagraph (A) with respect to an infant or child if the State agency or local agency determines that—

''(i) the area in which the infant or child resides does not pose a risk of lead poisoning; or

''(ii) the requirement would be contrary to the religious beliefs or moral convictions of the family of the infant or child.

''(C) SCREENINGS BY STATE AGENCIES.—

''(i) IN GENERAL.—On the request of a member of a family of an infant or child who has not been screened for lead poisoning and who seeks to participate in the program, at no charge to the family, a State agency shall perform a blood lead test on the infant or child that is appropriate for age and risk factors.

''(ii) REIMBURSEMENT.—On the request of a State agency that screens for lead poisoning under clause (i) an infant or child that is receiving medical assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), the Secretary of Health and Human Services shall reimburse the State agency, from funds that are made available under that title, for the cost of the screening (including the cost of purchasing portable blood lead analyzer instruments approved for sale by the Food and Drug Administration and providing screening with the use of such instruments through laboratories certified under section 353 of the Public Health Service Act (42 U.S.C. 263a)).''.

SEC. 5. LEAD POISONING SCREENING FOR EARLY HEAD START PROGRAMS.

Section 645A of the Head Start Act (42 U.S.C 9840a) is amended—

(1) in subsection (c)(2), by inserting before the semicolon the following: '', if the families comply with subsection (i)''; and

(2) by adding at the end the following:

''(i) LEAD POISONING SCREENING.—

''(1) IN GENERAL.—Subject to paragraph (2), for a child to be eligible to participate in a program described in subsection (a)(1), a member of the family of the child shall provide proof to the entity carrying out the program, not later than 180 days after enrollment of the child in the program and periodically thereafter (as determined by the entity), that the child has received a blood lead test for lead poisoning using an assessment that is appropriate for age and risk factors.

''(2) WAIVERS.—The entity may waive the requirement of paragraph (1) with respect to a child if the entity determines that—

''(A) the area in which the child resides does not pose a risk of lead poisoning; or

''(B) the requirement would be contrary to the religious beliefs or moral convictions of the family of the child.

''(3) SCREENINGS BY ENTITIES.—

''(A) IN GENERAL.—On the request of a member of a family of a child who has not been screened for lead poisoning and who seeks to participate in the program, at no charge to the family, the entity shall perform a blood lead test on the child that is appropriate for age and risk factors.

''(B) REIMBURSEMENT.—On the request of an entity that screens for lead poisoning under subparagraph (A) a child that is receiving medical assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), the Secretary shall reimburse the entity, from funds that are made available under that title, for the cost of the screening (including the cost of purchasing portable blood lead analyzer instruments approved for sale by the Food and Drug Administration and providing screening with the use of such instruments through laboratories certified under section 353 of the Public Health Service Act (42 U.S.C. 263a)).''.●

By Ms. SNOWE:

S. 2599. A bill to amend title 38, United States Code, to establish a presumption of service-connection for certain veterans with Hepatitis C, and for other purposes; to the Committee on Veterans' Affairs.

HEPATITIS C VETERANS LEGISLATION

● Ms. SNOWE. Mr. President, today I introduce legislation to address a serious health concern for veterans infected with the hepatitis C virus. This legislation would make hepatitis C a service-connected condition so that veterans suffering from this virus can be treated by the VA.

Specifically, the bill will establish a presumption of service connection for veterans with hepatitis C, meaning that we will assume that this condition was incurred or aggravated in military service, even if there is no record of evidence that the condition existed during the actual period of service, provided that certain conditions are met.

Under this legislation, veterans who received a transfusion of blood during a period of service before December 31, 1992; veterans who were exposed to blood during a period of service; veterans who underwent hemodyalisis during a period of service; veterans diagnosed with unexplained liver disease during a period of service; veterans with an unexplained liver dysfunction value or test; or veterans working in a health care occupation during service, will be eligible for treatment for this condition at VA facilities.

I am introducing this legislation today because of medical research that suggests many veterans were exposed to hepatitis C in service and are now suffering from liver and other diseases caused by exposure to the virus.

I am troubled that many ''hepatitis C veterans'' are not being treated by the VA because they can't prove the virus was service connected, despite that fact that hepatitis C was little known and could not be tested for until recently.

Mr. President, we are learning that those who served in Vietnam and other conflicts, tend to have higher than average rates of hepatitis C. In fact, VA data shows that 20 percent of its inpatient population is infected with the hepatitis C virus, and some studies have found that 10 percent of otherwise healthy Vietnam veterans are hepatitis C positive.

Although hepatitis C is a very serious infection, it was actually unknown until recently. Hepatitis C was not isolated until 1989, and the test for the virus has only been available since 1990. Hepatitis C is a hidden infection with few symptoms. However, most of those infected with the virus will develop serious liver disease 10 to 30 years after contracting it. For many of those infected, hepatitis C leads to liver failure, transplants, liver cancer, and ultimately death.

And yet, most people who have hepatitis C don't even know it and often do not get treatment until it's too late. Only five percent of the estimated four million Americans with hepatitis C know they have it, but with new treatments, some estimates indicate that 50 percent can have the virus eradicated.

Vietnam Veterans in particular are just now starting to show up with liver disease caused by hepatitis C. And detection and treatment now may help head off serious liver disease for many of them. However, many veterans with hepatitis C will not be treated by the VA because they cannot establish a service connection for their condition in spite of the fact that we now know that many Vietnam-era and other veterans got this disease serving their country.

Many of my colleagues may be interested to know how veterans likely were exposed to this virus. Many veterans received blood transfusions while in Vietnam. This is one of the most common ways hepatitis C is transmitted. Medical transmission of the virus through needles and other medical equipment is possible in combat. And Medical care providers in the services were likely at increased risk, and may have, in turn, posed a risk to the service members they treated.

Researchers have discovered that hepatitis C was widespread in Southeast Asia during the Vietnam war, and that some blood sent from the U.S. was also infected with the virus. Researchers and veterans organizations, including the Vietnam Veterans of America, with whom I worked to prepare this legislation, believe that many veterans were infected after being injured in combat and getting a transfusion or from working as a medic around combat injuries.

Yet, veterans cannot establish a service connection because frequently there were no symptoms when they were infected in Vietnam. In addition, while medical records may show a short bout of hepatitis, hepatitis C was not known then and there was no testing to detect the hepatitis C infection at discharge.

The hepatitis C infected veterans are essentially in a catch 22: the VA is reluctant to depart from their routine service connection requirements and veterans cannot prove that they contracted hepatitis C in combat because the science to detect it did not exist during the period of service. Without congressional authority in the form of legislation providing for presumptive service connection, thousands of Vietnam vets infected with hepatitis C in service will not get VA health care testing or treatment. I believe the government will actually save money in the long run by testing and treating this infection early on. The alternative is much more costly treatment of end-stage liver disease and the associated complications, or other disorders.

I would like to describe some of the research that has led me to the conclusion that hepatitis C may be service connected in many veterans. A number of studies have established a link between hepatitis C in veterans and high risk factors for hepatitis C that are unique to combat or are highly prevalent in combat situations.

A study published in the American Journal of Epidemiology in 1980 found that veterans have a higher incidence of hepatitis C compared to non-veterans. The study of veterans receiving liver transplants at the Nashville, Tennessee VA medical center, which was conducted by researchers at the Vanderbilt University Medical Center, found that there ''was a significantly greater incidence of hepatitis C . . . in veterans compared with non-VA patients.'' The study claims to confirm that ''veteran patients have a higher incidence of hepatitis C. . .''

A study published in Cancer in 1989 found that veterans have increased risk of liver cancer as compared to non-veterans. The study found that there was a 50 percent increase in the rate of liver cancer among male veterans using VA medical systems from 1970 to 1982.

A study published in Military Medicine in 1997 found that from 1991 to 1994, the number of veterans diagnosed with hepatitis C increased significantly from 6,612 in 1991 to 18,854 in 1994, which is an increase of more than 285 percent. The study notes that ''total patients seen nationally . . . increased by only 4.87 percent during the same period.'' Therefore, this increase cannot be explained by increased in workload. Over the subsequent year, this increased to 21,400 (in 1996), and has since continued to increase.

Some will argue that further epidemiologic data is needed to resolve or prove the issue of service connection. I agree that we have our work cut out for us, and further study is required. However, while the research being done is providing more and more data on the relationship between military service

and hepatitis C, we should not force those who fought for our country to wait for the treatment they deserve.

It should be noted that some progress has been made in recent years in the effort to address this health concern. This is not a new issue.

The VA has done some screening and testing for hepatitis C in veterans. VA Under Secretary for Health, Ken Kizer, issued a directive that all VA medical centers should test veterans for hepatitis C if they fall into certain risk categories. However, I understand that medical centers are not complying with this directive uniformly. In addition, there is no mention of treatment in the Kizer directive. Therefore, if the virus is detected, the VA does not necessarily treat it.

I would also note that the FY98 VA–HUD Appropriations report contains the following language: ''The Committee is concerned that the rates of serious liver disease, liver cancer and liver transplants related to hepatitis C infection are expected to rise rapidly among veterans populations over the next decade. Veterans health care facilities will bear a large part of the treatment cost. Those costs can be reduced with early screening and treatment of veterans infected with hepatitis C. Therefore, the Committee directs the Department to determine rates of hepatitis C infection among veterans receiving health services from the VA and to establish a protocol for screening new entrants to the VA health care system. The Committee also directs the Department to provide counseling and access to treatment for veterans who test positive for hepatitis C. The Department should pay special attention to rates of hepatitis C among veterans of Vietnam and more recent deployments.''

Former Surgeon General C. Everett Koop, well respected both within and outside of the medical profession, has said, ''In some studies of veterans entering the Department of Veterans Affairs health facilities, half of the veterans have tested positive for HCV. Some of these veterans may have left the military with HCV infection, while others may have developed it after their military service. In any event, we need to detect and treat HCV infection if we are to head off very high rates of liver disease and liver transplant in VA facilities over the next decade. I believe this effort should include HCV testing as part of the discharge physical in the military, and entrance screening for veterans entering the VA health system.''

The VA requires that a veteran demonstrate onset during service or within requisite presumptive periods with chronic residuals of a disease or injury that had its onset during active military service. How does a veteran prove service connection under these criteria for a condition that did not even have a name until 10 years ago.

Veterans have already fought their share of battles—these men and women who sacrificed in war so that others could live in peace shouldn't have to fight again for the benefits and respect they have earned.

In closing, let me say that we are just now beginning to learn the full extent of this emerging health threat to veterans and the general population. We still have a long way to go before we know how best to confront this deadly virus. A comprehensive policy to confront such a monumental challenge can not written overnight. It will require the long-term commitment of Congress and the Administration to a serious effort to address this health concern.

I hope this legislation will be a constructive step in this effort, and I look forward to working with the Veterans' Affairs Committee, the VA–HUD appropriators, Vietnam Veterans of America, and others to meet this emerging challenge.●

By Mr. HATCH:

S. 2600. A bill to amend section 402 of the Controlled Substances Act to reform the civil remedy provisions relating to recordkeeping violations; to the Committee on the Judiciary.

CONTROLLED SUBSTANCE CIVIL PENALTY REFORM ACT

Mr. HATCH. Mr. President, I rise today to introduce the ''Controlled Substances Civil Penalty Reform Act of 1998,'' S. 2600, legislation I have been developing for some months working in conjunction with Senator GREGG and the Appropriations Committee, our House colleague, BILL MCCOLLUM, and other interested parties including the Drug Enforcement Administration, the National Association of Chain Drug Stores, and the National Wholesale Druggists Association.

This is a ''good government'' bill, legislation which I intend to correct a situation which has proven to be of great concern to America's drug stores, the wholesale community which supplies them, and America's consumers.

As a House hearing amply documented last month, there have been a number of cases in which the Drug Enforcement Administration has imposed large fines for small, record-keeping errors committed by those the agency regulates, primarily drug stores and their suppliers.

The DEA has a critical mission to combat diversion of controlled substances. This is of great national significance, and the agency should zealously pursue to the limits of the law those who traffic in illicit drugs.

That being said, there is a difference between going after drug dealers and examining the records kept by legitimate wholesalers and pharmacies. Overzealously throwing the book at above-board businesses, who are doing so much to help America's consumers, for relatively minor record-keeping violations is not warranted.

In 1997, these fines, which may be assessed at up to $25,000 per violation, totaled a substantial $12 million. But given the nature of some of the minor deficiencies, which I am advised are sometimes for trivial matters such as incorrect zip codes, the question must be raised whether this particular enforcement activity is operating more life a hidden tax or user fees than a meaningful deterrent to drug diversion.

In short, S. 2600 amends the Controlled Substances Act in three important ways. First, it adds a negligence standard to current law, so that the government must prove that the record-keeping violation was due to a negligent act, rather than an unintended mistake or omission, prior to any fines being imposed. Second, it lowers the ceiling on these fines from ''up to $25,000'' per violation, to ''up to $10,000'' per violation.

The third provision adds a number of needed standards that the Attorney General must consider before any fine is imposed. These include: whether diversion actually occurred; whether actual harm to the public resulted from the diversion; whether the violations were intentional or negligent in nature; whether the violations were a first time offense; the time intervals between inspections where no, or any serious, violations were found; whether the violations were multiple occurrences of the same type of violation; whether and to what extent financial profits may have resulted from the diversion; and the financial capacity of registrants to pay the fines assessed.

