

S. 1104

At the request of Mr. GRAHAM, the names of the Senator from Mississippi (Mr. LOTT) and the Senator from Illinois (Mr. FITZGERALD) were added as cosponsors of S. 1104, a bill to establish objectives for negotiating, and procedures for, implementing certain trade agreements.

S. 1111

At the request of Mr. CRAIG, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 1111, a bill to amend the Consolidated Farm and Rural Development Act to authorize the National Rural Development Partnership, and for other purposes.

S. 1119

At the request of Mr. LEAHY, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 1119, a bill to require the Secretary of Defense to carry out a study of the extent to the coverage of members of the Selected Reserve of the Ready Reserve of the Armed Forces under health benefits plans and to submit a report on the study of Congress, and for other purposes.

S. 1209

At the request of Mr. BINGAMAN, the names of the Senator from Illinois (Mr. DURBIN) and the Senator from New York (Mr. SCHUMER) were added as cosponsors of S. 1209, a bill to amend the Trade Act of 1974 to consolidate and improve the trade adjustment assistance programs, to provide community-based economic development assistance for trade-affected communities, and for other purposes.

S. 1226

At the request of Mr. CAMPBELL, the names of the Senator from North Carolina (Mr. HELMS), the Senator from Kentucky (Mr. BUNNING), and the Senator from Arkansas (Mr. HUTCHINSON) were added as cosponsors of S. 1226, a bill to require the display of the POW/MIA flag at the World War II memorial, the Korean War Veterans Memorial, and the Vietnam Veterans Memorial.

S. 1265

At the request of Mr. DURBIN, the names of the Senator from California (Mrs. BOXER) and the Senator from Florida (Mr. GRAHAM) were added as cosponsors of S. 1265, a bill to amend the Immigration and Nationality Act to require the Attorney General to cancel the removal and adjust the status of certain aliens who were brought to the United States as children.

S. RES. 109

At the request of Mr. REID, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. Res. 109, a resolution designating the second Sunday in the month of December as "National Children's Memorial Day" and the last Friday in the month of April as "Children's Memorial Flag Day."

S. CON. RES. 3

At the request of Mr. FEINGOLD, the name of the Senator from Delaware

(Mr. BIDEN) was added as a cosponsor of S. Con. Res. 3, a concurrent resolution expressing the sense of Congress that a commemorative postage stamp should be issued in honor of the U.S.S. *Wisconsin* and all those who served aboard her.

S. CON. RES. 4

At the request of Mr. NICKLES, the name of the Senator from Missouri (Mrs. CARNAHAN) was added as a cosponsor of S. Con. Res. 4, a concurrent resolution expressing the sense of Congress regarding housing affordability and ensuring a competitive North American market for softwood lumber.

S. CON. RES. 31

At the request of Mr. THOMPSON, the name of the Senator from Tennessee (Mr. FRIST) was added as a cosponsor of S. Con. Res. 31, concurrent resolution commending Clear Channel Communications and the American Football Coaches Association for their dedication and efforts for protecting children by providing a vital means for locating the Nation's missing, kidnapped, and runaway children.

S. CON. RES. 59

At the request of Mr. HUTCHINSON, the names of the Senator from Oregon (Mr. WYDEN) and the Senator from Oklahoma (Mr. INHOFE) were added as cosponsors of S. Con. Res. 59, a concurrent resolution expressing the sense of Congress that there should be established a National Community Health Center Week to raise awareness of health services provided by community, migrant, public housing, and homeless health centers.

#### STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. HATCH (for himself and  
Mrs. FEINSTEIN):

S. 1272. A bill to assist United States veterans who were treated as slave laborers while held as prisoners of war by Japan during World War II, and for other purposes; to the Committee on Veterans' Affairs.

Mr. HATCH. Mr. President, I rise today with my co-sponsor, Senator FEINSTEIN, to introduce legislation that will help a very special cadre of Americans, a group of Americans that, over 50 years ago, paid a very dear price on behalf of our country. The incredible sacrifice made by these Americans has never properly been acknowledged, and it is high time that they receive some measure of compensation for that sacrifice.

On April 9, 1942, Allied forces in the Philippines surrendered the Bataan Peninsula to the Japanese. Ten to twelve thousand American soldiers were forced to march some 60 miles in broiling heat in a deadly trek known as the Bataan Death March. Following a lengthy internment under horrific conditions, thousands of POWs were shipped to Japan in the holds of freighters known as "Hell Ships." Once in Japan, the survivors of the Bataan

Death March were joined by hundreds of other American POWs, POWs who had been captured by the Japanese in actions throughout the Pacific theater of war, at Corregidor, at Guam, at Wake Islands, and at countless other battlegrounds.

After arriving in Japan, many of the American POWs were forced into slave labor for private Japanese steel mills and other private companies until the end of the war. During their internment, the American POWs were subjected to torture, and to the withholding of food and medical treatment, in violation of international conventions relating to the protection of prisoners of war.

More than 50 years have passed since the atrocities occurred, yet our veterans are still waiting for accountability and justice. Unfortunately, global political and security needs of the time often overshadowed their legitimate claims for justice, and these former POWs were once again asked to sacrifice for their country. Following the end of the war, for example, our government instructed many of the POWs held by Japan not to discuss their experiences and treatment. Some were even asked to sign non-disclosure agreements. Consequently, many Americans remain unaware of the atrocities that took place and the suffering our POWs endured.

Finally, after more than 50 years, a new effort is underway to seek compensation for the POWs from the private Japanese companies which profited from their labor.

Let me say at the outset, that this is not a dispute with the Japanese people and these are not claims against the Japanese government. Rather, these are private claims against the private Japanese companies that profited from the slave labor of our American soldiers who they held as prisoners. These are the same types of claims raised by survivors of the Holocaust against the private German corporations who forced them into labor.

Here in the Senate, we have been doing what we can to help these former prisoners of war. In June of last year, the Senate Judiciary Committee held a hearing on the claims being made by the former American POWs against the private Japanese companies, to determine whether the executive branch had been doing everything in its power to secure justice for these valiant men.

In the fall of last year, with the invaluable assistance of Senator FEINSTEIN, we were able to pass legislation declassifying thousands of Japanese Imperial Army records held by the U.S. government, to assist the POW's in the pursuit of their claims.

We can do even more. Recently, the State of California passed legislation extending the statute of limitations, under state law, to allow the POWs to bring monetary claims against the Japanese corporations that unlawfully employed them. Other States are contemplating such legislation.

The bill we are introducing today makes clear that any claims brought in state court, and subsequently removed to Federal court, will still have the benefit of the extended statute of limitations enacted by the state legislatures.

The legislators in California, and other States, have recognized the fairness of the allowing these claims to proceed for a decision on the merits. In light of the tangled history of this issue, including the role played by the U.S. government in discouraging these valiant men from pursuing their just claims, it is simply unfair to deny these men their day in court because their claims have supposedly grown stale.

These claims are not stale in their ability to inspire admiration for the men who survived this ordeal. These claims are not stale in their ability to inspire indignation against the corporations who flouted international standards of decency.

The statute of limitations should not be permitted to cut off these claims before they can be heard on the merits. Today's bill does nothing more than ensure that these valiant men receive their fair day in court.

I hope my fellow Senators will join with me, and with Senator FEINSTEIN, on this important legislation. These heroes of World War II have waited too long for a just resolution of their claims.

Mrs. FEINSTEIN. Mr. President, I rise alongside my colleague from Utah, Senator HATCH, to introduce the "POW Assistance Act of 2001".

This legislation makes an important statement in support of the many members of the U.S. Armed Forces who were used as slave labor by Japanese companies during the Second World War or subject to chemical and biological warfare experiments in Japanese POW camps.

The core of this bill is a clarification that in any pending lawsuit brought by former POWs against Japanese corporations, or any lawsuits which might be filed in the future, the Federal court shall apply the applicable statute of limitations of the State in which the action was brought.

This legislation is important because a recently enacted California law enables victims of WWII slave labor to seek damages up to the year 2010 against responsible Japanese companies, just as any citizen can sue a private company. Seventeen lawsuits have been filed on behalf of former POWs who survived forced labor, beatings, and starvation at the hands of Japanese companies. By asking Federal judges to look to the State statute of limitation, this legislation sends a clear message to the courts that we believe that suits with merit should not be precluded.

Today, too many Americans and Japanese do not know that American POWs performed forced labor for Japanese companies during the war.

American POWs, including those who had been forced through the Bataan Death March, were starved and denied adequate medical care and were forced to perform slave labor for private Japanese companies. American POWs toiled in mines, factories, shipyards, and steel mills. Many POWs worked virtually every day for 10 hours or more, often under extremely dangerous working conditions. They were starved and denied adequate medical care. Even today, many survivors still suffer from health problems directly tied to their slave labor.

It is critical that we do not forget the heroism and sacrifice of the POWs, and that the United States government does not stand in the way of their pursuit of recognition and compensation. They have never received an apology or payment from the companies that enslaved them, many of which are still in existence today.

The bill that Senator HATCH and I have introduced today does not prejudice the outcome of the lawsuits which are pending one way or another. The legislation we have introduced today simply holds that the lawsuits filed in California, or any which may still be filed under the California statute of limitations, should be allowed to go forward so that this issue can be settled definitively, without impeding the right of the POWs to pursue justice.

One of my most important goals in the Senate has been to see the development of a Pacific Rim community that is peaceful and stable. And I am pleased that the Government of Japan today is a close ally and good friend of the United States, and a responsible member of the international community.

And I want to clarify that this legislation is not directed at the people or government of Japan. The POWs and veterans are only seeking justice from the private companies that enslaved them, and this legislation has been designed in the interest of allowing these claims to move forward.

But I also believe that if Japan is to play a greater role in the international community it is important for Japan, the United States, and other countries in the Asia-Pacific region to be able to reconcile interpretations of memory and history, especially of the Second World War. If, as Gerrit Gong has written, Japan aspires to be a normal country, this question of "remembering and forgetting" is critical if Japan hopes to forge an environment in which its neighbors "do not object to that country's engaging in a full range of international activities and capabilities."

The goal of this legislation is to remove this outstanding issue in U.S.-Japan relations, and to try to heal wounds that still remain. I hope that the Senate will see fit to support this bill.

By Mr. HARKIN:

S. 1273. A bill to amend the Public Health Service Act to provide for rural

health services outreach, rural health network planning and implementation, and small health care provider quality improvement grant programs, and telehomecare demonstration projects; to the Committee on Health, Education, Labor, and Pensions.

Mr. HARKIN. Mr. President, I have introduced the "Improving Health Care in Rural America Act" that continues a rural health outreach program that I worked to establish as a part of the fiscal year 1991 Labor, Health and Human Services appropriations bill. We began this innovative program to demonstrate the effectiveness of outreach programs to populations in rural areas that have trouble obtaining health and mental health services. Too often, these people are not able to obtain health care until they are acutely ill and need extensive and expensive hospital care.

Indeed, rural Americans are at triple jeopardy, they are more often poor, more often uninsured, and more often without access to health care. Rural America is home to a disproportionately large segment of older citizens who more often require long-term care for their illnesses and disabilities. And rural America is not immune from the social stresses of modern society. This is manifest by escalating needs for mental health services to deal with necessary alcohol- and drug-related treatment, and by the significantly higher rate of suicide in rural areas. Yet, rural Americans are increasingly becoming commuters for their health care. Rural Americans deserve to be treated equitably and the legislation that I rise to describe today helps bring high quality health care to rural communities to meet their specific needs.

This grant program has proven itself highly successful because it responds to local community needs and is directed by the people in the community. These innovative grants bring needed primary and preventive care to those people who have few other options. These grants also help link health and social services, thereby reaching the people that most need these services.