Finally, my proposal makes clear that in determining whether to assess a penalty, the Attorney General may take into account whether the violator has taken immediate and effective corrective action, including demonstrating the existence of compliance procedures, in order to reduce the potential for any future violations. The Attorney General may also follow informal procedures such as sending one or more warning letters to the violator, as she determines appropriate.

Mr. President, I recognize that our time is short for the remainder of this session. However, given Senator GREGG's significant interest in this issue, and the abundant work that Representative MCCOLLUM and I have devoted to this issue this year, I am hopeful this needed reform is something we can accomplish before we adjourn.

By Mr. KYL:

S. 2601. A bill to provide block grant options for certain education funding; to the Committee on Labor and Human Resources.

DOLLARS FOLLOWS THE KID EDUCATION BLOCK GRANT

S. 2602. A bill to amend the Internal Revenue Code of 1986 to allow a credit against income tax for expenses of attending elementary and secondary schools and for contributions to charitable organizations which provide scholarships for children to attend such schools; to the Committee on Finance.

K THROUGH COMMUNITY PARTICIPATION ACT

● Mr. KLY. Mr. President, I rise to introduce two education legislative proposals that will increase parental and student choice, educational quality, and school safety.

A colleague from the Arizona delegation, Representative Matt Salmon, is today introducing these proposals in the House of Representatives.

The first proposal is the ''Dollars Follow the Student Education Block Grant Act.''

This proposal would ensure that education dollars are spent in the classroom on behalf of specific students rather than in bureaucracies like the Department of Education in Washington, D.C.

The second proposal is the ''K through 12 Community Participation Act'' which would offer tax credits to families and businesses of up to $500 annually for qualified K through 12 education expenses or activities.

Over the last 30 years, Americans have steadily increased their monetary commitment to education.

Unfortunately, we have not seen a corresponding improvement in the quality of the education our children receive.

Given our financial commitment, and the great importance of education, these results are unacceptable.

Mr. President, I believe the problem is not how much money is spent, but how it is spent, and by whom.

Our national commitment to education is clear from the ever-increasing sums we spend annually.

The problem is the big-government, Washington D.C.-based policies that have squandered these resources on well-meaning but misguided programs that are failing our children and our country.

By beginning the debate on these two legislative proposals at the end of the 105th Congress, I believe the Congress can build upon the great progress made in the direction of parental choice, educational quality, and safety—progress which has been led by Senator PAUL COVERDELL and Senator SLADE GORTON, and Senator TIM HUTCHINSON.

THE DOLLARS FOLLOW THE STUDENT EDUCATION BLOCK GRANT PROPOSAL

As a nation we have long recognized the supreme importance of educating our children.

It is the foundation for a productive and rewarding future for all individuals and, as Thomas Jefferson noted, ''is essential to the preservation of our democracy.''

The critical issue is whether the taxpayers are getting their money's worth for their education tax dollar in light of the disappointing conclusions of the recent congressional Education at the Crossroads report.

As the report pointed out, the federal government pays only seven percent of the cost of education, but imposes 50 percent of the paperwork requirements that schools face.

Our students are struggling to master just the basics in reading, math, and science. Around 40 percent of our fourth graders can't read, while the government pays to add subtitles to the ''Jerry Springer Show.''

It is clear that after more than 30 years of topdown control, hundreds of duplicative federal programs and one-size-fits-all policies from Washington are not working.

In fact, according to a recent study by the Heritage Foundation, 20 cents of each education tax dollar are lost to administrative and federal compliance costs. I believe these resources would be better spent on textbooks or making schools safer than on salaries of, and regulations issued by, bureaucrats in Washington.

It's clear that we need to get more from our education tax dollars by spending more of them in the classroom and less in Washington.

This idea—an education block grant—has been successfully promoted by Senator SLADE GORTON of Washington state. The Gorton block grant proposal passed the Senate and the House in 1997, but, at the Clinton administration's insistence, it was stripped from the Labor, Health and Human Services, and Education appropriations bill of 1997.

As with the Gorton proposal, my bill would consolidate most federally funded K through 12 education programs, except for special education. This money is sent directly to states and local school districts free from federal mandates or regulations.

Under both proposals, each state would choose one of three options: 1. To have federal block grant funds sent directly to local school districts minus federal regulations; 2. To have federal block grant funds sent to the state education authority, again without federal regulations; 3. Or to continue to receive federal funds under the current system of categorizing monies rigidly into specific programs.

But my amendment adds a new feature to the block grant idea for states that choose a block grant option. Several years ago, the Goldwater Institute, a Phoenix-based educational think tank, began to advocate market-based education finance reform in which a specific amount of money would follow each child to the school of his or her choice. I believe the time has come for this concept of ''dollars following kids'' to be debated and implemented on the national level.

Under this proposal, each state electing to have a block grant could also decide to allow parents of children in private schools, public schools (including charter schools), and parents of ''home schooled'' kids, to receive their ''per capita'' amount directly, rather than indirectly through the school district and school. This money would literally ''follow the child'' from school to school, thus creating an incentive for the school to muster the best education product possible in order to keep the child enrolled.

I believe the fundamental problem with today's method of federal education funding is that it provides little if any link between the quality of a school or school district's educational product and the education funding it receives. The absence of a link between school funding and education quality has led to a loss of accountability and to an education product that is, in many ways, severely deficient. Parents, students, and the nation suffer from this loss of accountability.

As we all know, under current education-funding procedures, federal dollars allocated by the U.S. Department of Education are sent to state education agencies, and then to each school district, and finally, to each school. At each level, important education decisions are being made by bureaucrats—and more importantly, not being made by parents. Also, at each level of bureaucracy, additional percentages of the original education-funding dollar that left Washington is being lost. Currently, fully 20 percent of all federal education dollars never make it to the classroom and the student.

I believe we need to explore a new education-funding framework that is child-centered rather than school, or school district, centered. The current system has proven to be inconsistent with the fundamental principles of parental choice, competition, and education quality.

This proposal would implement the fundamental reform needed in our education financing system. I believe we should consider financing public education by linking funding to individual students and requiring that the schools and school districts compete for those students by providing a quality education. This approach puts the child, rather than the system itself, at the center. With child-centered funding, students are more valuable to schools than the bureaucrats who make funding decisions.

Simply put, under my plan, the federal money that supports primary and secondary education would go directly from the state to parents, and only then to the schools in which parents chose to educate their children.

Practically speaking, what does this mean? First, the federal government funds about 6.3% of the total amount—$358 billion—invested in primary and secondary education each year. If every state chose the block grant, this proposal would result in a block grant of roughly $13 billion sent to the states with greatly reduced regulatory mandates. (It is important to note that federal funding through the Individuals with Disabilities Act is exempted from this block grant.)

This amount—$13 billion—divided among roughly 50 million students results in $255 dollars that will ''follow'' each student. When one considers that the average school enrollment is 530 students, this block grant proposal would mean that each school would receive an average of $135,000 in federal dollars and, more importantly, would

have the flexibility to sue it to address the specific educational needs of the students in that school.

Suppose the parents of 50 students decided to remove their children because they were unsatisfied with the educational product of the school: that school would lose over $12,000 as a result. This would mean that each school would have the strong incentive to improve its curriculum, its staff, and its overall performance, since, if parents weren't satisfied, they could move their child to another school—and the dollars along with the child.

To allay fears that federal funding will be cut if consolidated into a block grant, this proposal provides that, if federal funding falls below the levels agreed to in the 1997 budget agreement, it will revert back to funding under federally-designated categories.

Also, my bill encourages states that choose block grants to adjust the per-student amounts by two factors: The relative cost of living, i.e., rural v. urban; and the income of the child's parents.

Citizens in the states put their trust in members of Congress to represent them in the nation's capital. It is time Congress showed the same trust in them and gave them more discretion in how their education tax dollars are spent.

It comes down to this: Will local schools be improved through more control from Washington, or will they be improved by giving more control to parents, teachers, and principals? The question needs only to be asked to be answered. The K through 12 Community Participation Act.

Mr. President, the second education legislative proposal I am introducing today is the K through 12 Community Participation Act. This proposal addresses the problem of falling education standards by giving families and businesses a tax incentive to provide children with a higher quality education through choice and competition.

The problem of declining education standards is illustrated by a report just released by the Education and Workforce Committee of the House of Representatives, Education at the Crossroads. This is the most comprehensive review of federal education programs ever undertaken by the United States Congress. It shows that the federal government's response to the decline in American schools has been to build bigger bureaucracies, not a better education system.

According to the report: There are more than 760 federal education programs overseen by at least 39 federal agencies at a cost of $100 billion a year to taxpayers. These programs are overlapping and duplicative. For example, there are 63 separate (but similar) math and science programs, 14 literacy programs, and 11 drug-education programs.

Even after accounting for recent streamlining efforts, the U.S. Department of Education still requires over 48.6 million hours worth of paperwork per year—this is the equivalent of 25,000 employees working full time.

As I mentioned earlier, states get at most seven percent of their total education funds from the federal government, but most states report that roughly half of their paperwork is imposed by federal education authorities.

The federal government spends tax dollars on closed captioning of ''educational'' programs such as ''Baywatch'' and Jerry Springer's squalid daytime talk show.

With such a large number of programs funded by the federal government, it's no wonder local school authorities feel the heavy hand of Washington upon them.

And what are the nation's taxpayers getting for their money? According to the report, around 40 percent of fourth grades cannot read, and 57 percent of urban students score below their grade level. Half of all students from urban school districts fail to graduate on time, if at all. U.S. 12th graders ranked third from the bottom out of 21 nations in mathematics. According to U.S. manufacturers, 40 percent of all 17-year-olds do not have the math skills to hold down a production job at a manufacturing company.

The conclusion of the Education at the Crossroads report is that the federally designed ''one-size-fits-all'' approach to education is simply not working.

I believe we need a federal education policy that will: Give parents more control. Give local schools and school boards more control. Spend dollars in the classroom, not on a Washington bureaucracy. Reaffirm our commitment to basic academics.

As was the case regarding my block grant proposal, my state of Arizona has led the way with legislation passed in 1997. This state law provides tax credit that can be used by parents and businesses to cover certain types of expenses attendant to primary and secondary education.

Mr. President, today, Representative SALMON and I are introducing a form of the new Arizona education tax-credit law.

The K through 12 Community Participation Education Act would be phased in over four years and would impel parents, businesses, and other members of the community to invest in our children's education. Specifically, it offers every family or business a tax credit of up to $500 annually for any K through 12 education expense or activity. This tax credit could be applied to home schooling, private schools (including charter schools), or parochial schools. Allowable expenses would include tuition, books, supplies, and tutors.

Further, the tax credit could be given to a ''school-tuition organization'' for distribution. To qualify as a school-tuition organization, the organization would have to devote at least 90 percent of its income per year to offering available grants and scholarships for parents to use to send their children to the school of their choice.

How might this work? A group of businesses in any community could join forces to send sums for which they received tax credits to charitable ''school-tuition organizations'' which would make scholarships and grants available to low income parents of children currently struggling to learn in unsafe, non-functional schools.

Providing all parents—including low income parents—the freedom to choose will foster competition and increase parental involvement in education. Insuring this choice will make the federal education tax code more like Arizona's. It is a limited but important step the Congress and the President can—and I believe, must—take.

Mr. President, it's clear that top-down, one-size fits all, big government education policy has failed our children and our country.

This tax-credit legislation, as well as the block-grant legislation I described earlier, will refocus our efforts on doing what is in the best interests of the child as determined by parents, and will give parents and businesses the opportunity to take an important step to rescue American education so that we can have the educated citizenry that Jefferson said was essential to our health as a nation.●

By Mr. BAUCUS (for himself, Mr. DASCHLE, Mr. INOUYE, Mr. BINGAMAN, Mr. JOHNSON, and Mr. CONRAD):

S. 2603. A bill to promote access to health care services in rural areas; to the Committee on Finance.

PROMOTING HEALTH IN RURAL AREAS ACT OF 1998

Mr. BAUCUS. Mr. President, all Americans deserve access to primary health care and emergency treatment. But in rural America the delivery of these services is often difficult, given the vast distances and extreme weather conditions that typically prevail. Just as small communities' transportation, education and housing needs are different than those of urban areas, so too are their mechanisms for delivering health care.

That's why Senator DASCHLE and I are introducing the Promoting Health In Rural Areas Act of 1998. PHIRA would, among other things: reformulate the Adjusted Average Per Capita Cost for Medicare payments to managed care; direct Medicare payments to tribally-owned hospitals; rebase provisions for Sole Community Hospitals; revise the underserved criteria used by the Office of Personnel Management; and allow recently-closed hospitals to be designated on a Critical Access basis.

As you know, 1997 reforms went a long way towards ensuring the viability of the Medicare program, including its use by rural Americans. For example, under Section 4201 of the 1997 BBA, Congress established a rural-friendly

hospital program. Modeled on a demonstration project conducted in my state of Montana, the new program allows a rural hospital to convert to a limited-service hospital status, called a ''Critical Access Hospital,'' or CAH. These hospitals are given flexibility and relief from Medicare regulations designed for full-size, full-service acute care hospitals. By giving these smaller hospitals greater latitude on staffing and other cumbersome federal regulations, it is easier for rural hospitals to organize their staffs and facilities based on patient needs.

If the demonstration project on which this new program is based is any indication (and I certainly hope that it is), Congress can be proud of this new law. And rural folks across the country will benefit. They will receive access to quality care in a way that meets their unique needs, and they will be assisted in preserving a way of life that is increasingly threatened by the urban- and sub-urbanization of America.