This program has received overwhelmingly positive response from all fifty States because it has had a tremendous impact on improving coordination between health care providers and expanding access to needed health care.

In Iowa, the Ida County Community Hospital receives funds to improve the quality of life for older people who are chronically ill by making home visits, providing pain management, and telmonitoring, and other needed services.

In Maquoketa, IA, every school-age child is being given timely, high quality care because the local school district used their grant to team up with almost every health care provider in the county to provide services.

In Mason City, IA, the North Iowa Mercy Health Center is collaborating

with the Easter Seals Society of Northern Iowa, Rockwell Community Nursing, and the Pony Express Riders of Iowa to make sure seniors have access to physician, therapy, and dental services. This program also recycles and repairs assistive technology equipment to help seniors that are unable to afford new equipment.

The "Improving Health Care in Rural America Act" also establishes a telehomecare demonstration program for five separate projects to allow home health care professionals to provide some services through telehealth technologies. This program will allow rural residents to have better access to daily health care services and will reduce health care costs. This program is designed to improve patient access to care, quality of care, patient satisfaction with care while reducing the costs of providing care. Nurses and other health care professionals will be trained in how to use this advanced technology to provide better, more effective care. This program applies the highly effective telehealth technology to an area of health care that will benefit greatly.

As ranking member and as chairman of the Labor-HHS Appropriations Subcommittee, I have been pleased to be able to provide funding for this program during the previous decade. This bill will extend this highly successful program for 5 more years and I look forward to provide its funding. Programs that work this well deserve the support of Congress.

I urge my colleagues to join me in supporting this important legislation and ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1273

*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 "Improving Health Care in Rural America Act".

#### SEC. 2. GRANT PROGRAMS.

Section 330A of the Public Health Service Act (42 U.S.C. 254c) is amended to read as follows:

#### "SEC. 330A. RURAL HEALTH SERVICES OUTREACH, RURAL HEALTH NETWORK DEVELOPMENT, AND SMALL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANT PROGRAMS.

"(a) PURPOSE.—The purpose of this section is to provide grants for expanded delivery of health services in rural areas, for the planning and implementation of integrated health care networks in rural areas, and for the planning and implementation of small health care provider quality improvement activities.

"(b) DEFINITIONS.—

"(1) DIRECTOR.—The term 'Director' means the Director specified in subsection (d).

"(2) FEDERALLY QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC.—The terms 'Federally qualified health center' and 'rural health clinic' have the meanings given the terms in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

"(3) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' means a health professional shortage area designated under section 332.

"(4) HEALTH SERVICES.—The term 'health services' includes mental and behavioral health services and substance abuse services.

"(5) MEDICALLY UNDERSERVED AREA.—The term 'medically underserved area' has the meaning given the term in section 799B.

"(6) MEDICALLY UNDERSERVED POPULATION.—The term 'medically underserved population' has the meaning given the term in section 330(b)(3).

"(c) PROGRAM.—The Secretary shall establish, under section 301, a small health care provider quality improvement grant program.

"(d) ADMINISTRATION.—

"(1) PROGRAMS.—The rural health services outreach, rural health network development, and small health care provider quality improvement grant programs established under section 301 shall be administered by the Director of the Office of Rural Health Policy of the Health Resources and Services Administration, in consultation with State offices of rural health or other appropriate State government entities.

"(2) GRANTS.—

"(A) IN GENERAL.—In carrying out the programs described in paragraph (1), the Director may award grants under subsections (e), (f), and (g) to expand access to, coordinate, and improve the quality of essential health services, and enhance the delivery of health care, in rural areas.

"(B) TYPES OF GRANTS.—The Director may award the grants—

"(i) to promote expanded delivery of health services in rural areas under subsection (e);

"(ii) to provide for the planning and implementation of integrated health care networks in rural areas under subsection (f); and

"(iii) to provide for the planning and implementation of small health care provider quality improvement activities under subsection (g).

"(e) RURAL HEALTH SERVICES OUTREACH GRANTS.—

"(1) GRANTS.—The Director may award grants to eligible entities to promote rural health services outreach by expanding the delivery of health services to include new and enhanced services in rural areas. The Director may award the grants for periods of not more than 3 years.

"(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection for a project, an entity—

"(A) shall be a rural public or nonprofit private entity;

"(B) shall represent a consortium composed of members—

"(i) that include 3 or more health care providers or providers of services; and

"(ii) that may be nonprofit or for-profit entities; and

"(C) shall not previously have received a grant under this subsection or section 330A for the project.

"(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

"(A) a description of the project that the applicant will carry out using the funds provided under the grant;

"(B) a description of the manner in which the project funded under the grant will meet the health care needs of rural underserved

populations in the local community or region to be served;

"(C) a description of how the local community or region to be served will be involved in the development and ongoing operations of the project;

"(D) a plan for sustainability of the project after Federal support for the project has ended; and

"(E) a description of how the project will be evaluated.

"(f) RURAL HEALTH NETWORK DEVELOPMENT GRANTS.—

"(1) GRANTS.—

"(A) IN GENERAL.—The Director may award rural health network development grants to eligible entities to promote, through planning and implementation, the development of integrated health care networks that have integrated the functions of the entities participating in the networks in order to—

"(i) achieve efficiencies;

"(ii) expand access to, coordinate, and improve the quality of essential health services; and

"(iii) strengthen the rural health care system as a whole.

"(B) GRANT PERIODS.—The Director may award such a rural health network development grant for implementation activities for a period of 3 years. The Director may also award such a rural health network development grant for planning activities for a period of 1 year, to assist in the development of an integrated health care networks, if the proposed participants in the network have a history of collaborative efforts and a 3-year implementation grant would be inappropriate.

"(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an entity—

"(A) shall be a rural public or nonprofit private entity;

"(B) shall represent a network composed of members—

"(i) that include 3 or more health care providers or providers of services; and

"(ii) that may be nonprofit or for-profit entities; and

"(C) shall not previously have received a grant (other than a 1-year grant for planning activities) under this subsection or section 330A for the project.

"(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

"(A) a description of the project that the applicant will carry out using the funds provided under the grant;

"(B) an explanation of the reasons why Federal assistance is required to carry out the project;

"(C) a description of—

"(i) the history of collaborative activities carried out by the participants in the network;

"(ii) the degree to which the participants are ready to integrate their functions; and

"(iii) how the local community or region to be served will benefit from and be involved in the activities carried out by the network;

"(D) a description of how the local community or region to be served will experience increased access to quality health services across the continuum of care as a result of the integration activities carried out by the network;

"(E) a plan for sustainability of the project after Federal support for the project has ended; and

“(F) a description of how the project will be evaluated.

“(g) SMALL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANTS.—

“(1) GRANTS.—The Director may award grants to provide for the planning and implementation of small health care provider quality improvement activities. The Director may award the grants for periods of 1 to 3 years.

“(2) ELIGIBILITY.—In order to be eligible for a grant under this subsection, an entity—

“(A) shall be a rural public or nonprofit private health care provider, such as a critical access hospital or a rural health clinic;

“(B) shall be another rural provider or network of small rural providers identified by the Secretary as a key source of local care; or

“(C) shall not previously have received a grant under this subsection for the project.

“(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

“(A) a description of the project that the applicant will carry out using the funds provided under the grant;

“(B) an explanation of the reasons why Federal assistance is required to carry out the project;

“(C) a description of the manner in which the project funded under the grant will assure continuous quality improvement in the provision of services by the entity;

“(D) a description of how the local community or region to be served will experience increased access to quality health services across the continuum of care as a result of the activities carried out by the entity;

“(E) a plan for sustainability of the project after Federal support for the project has ended; and

“(F) a description of how the project will be evaluated.

“(4) PREFERENCE.—In awarding grants under this subsection, the Secretary shall give preference to entities that—

“(A) are located in health professional shortage areas or medically underserved areas, or serve medically underserved populations; or

“(B) propose to develop projects with a focus on primary care, and wellness and prevention strategies.

“(h) COORDINATION WITH OTHER AGENCIES.—The Secretary shall coordinate activities carried out under grant programs described in this section, to the extent practicable, with Federal and State agencies and nonprofit organizations that are operating similar grant programs, to maximize the effect of public dollars in funding meritorious proposals.

“(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2002 through 2006.”

### SEC. 3. CONSOLIDATION AND REAUTHORIZATION OF PROVISIONS.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq) is amended by adding at the end the following:

#### “SEC. 3301. TELEHOMECARE DEMONSTRATION PROJECT.

“(a) DEFINITIONS.—In this section:

“(1) DISTANT SITE.—The term ‘distant site’ means a site at which a certified home care provider is located at the time at which a health service (including a health care item) is provided through a telecommunications system.

“(2) TELEHOMECARE.—The term ‘telehomecare’ means the provision of health services through technology relating to the use of electronic information, or through telemedicine or telecommunication technology, to support and promote, at a distant site, the monitoring and management of home health services for a resident of a rural area.

“(b) ESTABLISHMENT.—Not later than 9 months after the date of enactment of the Health Care Safety Net Amendments of 2001, the Secretary may establish and carry out a telehomecare demonstration project.

“(c) GRANTS.—In carrying out the demonstration project referred to in subsection (b), the Secretary shall make not more than 5 grants to eligible certified home care providers, individually or as part of a network of home health agencies, for the provision of telehomecare to improve patient care, prevent health care complications, improve patient outcomes, and achieve efficiencies in the delivery of care to patients who reside in rural areas.

“(d) PERIODS.—The Secretary shall make the grants for periods of not more than 3 years.

“(e) APPLICATIONS.—To be eligible to receive a grant under this section, a certified home care provider shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(f) USE OF FUNDS.—A provider that receives a grant under this section shall use the funds made available through the grant to carry out objectives that include—

“(1) improving access to care for home care patients served by home health care agencies, improving the quality of that care, increasing patient satisfaction with that care, and reducing the cost of that care through direct telecommunications links that connect the provider with information networks;

“(2) developing effective care management practices and educational curricula to train home care registered nurses and increase their general level of competency through that training; and

“(3) developing curricula to train health care professionals, particularly registered nurses, serving home care agencies in the use of telecommunications.

“(g) COVERAGE.—Nothing in this section shall be construed to supercede or modify the provisions relating to exclusion of coverage under section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)), or the provisions relating to the amount payable to a home health agency under section 1895 of that Act (42 U.S.C. 1395fff).

“(h) REPORT.—

“(1) INTERIM REPORT.—The Secretary shall submit to Congress an interim report describing the results of the demonstration project.

“(2) FINAL REPORT.—Not later than 6 months after the end of the last grant period for a grant made under this section, the Secretary shall submit to Congress a final report—

“(A) describing the results of the demonstration project; and

“(B) including an evaluation of the impact of the use of telehomecare, including telemedicine and telecommunications, on—

“(i) access to care for home care patients; and

“(ii) the quality of, patient satisfaction with, and the cost of, that care.

“(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2002 through 2006.”

By Mr. KENNEDY (for himself, Mr. FRIST, Mr. DODD, Mr. HUTCHINSON, Mr. JEFFORDS, Ms. COLLINS, Mr. BINGAMAN, Mr. EDWARDS, Mrs. MURRAY, and Mr. SESSIONS):

S. 1274. A bill to amend the Public Health Service Act to provide programs for the prevention, treatment, and rehabilitation of stroke; to the Committee on Health, Education, Labor, and Pensions.