Yet despite many positive developments, it has become clear to the Minority Leader and I that much still needs to be done to facilitate the delivery of rural health services. In order to meet those needs, the Promoting Health in Rural Areas Act will do several things. First, it will change the Office of Personnel Management's underserved designation criteria by changing the way the Office of Personnel Management designates rural areas. Back in the 1960s, underserved areas were designated on a state-by-state basis. Now, the Department of Health and Human Services has the sophistication to designate areas by county, or even sub-county. The bill we are introducing today would require OPM to designate underserved areas on a county-by-county, not state-by-state, basis.

Second, PHIRA would direct Medicare payments to tribally-owned hospitals. As you know, Mr. President, a demonstration project conducted in Alaska, Mississippi and Oklahoma allowed four tribal health care providers operating Indian Health Services hospitals to bill Medicare and Medicaid directly. The demo project increased efficiency and, by allowing providers to directly bill Medicare, provided badly-needed revenue. Our bill would expand the demonstration project nationwide and make it permanent.

Mr. President, our bill would also allow recently-closed hospitals to be designated as Criticala Access Hospitals. Under the 1997 law establishing the Critical Access Hospital program, a closed or downsized hospital does not qualify. Our bill would allow a hospital that had closed within the last five years to qualify for conversion to CAH status.

Our bill also addresses rural needs for Medicare Graduate Medical Education (GME). As you know, BBA mandated a cap on the number of residents a teaching hospital is allowed to train. Because this provision threatens to exacerbate an already serious shortage of physicians in rural America, our bill would allow programs training residents targeted for rural areas to be exempt from the cap.

Mr. President, by reforming the way health care is delivered in rural areas, we are not only making government more efficient, we are making agencies more accountable. And we are preserving a way of life that American pioneers established long ago and that rural Americans continue today. It is in many ways a simpler lifestyle, uncomplicated by traffic, smog and a desire to get everything done yesterday. But it is also a difficult way of life, characterized by harsh weather, long distances, and the historic tendency of the Federal Government to view all areas—rural or urban—through a one-size-fits-all lens. I invite senators to join the Minority Leader and I today, to ensure that our rural residents are given proper access to the health care they need. I urge my colleagues to support this important legislation.

Mr. DASCHLE. Mr. President, today, with Senator BAUCUS, I introduce a bill intended to improve health care for Americans living in rural communities. The Promoting Health in Rural Areas Act of 1998 would help rural communities attract and retain health care providers and health plans, improve the viability of sole community hospitals, and make optimal use of the advances in medical technology available today.

Delivering health care in rural America presents unique challenges—issues related to geography, lack of transportation, and reimbursement. With a relatively small population spread over a large area, and health care professionals in short supply, patients often must travel long distances to see a physician or get to a hospital. While these rural communities strive to improve access through telemedicine and recruitment efforts, they must also struggle to maintain what they have, to ensure that providers who leave their area are replaced, and to keep their hospitals' doors open.

Rural communities have long had great difficulty recruiting and retaining health care providers to serve their needs. Despite great increases in the number of providers trained in this country over the past 30 years, rural communities have not shared equitably in the benefits of this expansion. Even though 20 percent of Americans live in non-metropolitan counties, only 11 percent of physicians practice in those counties, and that percentage has been falling for the last 25 years. Currently, 30 towns in South Dakota are looking for family physicians.

Telemedicine is a promising tool to provide medical expertise to rural communities. Through telemedicine technology, rural patients can have access to specialists they would otherwise never encounter. The benefits of telemedicine extend to rural health professionals as well, providing them with technical expertise and interaction with peers that can make practicing in a rural area more attractive. Yet the potential of telemedicine has been limited by reimbursement issues and a number of other obstacles.

In addition to problems with provider recruitment and limitations facing telemedicine, seniors in rural areas do not have the array of health plan options available in more urban areas due in part to a disparity in reimbursement. Although the Balanced Budget Act began to address the issue of low payment levels in rural areas, and has been successful to some degree, budgetary constraints have prevented the expected increase in rural areas.

The Promoting Health in Rural Areas Act of 1998 is intended to address some of the basic challenges facing rural health care. It will not address every health problem facing rural America. It is, however, intended to take important steps to improve access, increase choice, and improve the quality of care provided in more isolated parts of the country.

The bill addresses obstacles in current law to the recruitment and training of providers in rural areas. One provision in the bill ensures that new rules enacted as part of the Balanced Budget Act, regarding reimbursement for medical residents, do not discriminate against areas that train residents in rural health clinics or other settings outside a hospital.

The bill also helps medically underserved communities plan and be ready for the retirement of a physician. Current law effectively requires communities to actually lose a physician before they qualify for recruitment assistance to replace that doctor. Because recruitment is rarely less than a 6-month-long process, current policy places a community at risk of potentially having no physician available to them for long periods of time. This bill would provide communities with 12 months of lead time to secure recruitment assistance when they know a retirement or resignation is pending.

The bill would enhance the economic viability of Sole Community Hospitals, often the only source of inpatient services that are reasonably available in a geographic area, by updating the base cost reporting period.

The bill would ensure that health plans for Medicare beneficiaries who want to develop in rural counties get the increased reimbursement promised in the Balanced Budget Act, while maintaining budget neutrality. This provision is important to ensure that beneficiaries in rural areas begin to have some of the health plan choices available to urban seniors.

The bill also places significant focus on the promise of telemedicine for rural areas and attempts to overcome some of the barriers that have limited its potential. The bill would expand reimbursement for telemedicine to all rural areas, not just those designated as health professional shortage areas. The bill also would allow reimbursement for services currently covered by

Medicare in face-to-face interactions with health professionals. It also would make telemedicine more convenient, by allowing any health care practitioner to present a patient to a specialist on the other side of the video connection.

Mr. President, providing health care in rural communities raises unique challenges that require targeted responses. Rural America deserves appropriate access to health care—access to providers, access to hospitals, access to quality care, and greater choice. The bill we introduce today takes important steps to achieve these ends.

By Mr. TORRICELLI:

S. 2604. A bill to provide demonstration grants to local educational agencies to enable the agencies to extend time for learning and the length of the school year; to the Committee on Labor and Human Resources.

EXTENDED SCHOOL LEGISLATION

● Mr. TORRICELLI. Mr. President, today I introduce legislation authorizing funding for extended school day and extended school year programs across the country. The continuing gap between American students and those in other countries, combined with the growing needs of working parents and the growing popularity of extending both the school day and the school year, have made this educational option a valuable one for many school districts.

Students in the United States currently attend school an average of only 180 days per year, compared to 220 days in Japan, and 222 days in both Korea and Taiwan. American students also receive fewer hours of formal instruction per year compared to their counterparts in Taiwan, France, and Germany. We cannot expect our students to remain competitive with those in other industrialized countries if they must learn the same amount of information in less time.

Our school calendar is based on a no longer relevant agricultural cycle that existed when most American families lived in rural areas and depended on their farms for survival. The long summer vacation allowed children to help their parents work in the fields. Today, summer is a time for vacations, summer camps, and part-time jobs. Young people can certainly learn a great deal at summer camp, and a job gives them maturity and confidence. However, more time in school would provide the same opportunities while helping students remain competitive with those in other countries. As we debate the need to bring in skilled workers from other countries, the need to improve our system of education has become increasingly important.

In 1994, the Commission on Time and Learning recommended keeping schools open longer in order to meet the needs of both children and communities, and the growing popularity of extended-day programs is significant. Between 1987 and 1993, the availability of extended-day programs in public elementary schools has almost doubled. While school systems have begun to respond to the demand for lengthening the school day, the need for more widespread implementation still exists. Extended-day programs are much more common in private schools than public schools, and only 18 percent of rural schools have reported an extended-day program.

This bill would authorize $50 million over the next five years for the Department of Education to administer a demonstration grant program. Local education agencies would then be able to conduct a variety of longer school day and school year programs, such as extending the school year to 210 days, studying the feasibility of extending the school day, and implementing strategies to maximize the quality of extended core learning time.

The constant changes in technology, and greater international competition, have increased the pressure on American students to meet these challenges. Providing the funding for programs to lengthen the school day and school year would leave American students better prepared to meet the challenges facing them in the next century.●

By Mr. TORRICELLI (for himself and Mr. LAUTENBERG):

S. 2605. A bill to amend the Public Health Service Act to provide for the establishment of a national program of traumatic brain injury and spinal cord injury registries; to the Committee on Labor and Human Resources.

TRAUMATIC BRAIN AND SPINAL CORD INJURY REGISTRY ACT

● Mr. TORRICELLI. Mr. President, I introduce legislation that represents an important step forward in our national strategy for addressing traumatic brain injury (TBI) and spinal cord injury (SCI). Tragically, these injuries have enormous personal and economic costs on victims, their families, and our nation as a whole.

Today, an estimated 4.5 million Americans live with a disability as a result of a TBI. Each year, more than two million people suffer a TBI, 10,000 of whom live in my State of New Jersey. More than 200,000 Americans live with a SCI, with 10,000 new injuries reported each year. Collectively, TBI and SCI costs the U.S. more than $35 billion per year.

These statistics, however, reveal only a fraction of the problem. In the U.S., we have no standardized system of collecting information on these injuries. Instead, we rely on the work of a few limited State programs and private organizations who often lack the resources to collect complete, timely, and accurate data.

Mr. President, the legislation I introduce today, the TBI/SCI Registry Act, will allow the Centers for Disease Control and Prevention (CDC) to make grants available to states to establish their own TBI/SCI registries. The CDC and state departments of health will then work as partners in establishing and maintaining comprehensive tracking systems that ensures patient privacy.

The important information that state registries will be responsible for collecting will include: circumstances of injury and demographics of patients; length of stay in hospital and treatments used; severity of the injury; outcomes of treatments and services.

The benefits will be far-reaching because the collection of accurate data will help identify high-risk populations for future prevention programs and will help link patients to effective treatments and social services. Perhaps most important, the information from these registries will help advocates and legislators justify TBI/SCI as a greater funding priority.

The National Institutes of Health (NIH) currently spends approximately $60 million for SCI and $52 million for TBI. This research has contributed to tremendous progress, but we must improve our ability to identify innovative research projects and increase our financial commitment to those efforts.

Mr. President, this legislation will ultimately help achieve this goal by creating a foundation for a unified scientific and public health approach for preventing, treating, and someday finding a cure for TBI/SCI. I am proud that my bill has already received the endorsement of the Christopher Reeve Foundation, the American Paralysis Association, the Brain Injury Association, and the Eastern Paralyzed Veterans Association.

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

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

S. 2605

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 ''Traumatic Brain Injury and Spinal Cord Injury Registry Act''.

SEC. 2. FINDINGS.

Congress finds that—

(1) traumatic brain and spinal cord injury are severe and disabling, have enormous personal and societal costs;

(2) 51,000 people die each year from traumatic brain injury and 4,500,000 people live with lifelong and severe disability as a result of a traumatic brain injury;

(3) approximately 10,000 people sustain spinal cord injuries each year, and 200,000 live with life-long and severe disability; and

(4) a nationwide system of registries will help better define—

(A) who sustains such injuries and the impact of such injuries;

(B) the range of impairments and disability associated with such injuries; and

(C) better mechanisms to refer persons with traumatic brain injuries or spinal cord injuries to available services.

SEC. 3. TRAUMATIC BRAIN INJURY AND SPINAL CORD INJURY REGISTRIES PROGRAM.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

''PART O—NATIONAL PROGRAM FOR TRAUMATIC BRAIN INJURY AND SPINAL CORD INJURY REGISTRIES

''SEC. 399N. NATIONAL PROGRAM FOR TRAUMATIC BRAIN INJURY AND SPINAL CORD INJURY REGISTRIES.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to States or their designees to operate the State's traumatic brain injury and spinal cord injury registry, and to academic institutions to conduct applied research that will support the development of such registries, to collect data concerning—

''(1) demographic information about each traumatic brain injury or spinal cord injury;

''(2) information about the circumstances surrounding the injury event associated with each traumatic brain injury and spinal cord injury;

''(3) administrative information about the source of the collected information, dates of hospitalization and treatment, and the date of injury;

''(4) information characterizing the clinical aspects of the traumatic brain injury or spinal cord injury, including the severity of the injury, the types of treatments received, and the types of services utilized;

''(5) information on the outcomes associated with traumatic brain injuries and spinal cord injuries, such as impairments, functional limitations, and disability;

''(6) information on the outcomes associated with traumatic brain injuries and spinal cord injuries which do not result in hospitalization; and

''(7) other elements determined appropriate by the Secretary.

''(b) ELIGIBILITY FOR GRANTS.—

''(1) IN GENERAL.—No grant shall be made by the Secretary under subsection (a) unless an application has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such a manner, and be accompanied by such information, as the Secretary may specify. No such application may be approved unless it contains assurances that the applicant will use the funds provided only for the purposes specified in the approved application and in accordance with the requirements of subsection (a), that the application will establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds paid to the applicant under subsection (a) of this section, and that the applicant will comply with review requirements under sections 491 and 492.