By Mr. FRIST (for himself, Mr. KENNEDY, Mr. JEFFORDS, Mr. HUTCHINSON, Mr. DODD, Ms. COLLINS, Mr. BINGAMAN, Mr. FEINGOLD, Mrs. MURRAY, Mr. EDWARDS, and Mr. CORZINE):

S. 1275. A bill to amend the Public Health Service Act to provide grants for public access defibrillation programs and public access defibrillation demonstration projects, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. FRIST. Mr. President, I rise today with Senator KENNEDY to introduce two pieces of legislation, the STOP Stroke Act and the Community Access to Emergency Defibrillation Act. These bills represent our next step in the battle against cardiac arrest and stroke and are critical to increasing access to timely, quality health care.

The first bill we are introducing today focuses attention on stroke, the third leading cause of death and the leading cause of serious, long-term disability in the United States, through the implementation of a prevention and education campaign, the development of the Paul Coverdell Stroke Registry and Clearinghouse, and the provision of grants for statewide stroke care systems and for medical professional development. The untimely death of Senator Paul Coverdell points to the need to provide more comprehensive stroke care and to learn more about providing better quality care to the more than 700,000 Americans who experience a stroke each year. Our first step in doing so is the introduction of the Stroke Treatment and Ongoing Prevention Act (STOP Stroke Act).

One of the most significant factors that affects stroke survival rates is the speed with which one obtains access to health care services. About 47 percent of stroke deaths occur out of the hospital. Many patients do not recognize the signs of a stroke and attribute the common symptoms, such as dizziness, loss of balance, confusion, severe headache or numbness, to other less severe ailments. To increase awareness of this public health problem, the Secretary of Health and Human Services will implement a national, multimedia campaign to promote stroke prevention and encourage those with the symptoms of stroke to seek immediate treatment. This crucial legislation also provides for special programs to target high risk populations. For the professional community, continuing education grants are included to train physicians in

newly-developed diagnostic approaches, technologies, and therapies for prevention and treatment of stroke. With a more informed public and up-to-date physicians, our ability to combat the devastating effects of a stroke will be enhanced.

The Paul Coverdell National Acute Stroke Registry and Clearinghouse, authorized in the STOP Stroke Act, establish mechanisms for the collection, analysis, and dissemination of valuable information about best practices relating to stroke care and the development of stroke care systems. In order to facilitate the process of implementing statewide stroke prevention, treatment, and rehabilitation systems that reflect the research gathered by the Registry and Clearinghouse, grants will be made available to States that will ensure that stroke patients have access to quality care.

These legislative efforts have already proved successful. Lives are being saved. We can do more.

Therefore, we are moving today to expand on these successes by introducing the Community Access to Emergency Defibrillation Act. This important legislation will provide \$50 million for communities to establish public access defibrillation programs that will train emergency medical personnel, purchase AEDs for placement in public areas, ensure proper maintenance of defibrillators, and evaluate the effectiveness of the program.

Each year, over 250,000 Americans suffer sudden cardiac arrest. Sudden cardiac arrest is a common cause of death during which the heart suddenly stops functioning. Most frequently, cardiac arrest occurs when the electrical impulses that regulate the heart become rapid, ventricular tachycardia, or chaotic, ventricular fibrillation, causing the heart to stop beating altogether. As a result, the individual collapses, stops breathing and has no pulse. Often, the heart can be shocked back into a normal rhythm with the aid of a defibrillator. This is exactly what happened when I resuscitated a patient using cardiopulmonary resuscitation, CPR, and electrical cardioversion in the Dirksen Senate Office Building in 1995.

When a person goes into cardiac arrest, time is of the essence. Without defibrillation, his or her chances of survival decrease by about 10 percent with every minute that passes. Thus, having an automated external defibrillator, AED, accessible is not only important, but also could save lives. AEDs are portable, lightweight, easy to use, and are becoming an essential part of administering first aid to victims of sudden cardiac arrest.

We have seen that in places where AEDs are readily available, survival rates can increase by 20-30 percent. In some settings, survival rates have even reached 70 percent. Therefore, Congress has taken several important steps to increase access to AEDs over the past two Congresses.

In the 105th Congress, I authored the Aviation Medical Assistance Act. This bill directed the Federal Aviation Administration to decide whether to require AEDs on aircraft and in airports. As a result of this law, many airlines now carry AEDs on board, and some airports have placed AEDs in their terminals. At Chicago O'Hare, just four months after AEDs were placed in that airport, four victims were resuscitated using the publicly available AEDs.

In the last Congress, we passed two important bills expanding the availability of AEDs: the Cardiac Arrest Survival Act and the Rural Access to Emergency Devices Act. Respectively, these bills address the placement of automated external defibrillators, AEDs, in Federal buildings and provide liability protection to persons or organizations who use AEDs, as well as grants to community partnerships to enable them to purchase AEDs. The bills also provide defibrillator and basic life support training.

I am pleased to introduce these important pieces of legislation and I look forward to their ultimate enactment into law. I want to thank my colleague, Senator KENNEDY, for his work on these life saving proposals.

Mr. KENNEDY. Mr. President, it is a privilege to join my colleague, Senator FRIST, to introduce the Stroke Treatment and Ongoing Prevention Act. Stroke is a cruel affliction that takes the lives and blights the health of millions of Americans. Senator FRIST and I have worked closely on legislation to establish new initiatives to reduce the grim toll taken by stroke, and I commend him for his leadership. We are joined in proposing this important legislation by our colleagues on the Health Committee, Senators DODD, HUTCHINSON, JEFFORDS, COLLINS, BINGAMAN, EDWARDS, and MURRAY. The STOP Stroke Act is also supported by a broad coalition of organizations representing patients and the health care community.

Stroke is a national tragedy that leaves no American community unscarred.

Stroke is the third leading cause of death in the United States. Every minute of every day, somewhere in America, a person suffers a stroke. Every three minutes, a person dies from one. Strokes take the lives of nearly 160,000 Americans each year. Even for those who survive an attack, stroke can have devastating consequences. Over half of all stroke survivors are left with a disability.

Since few Americans recognize the symptoms of stroke, crucial hours are often lost before patients receive medical care. The average time between the onset of symptoms and medical treatment is a shocking 13 hours. Emergency medical technicians are often not taught how to recognize and manage the symptoms of stroke. Rapid administration of clot-dissolving drugs can dramatically improve the outcome of stroke, yet fewer than 3 percent of

stroke patients now receive such medication. If this lifesaving medication were delivered promptly to all stroke patients, as many as 90,000 Americans could be spared the disabling aftermath of stroke.

Even in hospitals, stroke patients often do not receive the care that could save their lives. Treatment of patients by specially trained health care providers increases survival and reduces disability due to stroke, but a neurologist is the attending physician for only about one in ten stroke patients. To save lives, reduce disabilities and improve the quality of stroke care, the Stroke Treatment and Ongoing Prevention, STOP Stroke, Act authorizes important public health initiatives to help patients with symptoms of stroke receive timely and effective care.

The Act establishes a grant program for States to implement systems of stroke care that will give health professionals the equipment and training they need to treat this disorder. The initial point of contact between a stroke patient and medical care is usually an emergency medical technician. Grants authorized by the Act may be used to train emergency medical personnel to provide more effective care to stroke patients in the crucial first few moments after an attack.

The Act provides important new resources for States to improve the standard of care given to stroke patients in hospitals. The legislation will assist States in increasing the quality of stroke care available in rural hospitals through improvements in telemedicine.

The Act directs the Secretary of Health and Human Services to conduct a national media campaign to inform the public about the symptoms of stroke, so that patients receive prompt medical care. The bill also creates the Paul Coverdell Stroke Registry and Clearinghouse, which will collect data about the care of stroke patients and assist in the development of more effective treatments.

Finally, the STOP Stroke Act establishes continuing education programs for medical professionals in the use of new techniques for the prevention and treatment of stroke.

These important new initiatives can make a difference in the lives of the thousands of American who suffer a stroke every year. For patients experiencing a stroke, even a few minutes' delay in receiving treatment can make the difference between healthy survival and disability or death. The Act will help make certain that those precious minutes are not wasted.

Increased public information on the symptoms of stroke will help stroke patients and their families know to seek medical care promptly. Better training of emergency medical personnel will help ensure that stroke patients receive lifesaving medications when they are most effective. Improved systems of stroke care will help patients receive the quality treatment

needed to save lives and reduce disability.

This legislation can make a real difference to every community in America, and I urge my colleagues to join Senator FRIST and myself in supporting the STOP Stroke Act.

I ask unanimous consent that additional material and letters of support relating to this bill be printed in the RECORD.

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

THE STROKE TREATMENT AND ONGOING PREVENTION ACT OF 2001

BACKGROUND AND NEED FOR LEGISLATION

Stroke is the third leading cause of death in the United States, claiming the life of one American every three and a half minutes. Those who survive stroke are often disabled and have extensive health care needs. The economic cost of stroke is staggering. The United States spends over \$30 billion each year on caring for persons who have experienced stroke.

Prompt treatment of patients experiencing stroke can save lives and reduce disability, yet thousands of stroke patients do not receive proper therapy during the crucial window of time when it is most effective. Rapid administration of clot-dissolving drugs can dramatically improve the outcome of stroke, yet fewer than 3 percent of stroke patients now receive such medication. Treatment of patients by specially trained health care providers increases survival and reduces disability due to stroke, but a neurologist is the attending physician for only about one in ten stroke patients. Most Americans cannot identify the signs of stroke and even emergency medical technicians are often not taught how to recognize and manage its symptoms. Even in hospitals, stroke patients often do not receive the care that could save their lives. To save lives, reduce disability and improve the quality of stroke care, the Stroke Treatment and Ongoing Prevention, STOP Stroke, Act authorizes the following important public health initiatives.

*Stroke prevention and education campaign*

The STOP Stroke Act provides \$40 million, fiscal year 2002, for the Secretary to carry out a national, multi-media awareness campaign to promote stroke prevention and encourage stroke patients to seek immediate treatment. The campaign will be tested for effectiveness in targeting populations at high risk for stroke, including women, senior citizens, and African-Americans. Alternative campaigns will be designed for unique communities, including those in the nation's "Stoke belt," a region with a particularly high rate of stroke incidence and mortality.

*Paul Coverdell Stroke Registry and Clearinghouse*

The STOP Stroke Act authorizes the Paul Coverdell Stroke Registry and Clearinghouse to collect data about the care of acute stroke patients and foster the development of effective stroke care systems. The clearinghouse will serve as a resource for States seeking to design and implement their own stroke care systems by collecting, analyzing and disseminating information on the efforts of other communities to establish similar systems. Special consideration will be given to the unique needs of rural facilities and those facilities with inadequate resources for providing quality services for stroke patients. The Secretary is also authorized to conduct and support research on stroke care. Where suitable research has already been conducted, the Secretary is charged with dis-

seminating this research to increase its effectiveness in improving stroke care.

*Grants for statewide stroke care systems*

The Secretary will award grants to States to develop and implement statewide stroke prevention, treatment, and rehabilitation systems. These systems must ensure that stroke patients in the State have access to quality care. The Secretary is also authorized to award planning grants to States to assist them in developing statewide stroke care systems. Each State that receives a grant will: implement curricula for training emergency medical services personnel to provide pre-hospital care to stroke patients; curricula may be modeled after a curriculum developed by the Secretary; have the option of identifying acute stroke centers, comprehensive stroke treatment centers, and/or stroke rehabilitation centers; set standards of care and other requirements for facilities providing services to stroke patients; specify procedures to evaluate the statewide stroke care system; and collect and analyze data from each facility providing care to stroke patients in the State to improve the quality of stroke care provided in that State.

The Act authorizes this grant program at \$50 million for fiscal year 2002, \$75 million for fiscal years 2003 and 2004, \$100 million for fiscal year 2005, and \$125 million for fiscal year 2006.

*Medical professional development*

The STOP Stroke Act provides grant authority to the Secretary for public and non-profit entities to develop and implement continuing education programs in the use of new diagnostic approaches, technologies, and therapies for the prevention and treatment of stroke. Grant recipients must have a plan for evaluation of activities carried out with the funding. The Secretary must ensure that any grants awarded are distributed equitably among the regions of the United States and between urban and rural populations.

*Secretary's role*

In addition to carrying out the national education campaign, operating the clearinghouse and registry, and awarding grants to States, the Secretary will: develop standards of care for stroke patients that may be taken into consideration by States applying for grants; develop a model curriculum that States may adopt for emergency medical personnel; develop a model plan for designing and implementing stroke care systems, taking into consideration the unique needs of varying communities; report to Congress on the implementation of the Act in participating States.

In carrying out the STOP Stroke Act, the Secretary will consult widely with those having expert knowledge of the needs of patients with stroke.

KEY STROKE FACTS

*The devastating effects of stroke*

There are roughly 700,000-750,000 strokes in the U.S. each year.

Stroke is the 3rd leading cause of death in the U.S.

Almost 160,000 Americans die each year from stroke.

Every minute in the U.S., an individual experiences a stroke. Every 3.3 minutes an individual dies from one.

Over the course of a lifetime, four out of every five families in the U.S. will be touched by stroke.

Roughly 1/3 of stroke survivors have another one within five years.

Currently, there are four million Americans living with the effects of stroke.

15 percent to 30 percent of stroke survivors are permanently disabled. 55 percent of stroke survivors have some level of disability.

40 percent of these patients feel they can no longer visit people; almost 70 percent report that they cannot read; 50 percent need day-hospital services; 40 percent need home help; 40 percent have a visiting nurse; and 14 percent need Meals on Wheels.

22 percent of men and 25 percent of women who have an initial stroke die within one year.

*The staggering costs of stroke*

Stroke costs the U.S. \$30 billion each year. The average cost per patient for the first 90 days following a stroke is \$15,000.

The lifetime costs of stroke exceed \$90,000 per patient for ischemic stroke and over \$225,000 per patient for subarachnoid hemorrhage.

*Improvements can be made*

When a stroke unit was first established at Mercy General Hospital in Sacramento, CA in December of 1990, the average length of stay for a Medicare stroke patient in the immediate care setting was 7 days and total hospital charges per patient were \$14,076. By June of 1994, the average length of stay was 4.6 days and the charges per patient were \$10,740. Overall, in the three and a half years during which the stroke unit was in operation, Mercy General's charges to Medicare for stroke patients declined \$1,621,296.

In a national survey of acute stroke teams ASTs, Duke University researchers found that the majority of ASTs cost only \$0-\$5,000, far less than the average cost for hospitalization of stroke patients.

STROKE PATIENTS OFTEN DO NOT RECEIVE EFFECTIVE TREATMENTS

Nationally, only 2 percent to 3 percent of patients with stroke are being treated with the clot-busting drug, tPA.

In the year following FDA approval of tPA, it was determined that only 1.5 percent of patients who might have been candidates for tPA therapy actually received it.

In a study of North Carolina's stroke treatment facilities, 66 percent of hospitals did not have stroke protocols and 82 percent did not have rapid identification for patients experiencing acute stroke.

A recent study of Cleveland, OH found that only 1.8 percent of area patients with ischemic stroke received tPA.

In a 1995 study of the Reading, Ohio Emergency Medical Services System EMS, almost half of all stroke patients who went through the MES system were dispatched as having something other than stroke and a quarter of all patients identified as having stroke by paramedics were later discovered to have another cause for their illness.

Out of 1000 hours of training for paramedics in Cincinnati, only 1 percent is devoted to recognition and management of acute stroke.

A 1993 study of patients who had a stroke while they were inpatient found a median delay between stroke recognition and neurological evaluation of 2.5 hours.

Neurologists are the attending physicians for only 11 percent of acute stroke patients.

PUBLIC AWARENESS OF STROKE SYMPTOMS IS POOR

In a 1989 survey by the American Heart Association of 500 San Francisco residents, 65 percent of those surveyed were unable to correctly identify any of the early stroke warning signs when given a list of symptoms.

In a national survey conducted by the American Heart Association, 29 percent of respondents could not name the brain as the site of a stroke and only 44 percent identified weakness or loss of feeling in an arm or leg as a symptom of stroke.

The International Stroke Trial found that only 4 percent of the 19,000 patients studied presented within 3 hours of symptom onset only 16 percent presented within 6 hours.

## TPA FACTS

A seminal NIH study found an 11 to 13 percent increase in the number of tPA-treated patients exhibiting minimal or no neurological deficits or disabilities compared with placebo treated patients.

That same study reported a 30 to 55 percent relative improvement in clinical outcome for tPA-treated patients compared with placebo-treated patients.

NATIONAL ORGANIZATIONS SUPPORTING THE  
STOP STROKE ACT OF 2001

American Academy of Neurology  
American Academy of Physical Medicine and Rehabilitation  
American Association of Neurological Surgeons  
American College of Chest Physicians  
American College of Emergency Physicians  
American College of Preventive Medicine  
American Heart Association/American Stroke Association  
American Physical Therapy Association  
American Society of Interventional and Therapeutic Neuroradiology  
American Society of Neuroradiology  
Association of American Medical Colleges  
Association of State and Territorial Chronic Disease Program Directors  
Association of State and Territorial Directors of Health Promotion and Public Health Education  
Boston Scientific  
Brain Injury Association  
Congress of Neurological Surgeons  
Emergency Nurses Association  
Genentech, Inc.  
National Association of Public Hospitals and Health Systems  
National Stroke Association  
North American Society of Pacing and Electrophysiology  
Partnership for Prevention  
Society of Cardiovascular and Interventional Radiology  
Stroke Belt Consortium  
The Brain Attack Coalition which is made up of the following advocacy organizations:  
American Academy of Neurology  
American Association of Neurological Surgeons  
American Association of Neuroscience Nurses  
American College of Emergency Physicians  
American Heart Association/American Stroke Association  
American Society of Neuroradiology  
National Stroke Association  
Stroke Belt Consortium

AMERICAN HEART ASSOCIATION,  
Dallas, TX, July 20, 2001.

Hon. EDWARD KENNEDY,  
U.S. Senate,  
Washington, DC.

DEAR CHAIRMAN KENNEDY: On behalf of the American Heart Association, our American Stroke Association division and our more than 22.5 million volunteers and supporters, thank you for leading the fight against stroke—the nation's third leading cause of death.

It has been our privilege to work with you and your staff to draft the Stroke Treatment and Ongoing Prevention Act (STOP Stroke Act). This vital legislation will help raise public awareness about stroke and dramatically improve our nation's stroke care. More specifically, the legislation will conduct a national stroke education campaign; provide critical resources for states to implement statewide stroke care systems; establish a clearinghouse to support communities aiming to improve stroke care; offer medical professional development programs in new stroke therapies; and conduct valuable stroke care research.

Stroke touches the lives of almost all Americans. Today, 4.5 million Americans are stroke survivors, and as many as 30 percent of them are permanently disabled, requiring extensive and costly care. In Massachusetts alone, stroke kills more than 3,300 people every year. Unfortunately, most Americans know very little about this disease. On average, stroke patients wait 22 hours after the onset of symptoms before receiving medical care. In addition, many health care facilities are not equipped to treat stroke aggressively like other medical emergencies.

Your legislation helps build upon our successful stroke programs. In 1998, the American Heart Association launched a bold initiative—Operation Stroke—to improve stroke care in targeted communities across the country by strengthening the stroke "Chain of Survival." The Chain is a series of events that must occur to improve stroke care and includes rapid public recognition and reaction to stroke warning signs; rapid assessment and pre-hospital care; rapid hospital transport; and rapid diagnosis and treatment.

The STOP Stroke Act will help ensure that the stroke Chain of Survival is strong in every community across the nation and that every stroke patient has access to quality care. We strongly support this legislation and look forward to continuing to work with you and Senator Frist to fight this devastating disease. Thank you again for your leadership and vision!

Sincerely,

LAWRENCE B. SADWIN,  
Chairman of the  
Board.

DAVID P. FAXON, M.D.,  
President.

NATIONAL STROKE ASSOCIATION,  
Englewood, CO, March 8, 2001.

Hon. EDWARD KENNEDY,  
Russell Senate Office Building,  
Washington, DC.

DEAR SENATOR KENNEDY: I am writing on behalf of the national Stroke Association (NSA) to express our strong commitment to helping you bring attention to, and secure passage of, the "Stroke Treatment and Ongoing Prevention Act of 2001" (the "STOP Stroke Act").

NSA is a leading independent, national nonprofit organization which dedicates 100 percent of its resources to stroke including prevention, treatment, rehabilitation, research, advocacy and support for stroke survivors and their families. Our mission is to reduce the incidence and impact of stroke—the number one cause of adult disability and 3rd leading cause of death in America.

NSA believes that your proposed legislation is historic—never before has comprehensive legislation been introduced to address this misunderstood public health problem. In fact, stroke has not been given the level of attention, focus or resources commensurate with the terrible toll it takes on Americans in both human and economic terms. We are grateful for your leadership in bringing this issue to the top of the public health agenda.

The STOP Stroke Act clearly recognizes an urgent need to build more effective systems of patient care and to increase public awareness about stroke. We are hopeful that the Stroke Prevention and Education Campaign which it authorizes will go a long way toward disseminating the most accurate and timely information regarding stroke prevention and the importance of prompt treatment. NSA is encouraged that the state grant program will facilitate the establishment of a comprehensive network of stroke centers to reduce the overwhelming disparity in personnel, technology, and other resources and target assistance to some of

the smaller, less advanced facilities. We also believe that the research program is a necessary component of the STOP Stroke Act in order to assess and monitor barriers to access to stroke prevention, treatment, and rehabilitation services, and to ultimately raise the standard of care for those at risk, suffering or recovering from stroke.

Over the past few months NSA has convened leaders in medicine, nursing, rehabilitation, healthcare, business, and advocacy to work with your staff on developing this important legislation. NSA is pleased to have contributed its ideas and expertise on this critical health issue. We look forward to working in partnership with you and your colleagues on getting the legislation passed by Congress.

Please count on us to work with you in any way possible to ensure we STOP stroke.

Sincerely,

PATTI SHWAYDER,  
Executive Director/CEO.

AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS; CONGRESS OF NEUROLOGICAL SURGEONS,

Washington, DC, March 5, 2001.

Hon. TED KENNEDY,  
U.S. Senate, Russell Senate Office Building,  
Washington, DC.

DEAR SENATOR KENNEDY: The American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing over 4,500 neurosurgeons in the United States, thank you for your leadership and vision in crafting the "STOP Stroke Act (Stroke Treatment and Ongoing Prevention Act) of 2001." We strongly endorse this bill and pledge to work with you to ensure its passage. Your legislation would not only educate the public about the burden of stroke and stroke-related disability, but would encourage states to develop stroke planning systems through the matching grant concept.

Stroke is the nation's third leading cause of death and is the leading cause of disability in our country creating a huge human and financial burden associated with this disease. The advances in research and treatment related to stroke over the last decade have been truly remarkable. For example, surgical techniques such as carotid endarterectomy have been proven effective and saved lives. Also, the discovery of therapeutic drugs that can be administered within three hours of the onset of a stroke have allowed many survivors to recover in a way that was impossible to imagine in even recent years.

What was once viewed as an untreatable and devastating disease has the potential to become as commonly treatable as heart attacks if appropriate resources are directed to the problem. Senator Kennedy, your legislation will allow all Americans to take advantage of these rapid advances in stroke treatment and prevention.