''(2) ESTABLISHMENT OF REGISTRIES.—Each applicant, prior to receiving Federal funds under subsection (a), shall provide for the establishment of a registry that will—

''(A) comply with appropriate standards of completeness, timeliness, and quality of data collection;

''(B) provide for periodic reports of traumatic brain injury and spinal cord injury registry data; and

''(C) provide for the authorization under State law of the statewide traumatic brain injury and spinal cord injury registry, including promulgation of regulations providing—

''(i) a means to assure timely and complete reporting of brain injuries and spinal cord injuries (as described in subsection (a)) to the statewide traumatic brain injury and spinal cord injury registry by hospitals or other facilities providing diagnostic or acute care or rehabilitative social services to patients with respect to traumatic brain injury and spinal cord injury;

''(ii) a means to assure the complete reporting of brain injuries and spinal cord injuries (as defined in subsection (a)) to the statewide traumatic brain injury and spinal cord injury registry by physicians, surgeons, and all other health care practitioners diagnosing or providing treatment for traumatic brain injury and spinal cord injury patients, except for cases directly referred to or previously admitted to a hospital or other facility providing diagnostic or acute care or rehabilitative services to patients in that State and reported by those facilities;

''(iii) a means for the statewide traumatic brain injury and spinal cord injury registry to access all records of physicians and surgeons, hospitals, outpatient clinics, nursing homes, and all other facilities, individuals, or agencies providing such services to patients which would identify cases of traumatic brain injury or spinal cord injury or would establish characteristics of the injury, treatment of the injury, or medical status of any identified patient; and

''(iv) for the reporting of traumatic brain injury and spinal cord injury case data to the statewide traumatic brain injury and spinal cord injury registry in such a format, with such data elements, and in accordance with such standards of quality timeliness and completeness, as may be established by the Secretary.

''(3) APPLIED RESEARCH.—Applicants for applied research shall conduct applied research as determined by the Secretary, acting through the Director of the Centers for Disease Control and Prevention, to be necessary to support the development of registry activities as defined in this section.

''(4) ASSURANCES FOR CONFIDENTIALITY OF REGISTRY DATA.—Each applicant shall provide to the satisfaction of the Secretary for—

''(A) a means by which confidential case data may in accordance with State law be disclosed to traumatic brain injury and spinal cord injury researchers for the purposes of the prevention, control and research of brain injuries and spinal cord injuries;

''(B) the authorization or the conduct, by the statewide traumatic brain injury and spinal cord injury registry or other persons and organizations, of studies utilizing statewide traumatic brain injury and spinal cord injury registry data, including studies of the sources and causes of traumatic brain injury and spinal cord injury, evaluations of the cost, quality, efficacy, and appropriateness of diagnostic, rehabilitative, and preventative services and programs relating to traumatic brain injury and spinal cord injury, and any other clinical, epidemiological, or other traumatic brain injury and spinal cord injury research;

''(C) the protection of individuals complying with the law, including provisions specifying that no person shall be held liable in any civil action with respect to a traumatic brain injury and spinal cord injury case report provided to the statewide traumatic brain injury and spinal cord injury registry, or with respect to access to traumatic brain injury and spinal cord injury case information provided to the statewide traumatic brain injury and spinal cord injury registry; and

''(D) the protection of individual privacy and confidentiality consistent with Federal and State laws.

''SEC. 399O. TECHNICAL ASSISTANCE IN OPERATIONS OF STATEWIDE REGISTRIES.

''The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may, directly or through grants and contracts, or both, provide technical assistance to the States in the establishment and operation of statewide registries, including assistance in the development of model legislation for statewide traumatic brain injury and spinal cord injury registries and assistance in establishing a computerized reporting and data processing system. In providing such assistance, the Secretary shall encourage States to utilize standardized procedures where appropriate.

''SEC. 399P. AUTHORIZATION OF APPROPRIATIONS.

''For the purpose of carrying out this part, there are authorized to be appropriated $10,000,000 for fiscal year 1999, and such sums as may be necessary for each of the fiscal years 2000 through 2004.

''SEC. 399Q. DEFINITIONS.

''In this part:

''(1) SPINAL CORD INJURY.—The term 'spinal cord injury' means an acquired injury to the spinal cord. Such term does not include spinal cord dysfunction caused by congenital or degenerative disorders, vascular disease, or tumors, or spinal column fractures without a spinal cord injury.

''(2) TRAUMATIC BRAIN INJURY.—The term 'traumatic brain injury' means an acquired injury to the brain, including brain injuries caused by anoxia due to near-drowning. Such term does not include brain dysfunction caused by congenital or degenerative disorders, cerebral vascular disease, tumors, or birth trauma. The Secretary may revise the definition of such term as the Secretary determines appropriate.''.●

By Mr. KYL (by request):

S. 2608. A bill to approve a mutual settlement of the Water Rights of the Gila River Indian Community and the United States, on behalf of the Community and the Allottees, and Phelps Dodge Corporation, and for other purposes; to the Committee on Indian Affairs.

THE GILA RIVER INDIAN COMMUNITY—PHELPS DODGE CORPORATION WATER RIGHTS SETTLEMENT ACT OF 1998

Mr. KYL: Mr. President, today I introduce, by request, a bill to authorize an Indian water rights settlement agreement that was entered into on May 4, 1998 by the Gila River Indian Community of Arizona and the Phelps Dodge Corporation.

As other Western members well know, any Indian water rights settlement is a difficult, lengthy, and often frustrating process. Reaching a settlement requires years of hard work and cooperation by all parties involved. But the work is worthwhile. By reaching settlement, parties avoid decades of costly litigation and the uncertainty regarding water rights that inevitable comes when the determination of rights and liabilities is delayed. I have been, both in my prior career, and in this one, an ardent supporter of the settlement process and I hope that by introducing this legislation, I can give the negotiating parties at home in Arizona some encouragement. There is light at the end of the tunnel.

This particular settlement agreement is part of a much larger, comprehensive settlement process that will eventually settle all claims of the Gila River Community. I have been involved in several aspects of the Gila negotiations and I am comforted that the negotiations are progressing far enough that the parties are beginning to put their agreements down on paper and actually sign their names to those documents. In reference to his particular

agreement, I want to note that my introduction of legislation does not endorse the May 4, 1994 agreement. Rather, my intention is to endorse and encourage the process. The settlement agreement is complex and lengthy and contains some elements that all parties in the larger Gila negotiation proceeds, including the federal government, may not agree with. My purpose in introducing a bill this year is to put a document on the table that will provide an opportunity for all interested parties to comment. In addition, a bill introduced this year will help move the process forward next year.

I encourage the parties to continue their discussions. Indian water settlements are among the most important bills that Congress passes—we in the federal government have a trust responsibility to provide water for tribes and in passing legislation that has been carefully crafted to consider the interests of all parties, we are able to take steps toward fulfilling that trust responsibility.

By Mr. BENNETT (for himself and Mr. MACK):

S. 2609. A bill to ensure confidentiality with respect to medical records and health care-related information, and for other purposes to the Committee on Labor and Human Resources.

THE MEDICAL INFORMATION PROTECTION ACT OF 1998

Mr. BENNETT. Mr. President, today I introduce the Medical Information Protection Act of 1998. I know it is late in the 105th Congress and that there will not be time to give this legislation full consideration. However, I feel strongly about this issue and did not want this session to end without the introduction of this legislation. I feel that great progress has been made and that the legislation that I am introducing addresses many of the concerns that have been expressed. I will include letters and statements of support for the RECORD from the following groups: American Medical Informatics Association; Joint Healthcare Information Technology Alliance; Intermountain Health Care; Premier Institute; Association of American Medical Colleges; American Health Information Management Association; Healthcare Leadership Council; Federation of American Health Systems; American Hospital Association and Pharmaceutical Research and Manufacturers of America. It is my intention to reintroduce this legislation early in the 106th Congress and seek for its passage.

Most individuals wrongly assume that their personal health information is protected under federal law. It is not. Federal law protects the confidentiality of our video rental records, and federal law ensures us access to information about us such as our credit history. However, there is no current federal law which will protect the confidentiality of our medical information and ensure us access to our own medical information. This is a circumstance that must change. This is a circumstance that the Medical Information Protection Act will correct.

At this time, the only protection of an individual's personal medical information is under state law. These state laws, where they exist, are incomplete, inconsistent and inadequate. At last check, there were over 34 states with each state having its own unique set of laws to protect medical records. In many states there is no penalty for releasing and disseminating the most private information about our health and the health care that we have received. Many of our local health care systems continue to expand across state lines and are forced to deal with multiple and conflicting state laws. In addition, advances in technology allow information to be moved instantaneously across the country or around the world. The majority of providers, insurers, health care professionals, researchers and patients agree that there is an increasingly urgent need for uniformity in our laws that govern access to and disclosure of personal health information.

Mr. President, I remind my colleagues that if we do not act by August of 1999, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Secretary of Health and Human Services (HHS) to put into place regulations governing health information in an electronic format. Thus, we could have a circumstance where paper based records and electronic based records are treated differently. I urge my colleagues to work with me to pass legislation that would give HHS clear direction and provide each American with greater protection of their health information.

Mr. President, I ask unanimous consent that the letters of support be printed in the RECORD.

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

PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA,
Washington, DC, October 7, 1998.

Hon. ROBERT F. BENNETT,
U.S. Senate,
Washington, DC.

DEAR SENATOR BENNETT: The Pharmaceutical Research and Manufacturers of America (PhRMA) applauds your introduction of the Medical Information Protection Act of 1998 and your leadership on this issue. This legislation would help patients in important ways. First, it would protect the confidentiality of their medical information. Second, it would help patients with unmet medical needs and their families by facilitating valuable biomedical research leading to the discovery and development of innovative medicines. Third, it would protect and promote health care quality by encouraging the appropriate use of medical information for epidemiological research, pharmaco-economics and outcomes analysis.

Your bill provides a sound regulatory framework to help foster biomedical research and the delivery of high-quality care in an increasingly integrated health care system, while at the same time preserving the confidentiality of sensitive medical information identifying patients.

PhRMA welcomes the Medical Information Protection Act of 1998 as a good prescription to help patients, commends you leadership on this issue, and looks forward to working together.

Sincerely,

ALAN F. HOLMER,
President.

AMERICAN HOSPITAL ASSOCIATION,
Washington, DC, October 2, 1998.

AHA APPLAUDS INTRODUCTION OF BILL THAT PROTECTS PRIVACY OF PATIENT MEDICAL INFORMATION

The American Hospital Association (AHA) applauds the introduction of a new bill which for the first time would establish a federal confidentiality law that protects patients' private health care information.

As guardians of patient medical information, hospitals and health systems have long sought strong federal legislation that would establish a uniform national standard to protect patient privacy. The bill, the Medical Information Protection Act of 1998, appropriately balances the need to protect the privacy of confidential patient information with the need for that information to flow freely among health care providers.

''Comprehensive confidentiality legislation is critical to thousands of patients who come through the doors of our nation's hospitals each day,'' said AHA President Dick Davidson. ''It puts in place the safeguards needed to protect the most sensitive and personal information. We commend Senator Bennett for introducing the bill and for his leadership and guidance on an issue that is relevant to everyone.''

The Medical Information Protection Act bill:

Allows patients in all states access to their records, a right not currently given in some areas.

Establishes full federal preemption of all state confidentiality laws—with the exception of some key public health laws—and sets a uniform standard over weaker or stronger state laws so that patient information is equally protected even as providers are linked across delivery sites and state boundaries.

Recognizes the need for confidential medical information to move appropriately and timely within groups and systems of providers without impeding the quality of care.

Broadly applies not only to providers, payers, and employers, but also to law enforcement agencies. The Bennett bill moves in the right direction on this issue by setting a national standard for how law enforcers can gain access to confidential patient records.

Contains language that, for the first time, would put in place federal sanctions against those who inappropriately disclose medical information.

''This is an issue that affects each of us personally,'' Davidson said. ''America's hospitals and health systems look forward to working with Senator Bennett and Congress to help enact legislation to protect the privacy of each and every individual they serve.''

The AHA is a not-for-profit organization of health care provider organizations that are committed to the health improvement of their communities. The AHA is the national advocate for its members, which includes 5,000 hospitals, health care systems, networks and other providers of care. Founded in 1898, AHA provides education for health care leaders and is a source of information on health care issues and trends. For more information, visit the AHA Web site at www.aha.org.

AMERICAN MEDICAL INFORMATICS ASSOCIATION,
Bethesda, MD, October 5, 1998.

Hon. ROBERT F. BENNETT,
U.S. Senate,
Washington, DC.

DEAR SENATOR BENNETT: The American Medical Informatics Association (AMIA) is a national organization dedicated to the development and application of medical informatics in support of patient care, teaching, research, and health care administration. On behalf of AMIA's more than 3,800 physicians, researchers, librarians, information systems managers, and other professionals with expertise in information technologies, I write to commend you on the introduction of the ''Medical Information Protection Act of 1998.''

AMIA recognizes that the enormous potential of computer and communications technology to improve health care delivery, quality and access cannot be realized unless individuals, and the society-at-large, are reasonably certain that safeguards are in place to protect the confidentiality of personal health information in medical records. Simply, every person must feel that his or her health data is protected against unnecessary disclosure. At the same time, there can be no doubt that the delivery of highest quality health care and advances in medical research cannot proceed without the timely and efficient transfer of health data across the health information infrastructure. Thus, in developing national standards for health information, Congress—as charged by the Health Insurance Portability and Accountability Act of 1996—must thoughtfully and carefully balance the rights of individuals, the capacity of the health care system to provide needed health care, and the interests of our nation as a whole. We believe that the ''Medical Information Protection Act'' does an admirable job of accomplishing those complex goals.