Once again, we strongly endorse this legislation. On behalf of all neurosurgeons and the patients we serve, thank you for your leadership on this issue. Please feel free to contact us should you need further assistance.

Sincerely,

STEWART B. DUNSKER, MD,  
President, American  
Association of Neurological Surgeons.

ISSAM A. AWAD, MD,  
President, Congress of  
Neurological Surgeons.

NATIONAL ASSOCIATION OF PUBLIC  
HOSPITALS AND HEALTH SYSTEMS,  
Washington, DC, March 22, 2001.

Hon. EDWARD M. KENNEDY,  
U.S. Senate,  
Washington, DC.

DEAR SENATOR KENNEDY: I am writing on behalf of the National Association of Public Hospitals & Health Systems (NAPH) to express our support for the "STOP Stroke Act of 2001," legislation to help states improve the level of stroke care that is offered to patients and to improve public education about the importance of seeking early emergency care to combat the effects of stroke.

NAPH represents more than 100 of America's metropolitan area safety net hospitals and health systems. The mission of NAPH members is to provide health care services to all individuals, regardless of insurance status or ability to pay. More than 54 percent of the patients served by NAPH systems are either Medicaid recipients or Medicare beneficiaries; another 28 percent are uninsured.

We applaud your efforts to raise public awareness about the signs and symptoms of this pernicious disease and to assure that all Americans—including our nation's poorest and most vulnerable—have access to state-of-the-art stroke treatment. In particular, we are pleased that your legislation would:

Establish a grant program to provide funding to states—with a particular focus on raising the level of stroke treatment in underserved areas—to assure that all patients have access to high-quality stroke care;

Ensure that all appropriate medical personnel are provided access to training in newly developed approaches for preventing and treating stroke;

Authorize a national public awareness campaign to educate Americans about the signs and symptoms of stroke and the importance of seeking emergency treatment as soon as symptoms occur; and,

Create a comprehensive research program to identify best practices, barriers to care, health disparities, and to measure the effectiveness of public awareness efforts.

NAPH has long supported efforts to assure that all Americans are afforded access to the highest quality health care services and most current technology that is available. Indeed, it is critical that facilities that provide acute care services to stroke patients have the resources necessary to assure patients access to a minimum standard of stroke care. Unfortunately, uncompensated care costs and high rates of uninsured patients often make it difficult for safety net providers to dedicate sufficient resources to meet these goals.

We are pleased that your legislation, through its state grants program, attempts to direct additional resources toward the providers that are most in need of updating their stroke care systems. We urge you to consider amending your legislation to allow local government and safety net providers to participate directly in this grants program. Allowing public hospitals and other safety net providers who seek to improve their stroke care infrastructure to apply for these grants will go a long way toward assuring that the providers most in need of these resources get access to them.

As the American population ages and promising discoveries are being made to improve the early detection and treatment of stroke, it is becoming increasingly important that additional resources be directed at stroke awareness, prevention and treatment programs. And, as federal funds are provided, it is critical that all of our citizens, in particular those who frequently slip through the cracks, are given access to the best available stroke-related specialists, diagnostic equipment and life-saving treatments and therapies.

We thank you for your ongoing leadership in developing legislation to preserve and improve our nation's public health systems and the healthy care safety net. We look forward to working with you further to develop solutions to the problems of our nation's poor and uninsured.

Sincerely,

LARRY S. GAGE,  
President.

PARTNERSHIP FOR PREVENTION,  
Washington, DC, March 16, 2001.

Re Stroke Treatment and Ongoing Prevention Act of 2001.

Hon. EDWARD KENNEDY,  
U.S. Senate, Russell Senate Office Building,  
Washington, DC.

DEAR SENATOR KENNEDY: We commend the introduction of the Stroke Treatment and Ongoing Prevention Act of 2001 (STOP Stroke Act). As you well know, stroke is the third leading cause of death in the United States, a principal cause of cardiovascular disease death, and a major cause of disability for Americans.

The STOP Stroke Act creates a framework for the nation to begin systematically addressing some important tertiary stroke prevention issues, namely timely diagnosis and treatment. We concur that much more can and should be done to ensure stroke guidelines are treated according to clinical guidelines based on up-to-date scientific evidence.

Investing in primary and secondary prevention is the best strategy for stopping stroke. Hypertension is the top contributor to stroke, followed by heart disease, diabetes, and cigarette smoking. According to the National Institutes of Health and the Centers for Disease Control and Prevention (CDC), prevention of stroke requires addressing the critical risk factors.

To prevent or delay hypertension, experts at both agencies recommend community-based interventions that promote healthy diets, regular physical activity, tobacco cessation, and limited alcohol intake. The Public Health Service's clinical guidelines on treating tobacco use and dependence is another resource to help Americans kick the habit. Lifestyle modifications for hypertension prevention not only contribute to overall cardiovascular health, but also reduce risk factors associated with other chronic diseases (e.g., obesity, diabetes, and cancer).

A second essential step is to improve management of hypertension once it develops. Recent studies indicate effective hypertension treatment can cut stroke incidence and fatality rates by at least a third. To advance hypertension treatment, we must invest in disease management systems that enable health care providers to prescribe the most effective therapies and assist patients with pharmacological regimens and healthy lifestyles.

The main prevention components in the STOP Stroke Act (i.e., the proposed research program and national stroke awareness campaign) should be coordinated with—and even integrated into—the CDC comprehensive cardiovascular disease program. Involving nearly every state, this program offers an integrated network that is addressing the underlying causes of stroke and other cardiovascular diseases.

Partnership welcomes the STOP Stroke Act and its intent to address stroke, a serious health problem. We also encourage strengthened primary and secondary prevention policies to protect health before strokes happen.

Sincerely yours,

ASHLEY B. COFFIELD,  
President.

BRAIN ATTACK COALITION,  
Bethesda, MD, May 7, 2001.

Hon. EDWARD M. KENNEDY,  
U.S. Senate, Russell Senate Office Building,  
Washington, DC.

DEAR SENATOR KENNEDY: The Brain Attack Coalition is a group of professional, voluntary and governmental organizations dedicated to reducing the occurrence, disabilities and death associated with stroke.

Stroke is our nation's third leading cause of death and the leading cause of adult long-term disability. Recent advances in stroke treatment can lead to improved outcomes if stroke patients are treated shortly after symptom onset. Currently only two to three percent of stroke patients who are candidates for thrombolytic therapy receive it. This must be remedied.

We urgently need to educate the public about stroke symptoms and the importance of seeking medical attention immediately. We also need to provide training to medical personnel in the new approaches for treating and preventing stroke. The Stroke Treatment and Ongoing Prevention Act of 2001 (STOP Stroke Act) is designed to address these issues and to establish a grant program to provide funding to states to help ensure that stroke patients in each state have access to high-quality stroke care.

The members of the Brain Attack Coalition strongly support the STOP Stroke Act and hope for prompt enactment of this legislation. Please note that the National Institute of Neurological Disorders and Stroke and the Centers for Disease Control and Prevention are not included in this endorsement because the Administration has not taken a position on the legislation.

Sincerely,

MICHAEL D. WALKER, M.D.,  
Chair, Brain Attack Coalition.

AMERICAN PHYSICAL  
THERAPY ASSOCIATION,  
Alexandria, VA, June 13, 2001.

Hon. EDWARD KENNEDY,  
U.S. Senate,  
Washington, DC.

DEAR SENATOR KENNEDY: I am writing to express the strong support of the American Physical Therapy Association (APTA) for the "Stroke Treatment and Ongoing Prevention Act of 2001," which you plan to introduce soon.

As you know, stroke is the third leading cause of death in the United States, and is one of the leading causes of adult disability. APTA believes your legislation is critical to establishing a comprehensive system for stroke prevention, treatment and rehabilitation in the United States. We appreciate your modification to the legislation to highlight the important role physical therapists play in stroke prevention and rehabilitation.

Every day, physical therapists across the nation help approximately 1 million people alleviate pain, prevent the onset and progression of impairment, functional limitation, disability, or changes in physical function and health status resulting from injury, disease, or other causes. Essential participants in the health care delivery system, physical therapists assume leadership roles in rehabilitation services, prevention and health maintenance programs. They also play important roles in developing health care policy and appropriate standards for the various elements of physical therapists practice to ensure availability, accessibility, and excellence in the delivery of physical therapy services.

Again, thank you for your leadership on this issue. Please call upon APTA to assist in the passage of this important legislation.

Sincerely,

BEN F. MASSEY, PT,  
President.

Mr. KENNEDY. Mr. President, today Senator FRIST and I are introducing the "Community Access to Emergency Defibrillation Act of 2001."

Every 2 minutes, sudden cardiac arrest strikes down another person. Cardiac arrest can strike at any time without any warning. Without rapid intervention, is unavoidable.

One thousand people will die today from cardiac arrest, and 200,000 people will lose their lives this year to this devastating disease. The good news is that we know that 90 percent of cardiac arrest victims can be saved, if immediate access is available to an automated external defibrillator, an AED.

We could save thousands of lives every year if AEDs are available in every public building. Yet few communities have programs to make this technology widely accessible.

That is why Senator FRIST and I today are introducing the "Community AED Act". Its goal is to provide funding for programs to increase access to emergency defibrillation. It will place AEDs in public areas like schools, workplaces, community centers, and other locations where people gather. It will provide training to use and maintain the devices, and funding for coordination with emergency medical personnel.

Furthermore, it also funds the development of community-based projects to enhance AED access and place them in unique settings where access is more difficult to achieve. Our bill also emphasizes monitoring cardiac arrest in children and putting AEDs in schools—so that we can also deal with cardiac arrest when it affects our youth.

Sudden cardiac arrest is a tragedy for families all across America. Communities that have already implemented programs to increase public access to AEDs—like the extremely successful "First Responder Defibrillator Program" in Boston—have been able to achieve survival rates of up to 50 percent. That's 100,000 lives that we can save each year if every community implements a program like this one. This bill will enable communities to save lives in public buildings, in workplaces, and in schools all across the nation, and I urge you to stand with Senator FRIST and I in support of this legislation—legislation that will have a life-saving impact on us all.

I ask unanimous consent that a bill summary for the "Community Access to Emergency Defibrillation Act of 2001" be printed in the RECORD.

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

THE COMMUNITY ACCESS TO EMERGENCY DEFIBRILLATION ACT OF 2001

BACKGROUND AND NEED FOR LEGISLATION

Cardiac arrest is not a heart attack—it is instant heart paralysis for which defibrillation is the only effective treatment. Every minute that passes after a cardiac arrest, a person's chance of surviving decreases by 10 percent. Cardiac arrest takes a tremendous toll on the American public; each year, it kills over 220,000 people.

The good news is that 90 percent of cardiac arrest victims who are treated with a defibrillator within one minute of arrest can be saved. In addition, cardiac arrest victims who are treated with CPR within four minutes and defibrillation within ten minutes have up to a 40 percent chance of survival. However, few communities have programs to make emergency defibrillation widely accessible to cardiac arrest victims. Communities that have implemented public access programs have achieved average survival rates for out-of-hospital cardiac arrest as high as 50 percent.

Automated external defibrillators, AEDs, have a 95 percent success rate in terminating ventricular fibrillation. Wide use of defibrillators could save as many as 50,000 lives nationally each year, yet fewer than half of the nation's ambulance services, 10–15 percent of emergency service fire units, and less than 1 percent of police vehicles are equipped with AEDs.