Our association is especially concerned that health information standards allow appropriate access to health data for research, while adequately protecting patient confidentiality. Dr. Don Detmer, Co-Chair of AMIA's Public Policy Committee, was pleased to consult with your staff on a number of occasions to address that issue, and to devise enforcement mechanisms to effectively sanction the misuse of protected health information.

The American Medical Informatics Association thanks you for introducing the ''Medical Information Protection Act of 1998.'' We look forward to passage of the bill, an essential first step in the development of a national health information strategy to advance the health of our nation.

Sincerely,

PAUL D. CLAYTON, PH.D.,
President.

JOINT HEALTHCARE INFORMATION TECHNOLOGY ALLIANCE,
October 5, 1998.

Hon. ROBERT F. BENNETT,
U.S. Senate,
Washington, DC.

DEAR SENATOR BENNETT: Representing a broad array of medical, information, and technology professionals involved in the development, use, management, and security of healthcare information systems, the organizations of the Joint Healthcare Information Technology Alliance (JHITA) strongly support enactment of federal legislation to protect the confidentiality of medical records. We write today to commend you on the introduction of the ''Medical Information Protection Act of 1998.''

The more than 50,000 members of our constituent organizatons—physicians, researchers and other health professionals, medical records professionals and information systems managers and executives, healthcare information technology developers and vendors—believe that computer and communications technologies hold enormous potential to improve healthcare delivery, quality and access, while also reducing costs. Yet, these benefits cannot be realized unless individuals, and society, are confident that safeguards are in place to protect the confidentiality of personal health information. Simply, every person must feel that his or her health data is protected against unnecessary disclosure. At the same time, there can be no doubt of the need for timely and efficient transfer of health data across the health information infrastructure. Thus, national standard for the collection, use and dissemination of healthcare information must thoughtfully and carefully balance the rights of individuals, the capacity of the healthcare system to provide needed services and the interests of our nation as a whole. The JHITA believes that the ''Medical Information Protection Act'' does an admirable job of accomplishing those complex goals.

In order for national fair information standards to offer consistent and genuine guidance and protection to healthcare professionals and consumers, and effect significant Federal penalties and sanctions for the misuse of health data, the JHITA believes that federal law must preempt the current patchwork of federal, state and local laws and regulations governing health information. We applaud your commitment in the ''Medical Information Protection Act'' to a uniform and high level of confidentiality for all health information, regardless of the individual's diagnosis or state of residence.''

The Joint Healthcare Information Technology Alliance thanks you for introducing the ''Medical Information Protection Act. We look forward to working with you to win passage of the bill, an essential first step in the development of a national health information strategy that will advance the health of our nation and protect the rights of all.

Sincerely,

LINDA KLOSS,
Executive Vice President & CEO, AHIMA.

CARLA SMITH,
Executive Director, CHIM.

JOHN PAGE,
Executive Director, HIMSS.

DENNIS REYNOLDS,
Executive Director, AMIA.

RICHARD CORRELL,
President, CHIME.

AMERICAN HEALTH INFORMATION MANAGEMENT ASSOCIATION,
Washington, DC, October 6, 1998.

Senator ROBERT F. BENNETT,
Dirksen Building,
Washington, DC.

DEAR SENATOR BENNETT: On behalf of the more than 37,000 members of the American Health Information Management Association (AHIMA), thank you for once again being in the forefront of the effort to pass legislation to protect the confidentiality of individually identifiable health information. AHIMA is pleased to offer its strong support for *the Medical Information Protection Act of 1998.*

During the past several years, we have worked with you and your Legislative Director Paul A. ''Chip'' Yost and developed several legislative proposals that have resulted in the current bill. The hard work put into the drafting of this landmark legislation has paid-off. The bill strikes a hard-to-achieve balance between protecting the confidentiality of a patient's health information while not impeding the provision of patient care or the operations of the nation's health care delivery system. One of the most important facets of *the Medical Information Protection Act* is that it contains strong criminal and civil sanctions to provide remedies against wrongful disclosure of health information. In addition, the legislation will eliminate the current patchwork-quilt of various state statutes and regulations, thus providing all Americans the confidentiality protections that they truly deserve.

Senator, AHIMA is pleased to continue working with you and your office on this important issue. Your dedication has kept us encouraged that Congress will pass legislation to establish a uniform national policy for the use and disclosure of individually identifiable health information. As you know from our past association, AHIMA has been a leader in the effort to pass comprehensive confidentiality legislation. Throughout the legislative process, we have achieved a reputation for working on a bipartisan basis with various elected officials and health policy makers. In this context, we continue to support your efforts and offer our assistance and expertise to help move this important issue forward.

Again, thank you for your dedication to this important issue. If AHIMA can provide any assistance, please do not hesitate to contact me in the AHIMA Washington, DC Office at (202) 218–3535.

Sincerely,

KATHLEEN A. FRAWLEY, JD,
Vice President, Legislative and Public Policy Services.

HEALTHCARE LEADERSHIP COUNCIL,
Washington, DC, October 7, 1998.

HEALTHCARE LEADERSHIP COUNCIL COMMENDS SENATOR BENNETT FOR MEDICAL INFORMATION ACT OF 1998

WASHINGTON, DC.—The Healthcare Leadership Council (HLC) today commended Sen. Robert Bennett (R–UT) for introducing the ''Medical Information Protection Act of 1998.''

''This bill protects the confidentiality of patient health information and establishes new federal penalties for its misuse,'' said HLC President Pamela G. Bailey. ''At the same time, the Bennett bill allows for the appropriate use of patient health information to promote a better health care delivery system and protect vital health care research.''

Information is the cornerstone of a high quality, innovative health care system,'' Bailey said. ''In fact, it can be an issue of life or death. Without access to patient information, physicians, health plans, hospitals and researchers would be unable to provide the high standard of care that Americans deserve.''

As the leading innovators in the health care industry, HLC members support federal rules to ensure patient confidentiality rather than the increasingly confusing patchwork of state laws. ''The Bennett bill would replace this patchwork of state laws with a strong federal law that protects patients and provides a workable, uniform framework that facilitates the delivery of the highest quality health care.''

''In the debate over patient confidentiality, we sometimes lose sight of what most patients want most—to get healthy. Fundamental to the fantastic advances made in treatment of so many diseases is our ability to use patient information throughout our increasingly complex health care system,'' said Bailey.

The HLC is committed to working toward final enactment of comprehensive, uniform

confidentiality legislation by the August 1999 deadline imposed under the Health Insurance Portability and Accountability Act.

The HLC is a coalition of the chief executive of America's leading health care institutions.

FEDERATION OF AMERICAN HEALTH SYSTEMS,
Washington, DC, October 7, 1998.

FAHS PRAISES INTRODUCTION OF MEDICAL INFORMATION PROTECTION ACT

APPLAUDS UTAH GOP SENATOR BENNETT FOR HIS LEADERSHIP AND HEALTH COMMUNITY OUTREACH EFFORTS

The Federation today praised Sen. Robert Bennett (R-UT) for introducing the Medical Information Protection Act of 1998 and applauded his leadership in drawing upon the input of a broad range of health care organizations in crafting the legislation.

''Although it's a bit like walking a tightrope, Sen. Bennett's commitment to working with varying interests on this important issue should be commended,'' said Laura Thevenot, Federation Executive Vice President and COO. ''He has approached the task before Congress of passing legislation relating to medical records confidentiality by August of 1999 with openness and a real determination to reach a consensus that protects patients and still allows hospitals and health systems to do their jobs. This legislation establishes a good framework for an issue that will be debated at length when the 106th Congress convenes next January.''

Thevenot highlighted a couple of key provisions in the legislation: uniform national confidentiality standards, which would avoid a cumbersome patchwork of state law and regulation, and enhanced security safeguards to ensure appropriate access to patient data.

''As the debate moves forward, one of the Federation's primary concerns is that Congress not tie the hands of hospitals and health systems by putting obstacles in the way of their commitment to provide the necessary treatment and care patients need,'' Thevenot added. ''Our commitment has always been and will remain to serve the patient. Proper uses of information for treatment, payment, quality improvement, and where appropriate, research, are a critical component of that commitment.''

INTERMOUNTAIN HEALTH CARE,
Salt Lake City, UT, October 2, 1998.

Hon. ROBERT F. BENNETT,
Dirksen Senate Office Building,
Washington, DC.

DEAR SENATOR BENNETT: Intermountain Health Care (''IHC'') applauds the introduction of the ''Medical Information Protection Act of 1998.'' IHC is deeply appreciative of your leadership in developing legislation to establish uniform federal confidentiality standards. IHC also wishes to express its deep appreciation of the hard work and dedication of Chip Yost and Mike Nielsen of your staff.

The bill you have crafted reflects a keen understanding of the need to strike an appropriate balance between safeguarding patient identifiable health information and facilitating the coordination and delivery of high quality, network-based health care, such as that provided at IHC. Indeed, striking the right balance is critical to the delivery of the best possible patient care.

As you well know, IHC has developed state-of-the-art electronic medical records and common databases which we used extensively not just for treatment and payment but for such fundamental quality enhancing activities as outcomes review, disease management, health promotion and quality assurance. You bill rightly recognizes that all of these efforts are essential to optimizing patient health.

In addition, we are particularly pleased that you have called for federal preemption of state law. Health systems like IHC, which operate across state lines, would have enormous difficulty complying with different federal and state standards.

As you know, IHC is a large integrated health care delivery system based in Salt Lake City and operating in the states of Utah, Idaho, and Wyoming. The IHC system includes 23 hospitals, 33 clinics, 16 home health agencies, and 400 employed physicians. Additionally, our system operates a large Health Plans Division with enrollment of 350,000 directly insured plus 430,000 who use our networks through other insurers. IHC's 20,000 employees are keenly aware of their responsibility to safeguard personal health information and IHC has invested considerable resources in order to develop effective protections and procedures.

IHC pledges to work with you toward enactment of this important legislation well in advance of the August 1999 deadline established by the Health Insurance Portability and Accountability Act of 1996. Please do not hesitate to contact me or IHC's Washington Counsel Michael A. Romansky (202/756–8069) and Karen S. Sealander (202/756–8024) of McDermott, Will & Emery with questions or for further information.

Sincerely,

JOHN T. NIELSEN, ESQ.,
Senior Counsel and
Director of Government Relations.

PREMIER INSTITUTE,
Washington, DC, October 5, 1998.

THE PREMIER INSTITUTE APPLAUDS INTRODUCTION OF THE MEDICAL INFORMATION PROTECTION ACT OF 1998

Washington, DC.—Jim Scott, president of the Premier Institute, commended Senator Robert F. Bennett (R-UT) for his leadership in introducing the ''Medical Information Protection Act of 1998.'' ''This legislation protects patients from being subjected to unauthorized or inappropriate use of their medical records and, at the same time, ensures that hospitals and health plans have access to information necessary to do their jobs in serving patients,'' said Scott. ''Senator Bennett creates workable standards that protect patient's confidentiality and assures that medical information is available for the treatment, quality assurance, and research needs that are so important to our health care system and the patients it serves.''

The Bennett bill recognizes the many legitimate uses for medical information and provides the right regulatory framework for safeguarding the use and disclosure of protected health information by the health care industry. The bill permits its use for patient treatment, quality enhancing activities, payment for health care activities, and research for the development of life saving pharmaceuticals and new medical procedures. By providing for a singular authorization process when a patient accesses the health care system, the bill avoids costly administrative burdens for health care providers and barriers to the efficient use of information within integrated care networks, hospital systems, physician-hospital organizations, or managed care organizations.

The bill also adopts uniform national confidentiality standards. Given the increasingly complex and interstate nature of the way health information flows in today's delivery system, strong preemption of state confidentiality laws protects consumers and minimizes the costs associated with the increasing patchwork of conflicting state laws.

Finally, the bill clearly recognizes the value of medical research and does not establish unnecessary barriers to research. It allows for the use of protected health information in research activities while holding medical researchers to confidentiality requirements that protect the identity of the individuals in a medical study. Under this bill, researchers will continue to have access to databases of patient information that are crucial in discovering trends and anomalies that lead to cures for diseases over time.

''Today marks the introduction of an important piece of legislation for the future of our health care system,'' said Scott. ''We look forward to working with Senator Bennett to enact the right patient confidentiality standards into law.''

Premier is a strategic alliance of leading hospitals and healthcare systems across the country, representing nearly 215 owners and the 800 hospitals and healthcare facilities they operate, and approximately 900 other affiliated hospitals. Premier provides hospitals and healthcare systems across the nation with products and services designed to help them reduce costs, develop integrated delivery systems, manage technology, and share knowledge. The organization maintains offices in Charlotte, NC; San Diego, CA; Chicago, IL; and Washington, DC.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES,
Washington, DC, October 2, 1998.

Hon. ROBERT BENNETT,
U.S. Senate, Dirksen Senate Offices Building,
Washington, DC.

DEAR SENATOR BENNETT: I write to convey the Association of American Medical Colleges' (AAMC) support for your bill entitled the ''Medical Information Protection Act.'' The AAMC represents the nation's 125 accredited medical schools, approximately 400 major teaching hospitals, and 86 academic and professional societies representing over 90,000 faculty members.

We believe the Medical Information Protection Act is a thoughtful effort to address the very important and complex issues surrounding the protection of patient health information. This legislation is a significant step in the right direction as Congress attempts to achieve the delicate balance between the competing goods of individual privacy and the considerable public benefit that results from controlled access to health information that is crucial to our country's continuing ability to deliver high-quality health care and cutting-edge research.

Over the past year, the AAMC has advocated for medical information privacy legislation that employees appropriate confidentiality safeguards while ensuring access to patient records and other archival materials required to pursue biomedical, behavioral, and health services research. The AAMC is pleased that the Medical Information Protection Act incorporates many of the major principles articulated by the Association.

In particular, the AAMC supports the legislation's clear and workable definitions for ''protected health information'' and ''non-identifiable health information,'' the creation of appropriate safeguards and stiff penalties to protect patient confidentiality, and the proposed preemption of state privacy laws. While recognizing that preemption is a politically highly-charged issue, the Association believes that, in an era of rapidly emerging information technology and major consolidation of the health care industry, protecting the ability of medical information to flow unimpeded across state lines is essential to the functioning of a high-quality, medically-effective and efficient care delivery system.

In addition, the AAMC applauds the bill's affirmation of support for the role of institutional review boards in the disclosure of protected health information for research purposes. We believe that the security of medical information created, maintained and used in the course of medical research would be significantly strengthened by the provisions of this bill.

We thank you for your leadership on this issue and look forward to continuing to work with you as this bill is considered by the Senate.

Sincerely,

JORDAN J. COHEN, M.D.
President.

By Mr. LIEBERMAN (for himself, Mr. DODD, Mr. KERRY, Mr. LAUTENBERG, and Mr. TORRICELLI):

S. 2610. A bill to amend the Clean Air to repeal the grandfather status for electric utility units; to the Committee on Environment and Public Works.

THE CLEAN ELECTRIC POWER ACT OF 1998

Mr. LIEBERMAN. Mr. President, I am pleased to introduce today the Clean Electric Power Act of 1998, and to be joined by my colleagues Senators DODD, KERRY, LAUTENBERG, and TORRICELLI.

This legislation would address a gap in the Clean Air Act that exempts older power plants from strict environmental standards, allowing them to emit more pollutants than newer facilities and contributing to serious environmental problems. This disparity is of particular concern right now as we enter the new world of restructuring of the electric utility industry—a world that was never envisioned at the time of any of the Clean Air Act Amendments, including the 1990 Amendments. Because most of the older plants don't have to expend the same amount of money on environmental controls that newer plants do, it is simple economics that these older plants will benefit under deregulation by increasing their generation of power and, therefore, their emissions of dangerous pollutants into the air. This situation is unfair to utilities that generate electricity while meeting stricter environmental standards, and it is unfair to the public whose health will be endangered.

Electricity deregulation carries the promise of enormous benefits for the consumer in terms of reduced electric bills which I strongly support. But unless we do it right, electricity deregulation also can result in significant adverse environmental and public health effects. Some of the early results from the initial efforts at deregulation of wholesale power sales, as well as studies containing projections about what might occur, are very disturbing:

In February, EPA projected increases of 553,000 tons of nitrogen oxides and 62 million tons of carbon by the year 2010 resulting from restructuring, without provisions in restructuring legislation to address pollution increases.

THe Northeast States for Coordinated Air Use Management in January 1998 found that several large Midwestern power companies substantially increased their wholesale electricity sales between 1995 and 1996. This meant substantially increased generation at several of the companies' highest polluting coal-fired power plants, large increases in the flow of power from the Midwest towards the east, and substantial increases in emissions from power plants.

A 1995 Harvard University Study concluded that electricity restructuring could adversely affect environmental quality for a number of reasons, including increasing utilization of older, higher emitting coal facilities.

A 1996 Resources for the Future Study examined the regional air pollution effects that could result from a more competitive market. The study concluded that in the year 2000, the Nation's NO_X emissions would increase by about 350,000 tons and the carbon dioxide emissions would increase by about 114 million tons.

Let me give a little background about how we got to where we are.

A series of requirements in the 1970 and 1977 Clean Air Act and amendments thereto required that utility plants meet new source performance standards for pollutants, including nitrogen oxides and sulfur dioxide. The act defines these standards as emissions limits reflecting the degree of emission limitation achievable through the application of the best system of emission reduction, taking into account cost, as determined by the Administrator. However, these standards were only imposed on new generating plants, and did not cover existing plants, plants under construction, or in the permitting process or being planned for, unless they undertook major construction.

At the time, the view was that it would be more cost-effective to impose stricter standards on new facilities than existing ones, and that many of the existing facilities would be retiring soon. But for a number of economic reasons, the anticipated retirement of plants did not occur. More than half of the power plants operating today were built before the new source standards went into effect.

My legislation would require that power plants that generate electricity that flows through transmission or connected facilities that cross State lines comply with the stricter environmental standards. It would also require EPA to set up a market-based allowance trading program to allow utilities to comply in the most cost-effective manner.

Electric power generating plants are among the largest sources of air pollution in the United States. According to EPA reports, power plants account for 67 percent of all sulfur dioxide emissions, 28 percent of all nitrogen oxide emissions, 36 percent of all carbon dioxide emissions and over 33 percent of mercury emissions. These pollutants contribute significantly to some of the most urgent public health and environmental problems in the United States, including smog, fine particles acid rain, excessive nutrient loads to important water bodies such as Long Island Sound, toxic impacts on health and ecosystems from mercury emissions, climate change, and nitrogen saturation of sensitive forest ecosystems.

This is not to say that older plants do not have any pollution controls. Some controls are required on these plants under older standards, State Implementation Plans, and the requirements under the acid rain provisions of the Clean Air Act Amendments of 1990. But in many cases, the controls fall far short of levels that would be achieved under the new source performance standards. Some studies show that the older plants emit pollutants at rates that are often four to ten times higher than the cleanest operating plants, but there is significantly less disparity in areas where states have imposed tighter controls under the State Implementation Plans, state laws or regional programs such as California and parts of the Northeast. In addition, EPA's new regulation requiring 22 states to reduce NO_x emissions will result in significant reductions at many power plants. The bill makes clear that nothing affects the obligations of sources to comply with that new regulation in the timeframe set forth by EPA or to comply with any other provision of the Clean Air Act.

But we still have a situation where there is currently an unacceptably high level of power plant emissions and, in many cases, a disparity in emission requirements between different generators. On top of this, we have a new era of electricity deregulation and restructuring which we are entering at a rapid pace; in the foreseeable future, retail consumers all over the country may be able to choose their supplier of electricity. As I've noted, this era of deregulation was never envisioned at the time of either the 1977 Clean Air Act Amendments or the more recent 1990 Amendments. Increasing competitive markets provide opportunities for relatively low cost generators to increase generation; where cost differentials are due in part to differences in emission standards this will mean increases in generation at the highest emitting plants.

Mr. President, the good news is that cost-effective technologies are available to meet these stricter standards. For example, the Northeast States for Coordinated Air Use Management and the Mid-Atlantic Regional Air Management Association have recently completed a report on the availability of controls for NO_x and the cost-effectiveness of those controls. The report shows that a number of advanced emissions control technologies are available that can reduce NO_x emissions from utilities by 85 percent or more, and that these controls are not only feasible but are highly cost-effective. The report looked at real world experience with the application of available technology at 19 coal fired facilities

and found that NO_x emissions nearly 50 percent stricter than EPA's new standard for NO_x can be achieved at the vast majority of coal utilities. Of course, under the bill grandfathered utilities would have the option of purchasing allowances as an alternative method of meeting the performance standards.

Mr. President, as we enter the era of deregulation we have a unique opportunity to provide great benefits for the consumers and reduce air pollution, which I strongly support. But we need to ensure that proper pollution safeguards are in place to rectify the current disparity in standards and to ensure that air pollution does not increase in a competitive market.

Mr. President, I ask unanimous consent that the full text of my legislation be included in the RECORD.

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

S. 2610

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

SECTION 1. STANDARDS OF PERFORMANCE FOR ELECTRIC UTILITY UNITS.

(a) FINDINGS.—Congress finds that—

(1) older electric utility units are exempt from strict emission control requirements applicable to newer facilities, allowing some older units to emit greater quantities of dangerous pollutants;

(2) this disparity in regulatory treatment is of particular concern in the new era of electric utility restructuring, which was never envisioned at the time of enactment of the Clean Air Act (42 U.S.C. 7401 et seq.) or amendments to that Act;

(3) in an era of electric utility restructuring, utilities that spend less money on environmental controls will be able to increase their generation of power and emissions of dangerous pollutants;

(4) this situation results in an unfair competitive disadvantage for utilities that generate electricity while meeting strict environmental standards; and

(5) electricity restructuring can result in enormous benefits for consumers and the environment if done right.

(b) STANDARDS.—Section 111 of the Clean Air Act (42 U.S.C. 7411) is amended by adding at the end the following:

''(k) STANDARDS OF PERFORMANCE FOR ELECTRIC GENERATING UNITS.—

''(1) DEFINITION OF GRANDFATHERED UNIT.—In this subsection, the term 'grandfathered unit' means a fossil fuel-fired electric utility unit that, before the date of enactment of this subsection, was not subject to the standards of performance set forth in subpart D of part 60 of title 40, Code of Federal Regulations, or to any subsequently adopted standard of performance under this section applicable to fossil fuel-fired electric utility units.

''(2) APPLICABILITY.—Notwithstanding any other provision of law, in the case of a fossil fuel-fired electric utility unit, a standard of performance under this section that applies to new or modified electric utility units shall also apply to a grandfathered unit that—

''(A) has the capacity to generate more than 25 megawatts of electrical output per hour; and

''(B) generates electricity that flows through transmission or connected facilities that cross State lines (including electricity in a transaction that for regulatory purposes is treated as an intrastate rather than an interstate transaction).

''(3) DEADLINES FOR COMPLIANCE.—Each grandfathered unit shall comply with—

''(A) a standard of performance established under this section before the date of enactment of this subsection, not later than 5 years after the date of enactment of this subsection; and

''(B) a standard of performance established under this section on or after the date of enactment of this subsection, not later than 3 years after the date of establishment of the standard.

''(4) ALTERNATIVE COMPLIANCE.—

''(A) IN GENERAL.—To provide an alternative means of complying with standards of performance made applicable by this subsection, the Administrator shall—

''(i) establish national annual limitations for calendar year 2003 and each calendar year thereafter for each pollutant subject to the standards at a level that is equal to the aggregate emissions of each pollutant that would result from application of the standards to all electric utility units subject to this section;

''(ii) allocate transferable allowances for pollutants subject to the standards to electric utility units subject to this section in an annual quantity not to exceed the limitations established under clause (i) based on each unit's share of the total electric generation from such units in each calendar year; and

''(iii) require grandfathered units to meet the standards by emitting in any calender year no more of each pollutant regulated under this section than the quantity of allowances that the unit holds for the pollutant for the calendar year.

''(B) CALCULATION OF LIMITATIONS.—In calculating the limitations under subparagraph (A)(i), the Administrator shall apply the standard for the applicable fuel type in effect in calendar year 2000.

''(5) NO EFFECT ON OBLIGATION TO COMPLY WITH OTHER PROVISIONS.—Nothing in this subsection affects the obligation of an owner or operator of a source to comply with—

''(A) any standard of performance under this section that applies to the source under any provision of this section other than this subsection; or

''(B) any other provision of this Act (including provisions relating to National Ambient Air Quality Standards and State Implementation Plans).''.

By Mr. ROTH (for himself, Mr. LIEBERMAN, and Mr. MACK):

S. 2611. A bill to amend title XVIII of the Social Security Act to enable medicare beneficiaries to remain enrolled in their chosen medicare health plan; to the Committee on the Judiciary.

MEDICARE LEGISLATION

Mr. ROTH. Mr. President, yesterday the President announced his plans for helping Medicare beneficiaries who are enrolled in health plans which are not renewing their Medicare contracts for next year. I am glad that President Clinton recognizes the problems Medicare beneficiaries are facing and I think it is important that we all work together to address this issue. But I am concerned that the President offered a 'tomorrow' solution for today's problem.

The problems facing Medicare HMO beneficiaries need attention now and cannot wait until next year. The President's proposal is inadequate and we must take immediate action to help Medicare beneficiaries to stay in their chosen health plans.

Across the country, including in my home state of Delaware, thousands of Medicare beneficiaries are losing their HMO coverage and being forced back into the original Medicare program with expensive Medigap policies. We need to help these beneficiaries today.

I am urging my colleagues in the House and Senate to act now to allow Medicare managed care plans that have withdrawn from the program to get back into Medicare. The legislation I am introducing today, along with my colleagues Senator LIEBERMANN and Senator MACK, would instruct the Health Care Financing Administration to allow these plans to restructure their costs where justified. This would give many of the health insurance providers the flexibility they need to go back in to these markets. But most critically important, it would give beneficiaries the opportunity to remain in their current plans without the disruption and increased costs that they will otherwise face.

I am presenting this legislation today after several attempts over the last month to work with the Administration to allow Medicare+Choice plans to update their cost and beneficiary filings for 1999. I had hoped to resolve this problem administratively—before these plans made their final decisions to pull out of 371 counties leaving 220 thousand beneficiaries to find another Medicare option. I sent a letter to HCFA head Nancy-Ann Min Deparle urging HCFA to take immediate action to prevent these manage care plans from leaving the Medicare+Choice program.

I find it highly regrettable that the Health Care Financing Administration decided not to allow Medicare+Choice plans to update their cost and benefit filings for 1999. This decision could undermine the Medicare+Choice program enacted into law just last year and which I believe holds so much promise for improving Medicare for seniors.