The Community Access to Emergency Defibrillation, Community AED Act, provides for the following public health initiatives to increase public awareness of emergency defibrillation and to expand public access to lifesaving AEDs:

*Community Grants Program to establish comprehensive initiatives to increase public access to AEDs*

The Community AED Act provides \$50 million for communities to establish public access defibrillation programs. Communities receiving these grants will: train local emergency medical services personnel to administer immediate care, including CPR and automated external defibrillation, to cardiac arrest victims; purchase and place automated external defibrillators in public places where cardiac arrests are likely to occur; train personnel in places with defibrillators to use them properly and administer CPR to cardiac arrest victims; inform local emergency medical services personnel, including dispatchers, about the location of defibrillators in their community; train members of the public in CPR and automated external defibrillation; ensure proper maintenance and testing of defibrillators in the community; encourage private companies in the community to purchase automated external defibrillators and train employees in CPR and emergency defibrillation; and collect data to evaluate the effectiveness of the program in decreasing the out-of-hospital cardiac arrest survival rate in the community.

*Community demonstration projects to develop innovative AED access programs*

The Community AED Act provides \$5 million for community-based demonstration projects. Grantees will develop innovative approaches to maximize community access to automated external defibrillation and provide emergency defibrillation to cardiac arrest victims in unique settings. Communities receiving these grants must meet many of the same requirements for equipment maintenance, public information, and data collection included in the larger grants program.

*National Clearinghouse to promote AED access in schools*

The Community AED Act provides for a national information clearinghouse to provide information to increase public awareness and promote access to defibrillators in schools. This center will also establish a database for information on sudden cardiac arrest in youth and will provide assistance to communities wishing to develop screening programs for at risk youth.

The Community AED Act is supported by these and other leading health care organizations:

American Heart Association; American Red Cross; Agilent Technologies; American College of Emergency Physicians; Cardiac Science; Citizen CPR Foundation; Congressional Fire Services Institute; Medical Device Manufacturers Association; Medical Research Laboratories, Inc.; Medtronic; MeetingMed; National Center for Early Defibrillation; National Emergency Medical Services Academy; National Fire Protection Association; National SAFE KIDS Campaign; National Volunteer Fire Council; and Survivalink.

By Mr. DOMENICI (for himself and Mr. BINGAMAN):

S. 1276. A bill to provide for the establishment of a new counterintelligence polygraph program for the Department of Energy, and for other purposes; to the Committee on Armed Services.

Mr. DOMENICI. Mr. President, I rise today to introduce a bill that modifies the requirements for polygraphs at facilities operated by the Department of Energy. I appreciate that Senator BINGAMAN joins me as a co-sponsor.

Polygraph requirements were added by Congress in response to concerns about security at the national laboratories. A set of mandates was first created in the Senate Armed Services Authorization Bill for Fiscal Year 2000, and they were expanded with broader mandates in Fiscal Year 2001.

Security at the our national security facilities is critically important, and General Gordon is working diligently as Administrator of the National Nuclear Security Administration to improve security through many initiatives. But frankly, I fear that Congress has given the General a little too much help in this particular area.

The effect of our past legislation was to require polygraphs for very broad categories of workers in DOE and in our DOE weapons labs and plants. But the categories specified are really much too broad, some don't even refer to security-related issues. They include many workers who have no relevant knowledge or others who may be authorized to enter nuclear facilities but have no unsupervised access to actual material. Many of the positions within these categories already require a two-person rule, precluding actions by any one person to compromise protected items.

This bill provides flexibility to allow the Secretary of Energy and General Gordon to set up a new polygraph program. Through careful examination of the positions with enough sensitivity to warrant polygraphs, I fully anticipate that the number of employees subject to polygraphs will be dramatically reduced while actually improving overall security.

My bill seeks to address other concerns. Polygraphs are simply not viewed as scientifically credible by Laboratory staff. Those tests have been the major contributor to substantial degradation in worker morale at the labs. This is especially serious when the labs and plants are struggling to cope with the new challenges imposed

by the absence of nuclear testing and with the need to recruit new scientific experts to replace an aging workforce.

I should note that these staff concerns are not expressed about drug testing, which many already must take. They simply are concerned with entrusting their career to a procedure with questionable, in their minds, scientific validity.

A study is in progress by the National Academy of Sciences that will go a long ways toward addressing this question about scientific credibility of polygraphs when they are used as a tool for screening large populations. By way of contrast, this use of polygraphs is in sharp contrast to their use in a targeted criminal investigation. That Academy's study will be completed in June 2002. Therefore, this bill sets up an interim program before the Academy's study is done and requires that a final program be established within 6 months after the study's completion.

This bill addresses several concerns with the way in which polygraphs may be administered by the Department. For example, some employees are concerned that individual privacies, like medical conditions, are not being protected using the careful procedures developed for drug testing. And facility managers are concerned that polygraphs are sometimes administered without enough warning to ensure that work can continue in a safe manner in the sudden absence of an employee. And of greatest importance, the bill ensures that the results of a polygraph will not be the sole factor determining an employee's fitness for duty.

With this bill, we can improve worker morale at our national security facilities by stopping unnecessarily broad application of polygraphs, while still providing the Secretary and General Gordon with enough flexibility to utilize polygraphs where reasonable. In addition, we set in motion a process, which will be based on the scientific evaluation of the National Academy, to implement an optimized plan to protect our national security.

Mr. BINGAMAN. Mr. President, I am pleased to cosponsor legislation being introduced by Senator DOMENICI that will help correct what I consider to be overzealous action on the part of the Congress to address security problems at our Department of Energy national laboratories. We're all aware of the security concerns that grew out of the Wen Ho Lee case. That case, and other incidents that have occurred since then, quite rightly prompted the Department of Energy and the Congress to assess security problems at the laboratories and seek remedies. Last year, during the conference between House and Senate on the Defense Authorization bill, a provision was added, Section 3135, that significantly expanded requirements for administering polygraphs to Department of Energy and contractor employees at the laboratories. That legislative action presumed that polygraph testing is an ef-

fective, reliable tool to reveal spies or otherwise identify security risks to our country.

The problem is that the Congress does not have the full story about polygraph testing. I objected when Section 3135 was included in the conference mark of the Defense bill last year, but it was too late in the process to effectively protest its worthiness. It has since become clear that the provision has had a chilling effect on current and potential employees at the laboratories in a way that could risk the future health of the workforce at the laboratories. The laboratory directors have expressed to me their deep concerns about recruitment and retention, and I'm certain that the polygraph issue is a contributing factor. Indeed, I've heard directly from many laboratory employees who question the viability of polygraphs and who have raised legitimate questions about its accuracy, reliability, and usefulness.

In response to those questions and concerns, I requested that the National Academy of Sciences undertake an effort to review the scientific evidence regarding polygraph testing. Needless to say, there are many difficult scientific issues to be examined, so the study will require considerable effort and time. We are expecting results next June. Once the Congress receives that report, I am hopeful that the Department of Energy, the National Nuclear Security Administration, and the national laboratories will be better able to consider the worthiness of polygraph testing to its intended purposes and determine whether and how to proceed with a program.

Until that time, however, the Congress has levied a burdensome requirement on the national laboratories to use polygraph testing broadly at the laboratories with the negative consequences to which I have alluded. I believe the legislation that Senator DOMENICI and I are introducing today will provide a more balanced, reasoned approach in the interim until the scientific experts report to the Congress with their findings on this very complex matter. The bill being introduced will provide on an interim basis the security protection that many believe is afforded by polygraphs, but will limit its application to those Department of Energy and contractor employees at the laboratories who have access to Restricted Data or Sensitive Compartmented Information containing the nation's most sensitive nuclear secrets. It specifically excludes employees who may operate in a classified environment, but who do not have actual access to the critical security information we are seeking to protect.

Other provisions in the bill would protect individual rights by extending guaranteed protections included under part 40 of Title 49 of the Code of Federal Regulations and by requiring procedures to preclude adverse personnel action related to "false positives" or individual physiological reactions that

may occur during testing. The bill also seeks to ensure the safe operations of DOE facilities by requiring advance notice for polygraph exams to enable management to undertake adjustments necessary to maintain operational safety.

Let me emphasize once again, that this legislation is intended as an interim measure that will meet three critical objectives until we have heard from the scientific community. This bill will ensure that critical secret information will be protected, that the rights of individual employees will be observed, and that the ability of the laboratories to do their job will be maintained. I thank Senator DOMENICI for his work on this bill, and urge my colleagues to support its passage. I yield the floor.

By Mr. DOMENICI (for himself and Mr. LUGAR):

S. 1277. A bill to authorize the Secretary of Energy to guarantee loans to facilitate nuclear nonproliferation programs and activities of the Government of the Russian Federation, and for other purposes; to the Committee on Foreign Relations.

Mr. DOMENICI. Mr. President, I rise to introduce the Fissile Material Loan Guarantee Act of 2001. This Act is intended to increase the suite of programs that reduce proliferation threats from the Russian nuclear weapons complex. I'm pleased that Senator LUGAR joins me as a co-sponsor of this Act.

This Act presents an unusual option, which I've discussed with the leadership of some of the world's largest private banks and lending institutions. I also am aware that discussions between Western lending institutions and the Russian Federation are in progress and that discussions with the International Atomic Energy Agency or IAEA have helped to clarify their responsibilities.

This Act would enable the imposition of international protective safeguards on new, large stocks of Russian weapons-ready materials in a way that enables the Russian Federation to gain near-term financial resources from the materials. These materials would be used as collateral to secure a loan, for which the U.S. Government would provide a loan guarantee. The Act requires that loan proceeds be used in either debt retirement for the Russian Federation or in support of Russian nonproliferation or energy programs. It also requires that the weapons-grade materials used to collateralize these loans must remain under international IAEA safeguards forevermore and thus should serve to remove them from concern as future weapons materials.

This Act does not replace programs that currently are in place to ensure that weapons-grade materials can never be used in weapons in the future. Specifically, it does not displace materials already committed under earlier

agreements. The Highly Enriched Uranium or HEU Agreement is moving toward elimination of 500 tons of Russian weapons-grade uranium. The Plutonium Disposition Agreement is similarly working on elimination of 34 tons of Russian weapons-grade plutonium, primarily by its use in MOX fuel.

The HEU agreement removes material usable in 20,000 nuclear weapons, while the plutonium disposition agreement similarly removes material for more than 4,000 nuclear weapons. Both of these agreements enable the transition of Russian materials into commercial reactor fuel, which, after use in a reactor, destroys its "weapons-grade" attributes. There should be no question that both these agreements remain of vital importance to both nations.

But estimates are that the Russian Federation has vast stocks of weapons-grade materials in addition to the amounts they've already declared as surplus to their weapons needs in these earlier agreements.

If we can provide additional incentives to Russia to encourage transition of more of these materials into configurations where it is not available for diversion or re-use in weapons, we've made another significant step toward global stability. And furthermore, this proposed mechanism provides a relatively low cost approach to reduction of threats from these materials.

Senator LUGAR and I introduced a similar bill near the end of the 106th Congress, to provide time for discussion of its features. Those discussions have progressed, and this bill has some slight refinements that grew out of those discussions. Since then, we have received additional assurances that this bill provides a useful route to reduce proliferation threats, and thus we are reintroducing this bill in the 107th Congress.

Within the last few months, former Senator Howard Baker and former White House Counsel Lloyd Cutler completed an important report outlining the importance of the non-proliferation programs accomplished jointly with Russia. They noted, as their top recommendation, that:

The most urgent unmet national security threat to the United States today is the danger that weapons of mass destruction or weapons-usable material in Russia could be stolen and sold to terrorists or hostile nation states and used against American troops or citizens at home. This threat is a clear and present danger to the international community as well as to American lives and liberties.

This new Act provides another tool toward reducing these threats to national, as well as global, security.

By Mrs. LINCOLN (for herself, Ms. SNOWE, Mr. DURBIN, Mr. BREAUX, and Ms. LANDRIEU):

S. 1278. A bill to amend the Internal Revenue Code of 1986 to allow a United States independent film and television production wage credit; to the Committee on Finance.