HCFA's shortsighted decision will result in large out-of-pocket cost increases, fewer benefits, and fewer choices for hundreds of thousands of Medicare beneficiaries. The beneficiaries who will bear the hardest brunt of the Administration's decision are the 455,000 enrolled in non-renewing Medicare+Choice plans in counties where no additional plans exist. These beneficiaries will now be left with only a significantly more expensive Medicare option; that is, the original Medicare program combined with a Medigap insurance policy. This is particularly unfortunate given that premiums for Medigap insurance policies have been sharply increasing each year. In fact, the American Association for Retired Persons announced just this week that its Medigap insurance premiums will increase by an average of 9 percent nationwide next year.

And even in areas where beneficiaries will be left with one or more health plan options, the plan withdrawal will result in reduced competition which translates to higher out-of-pocket costs for Medicare beneficiaries.

I am very concerned by the agency's failure to evaluate potential increased beneficiary cost-sharing when making the critical decision not to allow plans to update their cost and benefit filings. I believe this action demonstrates HCFA's continued resistance to facilitate private plan choices for Medicare beneficiaries, regardless of the consequence to beneficiaries.

I hope that the Congress and President Clinton will fight the temptation to play politics with Medicare and instead do the right thing for beneficiaries by taking action before Congress adjourns for the year to help beneficiaries to remain in their current Medicare health plans if they so choose. Next year, we can work together toward a more comprehensive solution to this issue.

By Mr. FORD:

S. 2612. A bill to provide that Tennessee may not impose sales taxes on any goods or services purchased by a resident of Kentucky at Fort Campbell, nor obtain reimbursement for any unemployment compensation claim made by a resident of Tennessee relating to work performed at Fort Campbell; to the Committee on Governmental Affairs.

FORT CAMPBELL TAX FAIRNESS ACT OF 1998

Mr. FORD. Mr. President, today I introduce the Fort Campbell Tax Fairness Act. This legislation is designed to restore some sense of balance and maintain some level of fairness in the taxation of individuals who work at the Fort Campbell military installation in Kentucky and Tennessee.

My colleagues may recall that earlier this month, an unprecedented provision was included in the Defense Authorization bill which granted special tax status for a single site—Fort Campbell—to Tennessee residents who work on the Kentucky side of the border. Even worse, the provision in the Defense bill preempted State tax law. It preempted the ability of my State to administer its own tax laws in a fair manner, and in a way in which the State determined was fairest and best.

The provision adopted in the Defense bill exempts Tennessee residents who work in Kentucky at Fort Campbell from paying Kentucky state income taxes. This special exemption was snuck into the House version of the bill, and then maintained in the conference committee. It is extremely unfair.

Mr. President, the Congress has no business dictating to States how they should administer their own tax laws. This is a matter for the States to determine by themselves. The basic principle of taxation is that income is taxed at the location where it is produced. There are exceptions to this rule, but generally they are worked out among and between States themselves. The only other exceptions of which I am aware relate to federal employees with a unique interstate aspect to their jobs, like members of the military or Members of Congress, or other employees with a special interstate job situation, like Amtrak employees or those involved in constructing interstate highways.

I have never heard of a special State tax exemption for private sector employees at a single site. That is, I had never heard of it until I saw this year's Defense Authorization bill.

But Mr. President, the provision in the Defense Authorization bill is a one way street. It preempts Kentucky state law for Tennessee residents who would otherwise be taxed within Kentucky's borders. But there is no comparable preemption of Tennessee state law for Kentucky residents who are taxed at Fort Campbell within Tennessee's borders.

As a matter of basic fairness, if Tennessee residents are to be granted a special tax exemption while on the Kentucky side of Fort Campbell, Kentucky residents should be given equal consideration while on the Tennessee side of Fort Campbell. In addition, it is currently the case that unemployment compensation for any Tennessee residents who work on the Kentucky side of Fort Campbell are paid out of Kentucky tax dollars. This should no longer be the case now that Tennessee workers are being given a special tax status and are exempt from Kentucky laws.

My legislation attempts to correct these new inequities created by the passage of this year's Defense Authorization bill. First, it would direct that Tennessee sales taxes imposed on the Tennessee side of Fort Campbell apply only to Tennessee residents. The distinguished Senator from Tennessee, in debate on the Defense Authorization bill, asserted that no such taxes are currently collected at Fort Campbell. Therefore, he should have no objection to this provision whatsoever. However, I have been informed that Tennessee sales taxes are in fact collected from private business operations within the Fort Campbell boundaries. So this provision is badly needed as a matter of fairness.

Second, the legislation clearly states that the Commonwealth of Kentucky has absolutely no obligation to continue paying the unemployment benefits of Tennessee residents out of Kentucky tax dollars. Since Tennessee residents have been given this special tax status and preemption of State laws, Kentucky should no longer have any liabilities should these workers become unemployed. Those claims should be the responsibility of the State of Tennessee.

Mr. President, I have always attempted to fiercely defend the interests of my State during my 24 years in the Senate. The special tax preemption provision tucked into the Defense Authorization bill was one of the most unfair provisions imaginable, singling out my State for unfair treatment. I realize the time is short in the current session, and the odds of enacting this legislation are not great in the days ahead. However, I am introducing this bill to go on the Record in advocating fairness for my State. It is my hope that when the Congress reconvenes vigorously pursue efforts to pass this legislation and correct an unfairness which has been imposed upon my State.

By Mr. COATS:

S. 2614. A bill to amend chapter 96 of title 18, United States Code, to enhance the protection of first amendment rights; to the Committee on the Judiciary.

THE FIRST AMENDMENT FREEDOMS ACT OF 1998

Mr. COATS. Mr. President, in 1970, Congress passed provisions known as the Racketeer Influenced and Corrupt Organization Act, or RICO, as part of the larger Organized Crime Control Act of 1970. The bill was designed to help law enforcement officials better address the plague of organized crime, and has been a valuable tool in this effort.

During drafting of this legislation, concerns were raised by several members of this body, including my colleague from Massachusetts, Senator KENNEDY, that the bill was written so broadly that it might be used against organized civil disobedience, including anti-war demonstrators. This was at the height of the Vietnam War, and anti-war demonstrations were taking place across the country. Senator KENNEDY, along with Senator HART of Michigan, submitted their views as part of the Senate Judiciary Committee Report on the Organized Crime Control Act of 1969.

I think their words deserve our attention today. They recognized that, and I quote: ''To combat organized crime, as distinguished from other forms of criminal activity, requires procedures specifically designed for that purpose.'' They continued, ''The reach of this bill goes beyond organized criminal activity. Most of its features propose substantial changes in the general body of criminal procedures. Finally, their statement notes that, ''Amended to restrict its scope solely to organized criminal activity and to assure the protection of individual rights, the bill could contribute important and useful means of eradicating organized crime.'' Mr. President, I ask that a copy of this statement from the Judiciary Committee Report be included in the RECORD.

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

INDIVIDUAL VIEWS OF MESSRS. HART AND KENNEDY

To combat organized crime, as distinguished from other forms of criminal activity, requires procedures specifically designed for that purpose.

S. 30, the Organized Crime Control Act of 1969, is billed as a means of providing the procedures necessary to eradicate the disease of organized crime and its serious threat to our national security.

But the reach of this bill goes beyond organized criminal activity. Most of its features propose substantial changes in the general body of criminal procedures.

New rules of evidence and procedure applicable to all criminal jurisprudence are established.

Amended to restrict its scope solely to organized criminal activity and to assure the protection of individual rights, the bill could contribute important and useful means of eradicating organized crime.

Mr. COATS, in direct response to the legitimate concerns raised by Senator KENNEDY, Senator HART, the ACLU, and others, the language of the Organized Crime Control Act was modified to narrow the definition of racketeering activity. These modifications were seen as adequate, and debate moved on to other issues. It is clear from the record of congressional debate that nobody—not the bill's author, Senator MCCLELLAN, not the Judiciary Committee, not the House of Representatives, not my colleague from Massachusetts—nobody was interested in prosecuting civil disobedience as organized crime.

Mr. President, our country has a long and distinguished history of political free speech under the First Amendment. At times, political and social protesters have seen civil disobedience as the best manner to bring the message home. From abolitionists of the 18th and 19th centuries to the civil rights demonstrations of Dr. Martin Luther King, non-violent civil disobedience has played a major role in shaping this nation. While civil disobedience is inherently ''disobedient'' to the law, and while such violations of the law have consequences, there is a vast difference between organized crime and organized political protest.

Today, this difference is becoming much less noticeable As many of us know, on April 20, 1998, a U.S. District Court jury ruled that anti-abortion leaders had violated federal anti-racketeering statutes by engineering a nationwide conspiracy that involved 21 acts of extortion, mostly the formation of barricades that prevented the use of clinics performing abortions. The defendants were ordered to pay nearly $86,000 in damages. That penalty was automatically tripled under RICO. We are not talking about abortion protesters being charged with political violence—murder, bombing of abortion clinics, or physical violence against patients or employees of the clinics involved. Rather, we are talking about these protesters being charged as racketeers for non-violent forms of civil disobedience.

This is not an isolated decision, but rather followed on the heels of a 1994 Supreme Court opinion regarding the scope of RICO. In the case of NOW v. Scheidler, the Supreme Court ruled that the National Orgnaization for Women could bring suit under RICO against a coalition of anti-abortion groups, alleging the defendants were members of a nationwide conspiracy to shut down abortion clinics through a pattern of racketeering activity. Both the U.S. District Court and Court of Appeals had dismissed the suit on grounds that RICO implied an ''economic motive'' for the racketeering activity. The Supreme Court reversed the lower court decisions in finding that the letter of the law in RICO did not require proof that either racketeering enterprise or predicate acts of racketeering be motivated by economic purpose. The Supreme Court then remanded the case to the District Court.

The Supreme Court ruling and the subsequent U.S. District Court decision have radically expanded the scope of federal anti-racketeering statues in direct contradiction to the clear intent of Congress in the creation of RICO. The result of the rulings is that civil disobedience is now open to prosecution as organized crime. This is already having a chilling effect on free speech in this country.

Mr. President, before going further on this matter, let me make several things very clear. First, this is not an abortion issue. The Senate must continue to wrestle with the morality of the legality of abortion in this country, and my colleagues are well aware of my deep convictions on this matter, but that is not what I am here to discuss. The application of federal anti-racketeering statues to political protest and civil disobedience is not an abortion issue—it is a First Amendment issue. While the catalyst for the expansion of RICO was its application to pro-life demonstrators, the case could just as easily could have involved civil rights advocates, animal rights activities, anti-war demonstrators, or AIDS activists. The issue is not abortion, it is political speech.

Let me also make clear that the issue is not whether civil disobedience should be punished: it is, and it should be. This country has a proud history of both the rule of law and the practice of civil disobedience. In a nation under the rule of law, civil disobedience has legal consequences. I am not here to debate whether abortion protesters, AIDS activists, or animal rights demonstrators should abide by the law, or, when they break the law, they should be accountable. There are federal and state laws on the books dealing with trespassing, vandalism, and many other crimes commonly associated with civil disobedience. However, the punishment ought to fit the crime. What we have, in the expansion of RICO, is the application of the heavy rod intended for organized crime, being turned against organized political protest.

Finally, let me emphasize that I am not here to debate political violence. Murder, arson, death threats, physical harm—these are not acts of civil disobedience, but of terrorism, and RICO specifically applies to a pattern of such activities. I am not concerned with protecting these actions, whether engaged in by anti-abortion demonstrators or environmental activists.

What does concern me deeply, is the prosecution of non-violent civil disobedience as racketeering activity. Under RICO, whoever participates in a commercial ''enterprise'' or an ''enterprise'' which has an impact on commerce, through a pattern of specific criminal ''racketeering'' activity, can be penalized. Typical ''racketeering'' activity includes murder, kidnapping, robbery, arson, bribery, loan-sharking, mail fraud, wire fraud, obstruction of justice, witness retaliation, or extortion. Also included as racketeering activity is violation of the Hobbs Act, which modified the Anti-Racketeering Act of 1934. The Hobbs Act includes a provision which prohibits affecting commerce by ''extortion'' using ''wrongful or threatened force, violence, or fear.''

It is this final provision which has been expanded by the Courts to apply to those engaged in civil disobedience. While under common law understanding, ''extortion'' requires the actual trespatory taking of property, the term is now being interpreted as ''coercion,'' which involves compulsion of action. Political and social protest by its very nature attempts to compel a change of actions, whether it be the actions of a logging company cutting old growth forests, a restaurant that will not serve minorities, a business that will not promote women, or a health clinic performing abortions. Such organized efforts to compel action, inherent in civil disobedience, are now captured in the net of RICO.

As I stated earlier, Congress did not envision, and could not conceive, of this application of the law, especially in the wake of the modifications undertaken at the time. In its original draft, RICO specified, and I quote, ''any act dangerous to life, limb, or property,'' as predicate offenses. In direct response to concerns raised by several members of Congress, including the Senator from Massachusetts, that this wording could put civil disobedience into jeopardy, the language was redrafted to clearly define RICO's predicate offenses, specifying particular state and federal offenses. No offense remotely related to rioting, trespass, vandalism, or any other aspect of a demonstration that might stray beyond constitutional limits was included as racketeering activity. While state and federal law continues to apply to many of these violations, these were intentionally excluded from the scope of anti-racketeering laws and the increased punishments these entailed.

Mr. President, in response to recent Court rulings which have grossly expanded the scope of federal anti-racketeering laws to cover non-violent political protest, I am introducing the First Amendment Freedoms Act today. This legislation restores RICO to its originally intended application of organized criminal activity, and codifies Supreme court opinion regarding the protection of First Amendment rights.

Specifically, the bill does two things. First, it narrows the judicially expanded definition of ''extortion'' under RICO, which has allowed for the erroneous prosecution of civil disobedience under this statute. Second, it assures that, in any civil action brought under RICO or any other legal theory, the litigation is conducted consistent with the First Amendment guidelines of the Supreme Court.

Our nation has a long and distinguished history of non-violent civil disobedience as a legitimate form of political and social protest. Such activity has legal consequences. However, such activity is not the equivalent of organized crime. The prosecution of political and social protest under federal anti-racketeering statutes is entirely contrary to anything Congress foresaw in enacting RICO. Congress should act expeditiously to correct this obvious misapplication of the law.

Martin Luther king, Jr., in his acceptance of the Nobel Peace Prize in 1964, said that: ''Nonviolence is the answer to the crucial political and moral questions of our time; the need for man to overcome oppression and violence without resorting to oppression and violence.'' Those who engage in non-violent civil disobedience should not, and it was never the intent of Congress that they would be, prosecuted as criminal racketeers. If the current interpretation of the law had been in effect in the 1950's and 60's, the civil rights movement could easily have been quashed. I trust that Congress will take steps to address this matter in a timely manner.

Mr. President, I send my bill to the desk, and I yield the floor.

By Mr. MURKOWSKI:

S. 2615. A bill to study options to improve and enhance the protection, management, and interpretation of the significant natural and other resources of certain units of the National Park System in northwest Alaska, to implement a pilot program to better accomplish the purposes for which those units were established by providing greater involvement by Alaska Native communities, and for other purposes; to the Committee on Energy and Natural Resources.

ALASKA NATIONAL INTEREST LEGISLATION

• Mr. MURKOWSKI. Mr. President, the legislation that I have introduced today will require the Secretary of the Interior to report on what he has done, or not done, to implement the requirements of sections 1307 and 1308 of the Alaska National Interest Lands Conservation Act. Those provisions sought to mitigate the effect of the designation of over 100 million acres of land in Alaska for permanent preservation on the Alaska Natives who have lived in the areas for centuries. Those provisions required the Secretary to allow those who were already providing visitor services to continue to provide such services and also provided a preference in hiring at those conservation units for local residents.

Those provisions were intended to accomplish several objectives. First and foremost, they were designed to ensure that local residents who would assume the costs attendant to the establishment of these conservation units as a result of future limitations on economic opportunities received some of the benefits from whatever jobs were created. The provisions also ensured that the rich history and knowledge of the area that the local native population possessed was made available to visitors. For a change, Washington could learn from those in the surrounding communities. There would also be an incidental benefit from hiring local residents to the budget of the National Park Service since they would not have to pay employees to relocate to Alaska.

Mr. President, while speaking to the issue of benefits, I have been told by several of the residents of Kotzebue that they have assisted in the rescue of Park Service personnel on a number of occasions. It makes little sense to me to bring someone to the Northwest parks from the lower forty-eight who is unfamiliar with the rugged terrain and treacherous weather. It makes better sense to hire an individual who stands little chance of getting lost or stranded.

This is not a new concept. In various other units of the National Park System we have made provisions to take advantage of local communities, especially where the resource has particular historic or religious significance. At Zuni-Cibola Historical Park, for example, section 4 of Public Law 100-567 specifically authorizes the Secretary to enter into cooperative agreements with the Zuni Tribe and individual tribal members to provide training for the interpretation, management, protection, and preservation of archaeological and historical properties and in the provision of public services on the Zuni Indian Reservation to accomplish the purposes for which that unit of the Park System was established.

At the National Park of American Samoa, the Secretary has been directed to establish a program to train native American Samoan personnel to function as professional park service employees and to provide services to visitors and operate and maintain park facilities. The law establishing the park also provided a preference for the hiring of local Samoans both as employees and under any contract. The general management plan for the park is to be developed in cooperation with the Governor of American Samoa. It is also conceivable, under the legislation, that after fifty years, sole authority to administer the park could be turned over to the Governor of American Samoa from the Secretary.

There are other examples, but I think the time is long overdue for this philosophy to be realized at conservation units in Alaska. The Department of the Interior, in my view, has been dragging its feet and has failed to take advantage of the rich human resources present in the Alaska Native communities that lie in proximity to National Parks and Refuges. These units are remarkable and this Nation is not well served when the Secretary fails to take advantage of the local population.

In particular, the four northwest Alaska units of the National Park System would be a good place for the Secretary to begin complying with section 1307 and 1308 of ANILCA and start contracting with the local people for the management of these park units.

Bering Land Bridge National Preserve is a remnant of the land bridge that connected Asia with North America more than 13,000 years ago. The land bridge itself is now overlain by the Chukchi Sea and the Bering Sea. During the glacial epoch, this area was part of a migration route for people, animals, and plants whenever ocean levels fell enough to expose the land bridge. Scientists find it one of the most likely regions where prehistoric Asian hunters entered the New World.

Today Eskimos from neighboring villages pursue subsistence lifestyles and manage their reindeer herds in and around the preserve. Some 112 migratory bird species may be seen in the Preserve, along with occasional seals, walrus, and whales. Grizzly bears, fox, wolf, and moose also inhabit the Preserve. Other interesting features are rimless volcanoes called Maar craters, Serpentine Hot Springs, and seabird colonies at Sullivan Bluffs.

Cape Krusenstern National Monument is comprised of 659,807 acres of land and water—a coastal plain dotted with sizable lagoons and backed by gently rolling, limestone hills. The Cape Krusenstern area has been designated an Archeological District in the National Register of Historic Places, and a National Historic Landmark. The core of the archeologic district is made up of approximately 114 marine beach ridges. These beach ridges, formed of gravel deposited by major storms and regular wind and wave action, record in horizontal succession the major cultural periods of the last 4,500 years. The prehistoric inhabitants of northwest Alaska occupied the cape seasonally to hunt marine mammals, especially seals. As new beach ridges were formed, camps were made on the ridges closest to the water. Thus, over centuries, a chronological horizontal stratigraphy was laid down in which the oldest cultural remains were found on the beach ridges farthest from the ocean. The discoveries made at Cape Krusenstern National Monument provided a definite, datable outline of cultural succession and development in northwest Alaska.

The park contains approximately 1,726,500 acres of federal lands and encompasses a nearly enclosed mountain basin in the middle section of the Kobuk River in the Northwest Alaska Areas. Trees approach their northern limit in the Kobuk Valley, where forest and tundra meet. Today's dry, cold climate of the Kobuk Valley still approximates that of late Pleistocene times, supporting a remnant flora once covering the vast Arctic steppe tundra bridging Alaska and Asia. Sand created by the grinding of glaciers has been carried to the Kobuk Valley by winds and water. The great Kobuk Sand Dunes—25 square miles of shifting dunes—is the largest active dune field in the arctic latitudes.

Native people have lived in the Kobuk Valley for at least 12,500 years. This human use is best recorded at the extensive archeological sites at Onion Portage. The Kobuk Valley remains an important area for traditional subsistence harvest of caribou, moose, bears, fish, waterfowl, and many edible and medicinal plants. The slow-moving, gentle Kobuk River is tremendous for fishing and canoeing or kayaking.

Noatak National Preserve lies in northwestern Alaska, in the western Brooks Range, and encompasses more than 250 miles of the Noatak River. The preserve protects the largest untouched mountain-ringed river basin in the United States. The river basin provides an outstanding resource for scientific research, environmental education, and subsistence and recreational opportunities.

Above the Arctic Circle, the Noatak River flows from glacial melt atop Mount Igikpak in the Brooks Range out to Kotzebue Sound. Along its 425-mile course, the river has carved out the Grand Canyon of the Noatak. The preserve is in a transition zone between the northern coniferous forests and tundra biomes. The river basin contains most types of arctic habitat, as well as one of the finest arrays of flora and fauna. Among the Preserve's large mammals are brown bears, moose, caribou, wolves, lynx, and Dall sheep. Birdlife also is plentiful in the area because of the migrations from Asia and the tip of South America. The Noatak River supports arctic char, whitefish, grayling, and salmon and is an important resource for fishing, canoeing, and kayaking.

Mr. President, these are the human and natural resources of Northwest Alaska. This legislation will direct the Secretary to finally bring the two together for the benefit of both Alaska Natives and the nation.●

By Mr. ROTH (for himself and Mr. MOYNIHAN):

S. 2616. A bill to amend title XVIII of the Social Security Act to make revisions in the per beneficiary and per visit payment limits on payment for health services under the Medicare program; to the Committee on Finance.

HEALTH SERVICES LEGISLATION

Mr. MOYNIHAN. Mr. President, I am pleased to join my distinguished Chairman, Senator ROTH, and other colleagues in introducing a bill to improve the home health interim payment system.

Prior to the Balanced Budget Act of 1997 (BBA), home health agencies were reimbursed on a cost basis for all their costs, as long as they maintained average costs below certain limits. That payment system provided incentives for home health agencies to increase the volume of services delivered to patients, and it attracted many new agencies to the program. From 1989 to 1996, Medicare home health payments grew at an average annual rate of 33 percent, while the number of home health agencies increased from about 5,700 in 1989 to more than 10,000 in 1997.

In order to constrain the growth in costs and usage of home care, the BBA included provisions that would establish a Prospective Payment System (PPS) for home health care, a method of paying health care providers whereby rates are established in advance. An interim payment system (IPS) was also established while the Health Care Financing Administration works to develop the PPS for home health care agencies.

The home health care industry is dissatisfied with the IPS. The resulting concern expressed by many Members of Congress prompted us to ask the General Accounting Office (GAO) to examine the question of beneficiary access to home care. While the GAO found that neither agency closures nor the interim payment system significantly affected beneficiary access to care, I remain concerned that the potential closure of many more home health agencies might ultimately affect the care that beneficiaries receive, particularly beneficiaries with chronic illness.

The bill we are introducing today adjusts the interim payment system to achieve equity and fairness in payments to home health agencies. It would reduce extreme variations in payment limits applicable to old agencies within states and across states and would reduce artificial payment level differences between ''old'' and ''new'' agencies. The bill would provide all agencies a longer transition period in which to adjust to changed payment limits.

Clearly, since the bill may not address all the concerns raised by Medicare beneficiaries and by home health agencies, we should revisit this issue next year. A thorough review is needed to determine whether the funding mechanism for home health is sufficient, fair and appropriate, and whether the benefit is meeting the needs of Medicare beneficiaries.

America's home health agencies provide invaluable services that have given many Medicare beneficiaries the ability to stay home while receiving medical care. An adjustment to the interim payment system and delay in further payment reductions will enable home health agencies to survive the transition into the prospective payment system while continuing to provide essential care for beneficiaries.

ADDITIONAL COSPONSORS

S. 35

At the request of Mr. FEINGOLD, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 35, a bill to amend the Reclamation Reform Act of 1982 to clarify the acreage limitations and incorporate a means test for certain farm operations, and for other purposes.

S. 1459

At the request of Mr. GRASSLEY, the names of the Senator from Maine (Ms. COLLINS) and the Senator from Minnesota (Mr. WELLSTONE) were added as cosponsors of S. 1459, a bill to amend the Internal Revenue Code of 1986 to provide a 5-year extension of the credit for producing electricity from wind and closed-loop biomass.

S. 1557

At the request of Mr. TORRICELLI, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 1557, a bill to end the use of steel jaw leghold traps on animals in the United States.

S. 1855

At the request of Mr. WYDEN, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 1855, a bill to require the Occupational safety and Health Administration to recognize that electronic forms of providing MSDSs provide the same level of access to information as paper copies.

S. 1868

At the request of Mr. LAUTENBERG, his name was added as a cosponsor of S. 1868, a bill to express United States foreign policy with respect to, and to strengthen United States advocacy on behalf of, individuals persecuted for their faith worldwide; to authorize United States actions in response to religious persecution worldwide; to establish an Ambassador at Large on International Religious Freedom within the Department of State, a Commission on International Religious Persecution, and a Special Adviser on International Religious Freedom within the National Security Council; and for other purposes.

S. 2024

At the request of Mr. ASHCROFT, the names of the Senator from Iowa (Mr. GRASSLEY), the Senator from Utah (Mr. HATCH), and the Senator from South Carolina (Mr. THURMOND) were added as cosponsors of S. 2024, a bill to increase the penalties for trafficking in methamphetamine in order to equalize those penalties with the penalties for trafficking in crack cocaine.

S. 2078

At the request of Mr. GRASSLEY, the names of the Senator from Washington (Mr. GORTON), the Senator from Texas (Mrs. HUTCHISON), and the Senator from Louisiana (Mr. BREAUX) were added as cosponsors of S. 2078, a bill to amend the Internal Revenue Code of 1986 to provide for Farm and Ranch Risk Management Accounts, and for other purposes.

S. 2110

At the request of Mr. BIDEN, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 2110, a bill to authorize the Federal programs to prevent violence against women, and for other purposes.

S. 2182

At the request of Mr. GORTON, the name of the Senator from Utah (Mr. BENNETT) was added as a cosponsor of S. 2182, a bill to amend the Internal Revenue Code of 1986 to provide tax-exempt bond financing of certain electric facilities.