Mrs. LINCOLN. Mr. President, I rise today to introduce the U.S. Inde-

pendent Film and Television Production Incentive Act of 2001, a bill designed to address the problem of "run-away" film and television production. I am joined by Senators SNOWE, DURBIN, BREAUX, and LANDRIEU.

Over the past decade, production of American film projects has fled our borders for foreign locations, migration that results in a massive loss for the U.S. economy. My legislation will encourage producers to bring feature film and television production projects to cities and towns across the United States, thereby stemming that loss.

In recent years, a number of foreign governments have offered tax and other incentives designed to entice production of U.S. motion pictures and television programs to their countries. Certain countries, such as Australia, Canada, New Zealand, and several European countries, have been particularly successful in luring film projects to their towns and cities through offers of large tax subsidies.

These governments understand that the benefits of hosting such productions do not flow only to the film and television industry. These productions create ripple effects, with revenues and jobs generated in a variety of other local businesses. Hotels, restaurants, catering companies, equipment rental facilities, transportation vendors, and many others benefit from these ripple effects.

What began as a trickle has become a flood, a significant trend affecting both the film and television industry as well as the smaller businesses that they support.

Many specialized trades involved in film production and many of the secondary industries that depend on film production, such as equipment rental companies, require consistent demand in order to operate profitably. This production migration has forced many small- and medium-sized companies out of business during the last ten years.

Earlier this year, a report by the U.S. Department of Commerce estimated that runaway production drains as much as \$10 billion per year from the U.S. economy.

These losses have been most pronounced in made-for-television movies and miniseries productions. According to the report, out of the 308 U.S.-developed television movies produced in 1998, 139 were produced abroad. That's a significant increase from the 30 produced abroad in 1990.

The report makes a compelling case that runaway film and television production has eroded important segments of a vital American industry. According to official labor statistics, more than 270,000 jobs in the U.S. are directly involved in film production. By industry estimates, 70 to 80 percent of these workers are hired at the location where the production is filmed.

And while people may associate the problem of runaway production with California, the problem has seriously

affected the economies of cities and States across the country, given that film production and distribution have been among the highest growth industries in the last decade. It's an industry with a reach far beyond Hollywood and the west coast.

For example, my home State of Arkansas has been proud to host the production of a number of feature and television films, with benefits both economic and cultural. Our cinematic history includes the opening scenes of "Gone With the Wind," and civil war epics like "The Blue and the Gray" and "North and South." It also includes "A Soldier's Story," "Biloxi Blues," "The Legend of Boggy Creek," and, most recently, "Sling Blade," an independent production written by, directed by, and starring Arkansas' own Billy Bob Thornton. So even in our rural State, there is a great deal of local interest and support for the film industry. My bill will make it possible for us to continue this tradition, and we hope to encourage more of these projects to come to Arkansas.

But to do this, we need to level the playing field. This bill will assist in that effort. It will provide a two-tiered wage tax credit, equal to 25 percent of the first \$25,000 of qualified wages and salaries and 35 percent of such costs if incurred in a "low-income community", for productions of films, television or cable programming, mini-series, episodic television, pilots or movies of the week that are substantially produced in the United States.

This credit is targeted to the segment of the market most vulnerable to the impact of runaway film and television production. It is, therefore, only available if total wage costs are more than \$20,000 and less than \$10 million (indexed for inflation). The credit is not available to any production subject to reporting requirements of 18 USC 2257 pertaining to films and certain other media with sexually explicit conduct.

My legislation enjoys the support of a broad alliance of groups affected by the loss of U.S. production, including the following: national, State and local film commissions, under the umbrella organization Film US as well as the Entertainment Industry Development Corporation; film and television producers, Academy of Television Arts and Sciences, the Association of Independent Commercial Producers, the American Film Marketing Association, the Producers Guild; organizations representing small businesses such as the post-production facilities, The Southern California Chapter of the Association of Imaging Technology and Sound, and equipment rental companies (Production Equipment Rental Association); and organizations representing the creative participants in the entertainment industry, Directors Guild of America, the Screen Actors Guild and Recording Musicians Association. In addition, the United States Conference

of Mayors formally adopted the "Run-away Film Production Resolution" at their annual conference in June.

Leveling the playing field through targeted tax incentives will keep film production, and the jobs and revenues it generates, in the United States. I urge my colleagues to join me in supporting this bill in order to prevent the further deterioration of one of our most American of industries and the thousands of jobs and businesses that depend on it.

By Mr. BREAUX:

S. 1279. A bill to amend the Internal Revenue Code of 1986 to modify the active business definition under section 355; to the Committee on Finance.

Mr. BREAUX. Mr. President, I rise today to introduce tax legislation which proposes only a small technical modification of current law, but, if enacted, would provide significant simplification of routine corporate reorganizations. The legislation is identical to S. 773 which I introduced on April 13 of last year.

This proposed change is small but very important. It would not alter the substance of current law in any way. It would, however, greatly simplify a common corporate transaction. This small technical change will alone save corporations millions of dollars in unnecessary expenses and economic costs that are incurred when they divide their businesses.

Past Treasury Departments have agreed, and I have no reason to believe the current Treasury Department will feel any differently, that this change would bring welcome simplification to section 355 of the Internal Revenue Code. Indeed, the Clinton Administration in its last budget submission to the Congress had proposed this change. The last scoring of this proposal showed no loss of revenue to the U.S. Government, and I am aware of no opposition to its enactment.

Corporations, and affiliated groups of corporations, often find it advantageous, or even necessary, to separate two or more businesses. The division of AT&T from its local telephone companies is an example of such a transaction. The reasons for these corporate divisions are many, but probably chief among them is the ability of management to focus on one core business.

At the end of the day, when a corporation divides, the stockholders simply have the stock of two corporations, instead of one. The Tax Code recognizes this is not an event that should trigger tax, as it includes corporate divisions among the tax-free reorganization provisions.

One requirement the Tax Code imposes on corporate divisions is very awkwardly drafted, however. As a result, an affiliated group of corporations that wishes to divide must often engage in complex and burdensome preliminary reorganizations in order to accomplish what, for a single corporate entity, would be a rather simple and

straightforward spinoff of a business to its shareholders. The small technical change I propose today would eliminate the need for these unnecessary transactions, while keeping the statute true to Congress's original purpose.

More specifically, section 355, and related provision of the Code, permits a corporation or an affiliated group of corporations to divide on a tax-free basis into two or more separate entities with separate businesses. There are numerous requirements for tax-free treatment of a corporate division, or "spinoff," including continuity of historical shareholder interest, continuity of the business enterprises, business purpose, and absence of any device to distribute earnings and profits. In addition, section 355 requires that each of the divided corporate entities be engaged in the active conduct of a trade or business. The proposed change would alter none of these substantive requirements of the Code.

Section 355 (b)(2)(A) currently provides an attribution or "look through" rule for groups of corporations that operate active businesses under a holding company, which is necessary because a holding company, by definition, is not itself engaged in an active business.

This lookthrough rule inexplicably requires, however, that "substantially all" of the assets of the holding company consist of stock of active controlled subsidiaries. The practical effect of this language is to prevent holding companies from engaging in spinoffs if they own almost any other assets. This is in sharp contrast to corporations that operate businesses directly, which can own substantial assets unrelated to the business and still engage in tax-free spinoff transactions.

In the real world, of course, holding companies may, for many sound business reasons, hold other assets, such as non-controlling, less than 80 percent, interests in subsidiaries, controlled subsidiaries that have been owned for less than five years, which are not considered "active businesses" under section 355, or a host of non-business assets. Such holding companies routinely undertake spinoff transactions, but because of the awkward language used in section 355 (b)(2)(A), they must first undertake one or more, often a series of, preliminary reorganizations solely for the purpose of complying with this inexplicable language of the Code.

Such preliminary reorganizations are at best costly, burdensome, and without any business purpose, and at worst, they seriously interfere with business operations. In a few cases, they may be so costly as to be prohibitive, and cause the company to abandon an otherwise sound business transaction that is clearly in the best interest of the corporation and the businesses it operates.

There is no tax policy reasons, tax advisors agree, to require the reorganization of a consolidated group that is clearly engaged in the active conduct of a trade or business, as a condition to

a spinoff. Nor is there any reason to treat affiliated groups differently than single operating companies. Indeed, no one had ever suggested one. The legislative history indicates Congress was concerned about non-controlled subsidiaries, which is elsewhere adequately addressed, no consolidated groups.

For many purposes, the Tax Code treats affiliated groups as a single corporation. Therefore, the simple remedy I am proposing today for the problem created by the awkward language of section 355 (b)(2)(A) is to apply the active business test to an affiliated group as if it were a single entity.

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. 1279

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

**SECTION 1. MODIFICATION OF ACTIVE BUSINESS DEFINITION UNDER SECTION 355.**

(a) IN GENERAL.—Section 355(b) of the Internal Revenue Code of 1986 (defining active conduct of a trade or business) is amended by adding at the end the following new paragraph:

"(3) SPECIAL RULES RELATING TO ACTIVE BUSINESS REQUIREMENT.—

"(A) IN GENERAL.—For purposes of determining whether a corporation meets the requirement of paragraph (2)(A), all members of such corporation's separate affiliated group shall be treated as one corporation. For purposes of the preceding sentence, a corporation's separate affiliated group is the affiliated group which would be determined under section 1504(a) if such corporation were the common parent and section 1504(b) did not apply.

"(B) CONTROL.—For purposes of paragraph (2)(D), all distributee corporations which are members of the same affiliated group (as defined in section 1504(a) without regard to section 1504(b)) shall be treated as one distributee corporation."

(b) CONFORMING AMENDMENTS.—

(1) Subparagraph (A) of section 355(b)(2) of the Internal Revenue Code of 1986 is amended to read as follows:

"(A) it is engaged in the active conduct of a trade or business,".

(2) Section 355(b)(2) of such Code is amended by striking the last sentence.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to distributions after the date of the enactment of this Act.

(2) TRANSITION RULE.—The amendments made by this section shall not apply to any distribution pursuant to a transaction which is—

(A) made pursuant to an agreement which was binding on such date and at all times thereafter,

(B) described in a ruling request submitted to the Internal Revenue Service on or before such date, or

(C) described on or before such date in a public announcement or in a filing with the Securities and Exchange Commission.

(3) ELECTION TO HAVE AMENDMENTS APPLY.—Paragraph (2) shall not apply if the distributing corporation elects not to have such paragraph apply to distributions of such corporation. Any such election, once made, shall be irrevocable.

By Mr. CLELAND:

S. 1280. A bill to authorize the Secretary of Veterans Affairs to carry out construction projects for the purpose of improving, renovating, and updating patient care facilities at Department of Veterans Affairs medical centers; to the Committee on Veterans' Affairs.

Mr. CLELAND. Mr. President, I am very proud to be a Vietnam veteran and to have served as director of the Department of Veterans Affairs, VA, from 1977 to 1980. The VA has continued to provide high quality health care to our Nation's veterans and is a health care system leader on patient safety tracking, long-term care, Post-Traumatic Stress disorder treatment and dozens of other innovative health care programs. The VA Health Care System has also enhanced its access to veterans with the development of approximately 600 community-based outpatient clinics, CBOC's, across the Nation.

But as I visit the VA medical centers in Georgia and across the Nation, I am very alarmed to see patient care areas which look as if they have not been renovated or upgraded in decades. These VA medical centers serve as the hub for all major health care activities and can not be compromised without affecting veterans' care. The president's annual budget for the VA has not requested crucial funding for major medical facility construction. The VA is currently reevaluating their present VA facility infrastructure needs through a process known as CARES or the "Capital Assets Realignment for Enhanced Services." Veteran health care and safety may pay the price as this process may take years to complete. With the increasing numbers of female veterans, many inpatient rooms and bathrooms continue to be inadequate to provide needed space and privacy. Many VA facilities, like the VA Spinal Cord Injury Center in Augusta, Georgia, which serves veterans from Alabama, Georgia, South Carolina, North Carolina, and Tennessee have long waits for care. At least 25 VA construction projects across the Nation would be appropriate for consideration. A Price Waterhouse report recommended that VA spend from 2 to 4 percent of its plant replacement value, PRV, on upkeep and replacement of current medical centers. Based on a PRV of \$35 billion, for fiscal year 2001, VA would need approximately \$170 million to meet these basic safety and upkeep needs. The VA health care system is the largest health care provider in the nation, yet we are not maintaining these essential medical centers. I urge my colleagues to support the Veterans Hospitals Emergency Repair Act and to provide the crucial assistance needed now for our veterans. This proposal would give the VA Secretary limited authority to complete identified medical facility projects thus helping to preserve the VA health care system until the CARES process can be completed.

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

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

S. 1280

*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 "Veterans' Hospital Emergency Repair Act".

**SEC. 2. AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS FOR PATIENT CARE IMPROVEMENTS.**

(a) IN GENERAL.—(1) The Secretary of Veterans Affairs is authorized to carry out major medical facility projects in accordance with this section, using funds appropriated for fiscal year 2002 or fiscal year 2003 pursuant to section 3. The cost of any such project may not exceed \$25,000,000.

(2) Projects carried out under this section are not subject to section 8104(a)(2) of title 38, United States Code.

(b) PURPOSE OF PROJECTS.—A project carried out pursuant to subsection (a) may be carried out only at a Department of Veterans Affairs medical center and only for the purpose of improving, renovating, and updating to contemporary standards patient care facilities. In selecting medical centers for projects under subsection (a), the Secretary shall select projects to improve, renovate, or update facilities to achieve one or more of the following:

(1) Seismic protection improvements related to patient safety.

(2) Fire safety improvements.

(3) Improvements to utility systems and ancillary patient care facilities.

(4) Improved accommodation for persons with disabilities, including barrier-free access.

(5) Improvements to facilities carrying out specialized programs of the Department, including the following:

(A) Blind rehabilitation centers.

(B) Facilities carrying out inpatient and residential programs for seriously mentally ill veterans, including mental illness research, education, and clinical centers.

(C) Facilities carrying out residential and rehabilitation programs for veterans with substance-use disorders.

(D) Facilities carrying out physical medicine and rehabilitation activities.

(E) Facilities providing long-term care, including geriatric research, education, and clinical centers, adult day care centers, and nursing home care facilities.

(F) Facilities providing amputation care, including facilities for prosthetics, orthotics programs, and sensory aids.

(G) Spinal cord injury centers.

(H) Facilities carrying out traumatic brain injury programs.

(I) Facilities carrying out women veterans' health programs (including particularly programs involving privacy and accommodation for female patients).

(J) Facilities for hospice and palliative care programs.

(c) REVIEW PROCESS.—(1) Before a project is submitted to the Secretary with a recommendation that it be approved as a project to be carried out under the authority of this section, the project shall be reviewed by an independent board within the Department of Veterans Affairs constituted by the Secretary to evaluate capital investment projects. The board shall review each such project to determine the project's relevance to the medical care mission of the Department and whether the project improves, ren-

ovates, and updates patient care facilities of the Department in accordance with this section.

(2) In selecting projects to be carried out under the authority of this section, the Secretary shall consider the recommendations of the board under paragraph (1). In any case in which the Secretary selects a project to be carried out under this section that was not recommended for approval by the board under paragraph (1), the Secretary shall include in the report of the Secretary under section 4(b) notice of such selection and the Secretary's reasons for not following the recommendation of the board with respect to the project.

**SEC. 3. AUTHORIZATION OF APPROPRIATIONS.**

(a) IN GENERAL.—There are authorized to be appropriated to the Secretary of Veterans Affairs for the Construction, Major Projects, account for projects under section 2—

(1) \$250,000,000 for fiscal year 2002; and

(2) \$300,000,000 for fiscal year 2003.

(b) LIMITATION.—Projects may be carried out under section 2 only using funds appropriated pursuant to the authorization of appropriations in subsection (a).

**SEC. 4. REPORTS.**

(a) GAO REPORT.—Not later than April 1, 2003, the Comptroller General shall submit to the Committees on Veterans' Affairs and on Appropriations of the Senate and House of Representatives a report evaluating the advantages and disadvantages of congressional authorization for projects of the type described in section 2(b) through general authorization as provided by section 2(a), rather than through specific authorization as would otherwise be applicable under section 8104(a)(2) of title 38, United States Code. Such report shall include a description of the actions of the Secretary of Veterans Affairs during fiscal year 2002 to select and carry out projects under section 2.

(b) SECRETARY REPORT.—Not later than 120 days after the date on which the site for the final project under section 2 is selected, the Secretary shall submit to the committees referred to in subsection (a) a report on the authorization process under section 2. The Secretary shall include in the report the following:

(1) A listing by project of each project selected by the Secretary under that section, together with a prospectus description of the purposes of the project, the estimated cost of the project, and a statement attesting to the review of the project under section 2(c), and, if that project was not recommended by the board, the Secretary's justification under section 2(d) for not following the recommendation of the board.

(2) An assessment of the utility to the Department of Veterans Affairs of the authorization process.

(3) Such recommendations as the Secretary considers appropriate for future congressional policy for authorizations of major and minor medical facility construction projects for the Department.

(4) Any other matter that the Secretary considers to be appropriate with respect to oversight by Congress of capital facilities projects of the Department.

By Mr. HATCH:

S. 1282. A bill to amend the Internal Revenue Code of 1986 to exclude from gross income of individual taxpayers discharges of indebtedness attributable to certain forgiven residential mortgages obligations; to the Committee on Finance.

Mr. HATCH. Mr. President, I rise today to introduce the Mortgage Cancellation Act of 2001. This bill would fix

a flaw in the tax code that unfairly harms homeowners who sell their home at a loss.

Today, our Nation has achieved an amazing 67.5 percent rate of homeownership, the highest rate in our history. It is notable that in recent years, the largest category of first-time homebuyers has been comprised of immigrants and minorities. This is a great success story. Homeownership is still the most important form of wealth accumulation in our society.

From time to time, however, the value of housing in a whole market goes down through no fault of the homeowner. A plant closes, environmental degradations are found nearby, a regional economic slump hits hard. This happened during the 1980s in the oil patch and in Southern California and New England at the beginning of the 1990s. A general housing market downturn can be devastating to what is very often a family's largest asset. Unfortunately, a loss in value to the family home may not be the worst of it. Sometimes when people must sell their homes during a downturn, they get a nasty surprise from the tax law.

For example, suppose Keith and Mary Turner purchased a home for \$120,000 with a five percent down payment and a mortgage of \$114,000. Four years later, the local housing market experiences a downturn. While the market is down, the Turners must sell the home because Keith was laid off and has accepted a job in another city. The house sells for \$105,000. However, the Turners still owe \$112,000 on their mortgage. They are \$7,000 short on what they owe on the mortgage, but have no equity and received no cash.

Often, homeowners who must sell their home at a loss are able to negotiate with their mortgage holder to forgive all or part of the mortgage balance that exceeds the selling price. However, under current tax law, the amount forgiven is taxable income to the seller, taxed at ordinary rates.

In the case of the Turner family, the mortgage holder agreed to forgive the \$7,000 excess of the mortgage balance over the sales price. However, under current law, this means the Turners will have to recognize this \$7,000 as taxable income at a time when they can least afford it. This is true even though the family suffered a \$15,000 loss on the sale of the home.

I find this predicament both ironic and unfair. If this same family, under better circumstances, had been able to sell their house for \$150,000 instead of \$105,000, then they would owe nothing in tax on the gain under current tax law because gains on a principal residence are tax-exempt up to \$500,000. I believe that this discrepancy creates a tax inequity that begs for relief.

It is simply unfair to tax people right at the time they have had a serious loss and have no cash with which to pay the tax. The bill I introduce today, the Mortgage Cancellation Relief Act, will relieve this unfair tax burden so

that in the case where the lender forgives part of the mortgage, there will be no taxable event.

Who are the people that are most vulnerable to this mortgage forgiveness tax dilemma? Unfortunately, people who have a very small amount of equity in their homes are most likely to experience this problem. Today, about 4.6 million households have low equity in their homes. Of those, about 2 million have no equity in their homes, which is defined as less than 10 percent of the value of the home. In a housing value downturn, these people would be wiped out first if they had to sell.

Sixty-seven percent of these low-equity owners are first-time homebuyers, and 26 percent of them have less than \$30,000 of annual family income. The median value of their homes is \$70,000, while the median value of all homes nationally is \$108,000. More than half of these low equity owners live in the South or in the West.

I want to emphasize that now is the time to correct this inequity. Today, the National Association of Realtors reports that there are no markets that are in the woeful condition of having homes lose value. Still, in our slowing economy, families are vulnerable. Because today's real estate market is strong, now is the optimal time to correct this fundamental unfairness. The bill applies only to the circumstance in which a lender actually forgives some portion of a mortgage debt and is not intended to be an insurance policy against economic loss. My bill provides safeguards against abuse and will help families at a time when they are most in need of relief.

The estimated revenue effect of this bill is not large. The Joint Committee on Taxation last year estimated that this correction would result in a loss to the Treasury of only about \$27 million over five years and \$64 million over ten years. Again, it is important to note that if we wait to correct this problem until it becomes more widespread, and thus more expensive, it will be much more difficult to find the necessary offset.

I hope my colleagues will take a close look at this small, but important, bill, and join me in sponsoring it and pushing for its inclusion in the next appropriate tax cut bill the Senate considers.

I ask unanimous consent that a copy of the bill be printed in the RECORD.

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

S. 1282

*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 "Mortgage Cancellation Relief Act of 2001".

**SEC. 2. EXCLUSION FROM GROSS INCOME FOR CERTAIN FORGIVEN MORTGAGE OBLIGATIONS.**

(a) IN GENERAL.—Paragraph (1) of section 108(a) of the Internal Revenue Code of 1986

(relating to exclusion from gross income) is amended by striking "or" at the end of both subparagraphs (A) and (C), by striking the period at the end of subparagraph (D) and inserting ", or", and by inserting after subparagraph (D) the following new subparagraph:

"(E) in the case of an individual, the indebtedness discharged is qualified residential indebtedness."

(b) QUALIFIED RESIDENTIAL INDEBTEDNESS SHORTFALL.—Section 108 of the Internal Revenue Code of 1986 (relating to discharge of indebtedness) is amended by adding at the end the following new subsection:

"(h) QUALIFIED RESIDENTIAL INDEBTEDNESS.—

"(1) LIMITATIONS.—The amount excluded under subparagraph (E) of subsection (a)(1) with respect to any qualified residential indebtedness shall not exceed the excess (if any) of—

"(A) the outstanding principal amount of such indebtedness (immediately before the discharge), over

"(B) the sum of—

"(i) the amount realized from the sale of the real property securing such indebtedness reduced by the cost of such sale, and

"(ii) the outstanding principal amount of any other indebtedness secured by such property.

"(2) QUALIFIED RESIDENTIAL INDEBTEDNESS.—

"(A) IN GENERAL.—The term 'qualified residential indebtedness' means indebtedness which—

"(i) was incurred or assumed by the taxpayer in connection with real property used as the principal residence of the taxpayer (within the meaning of section 121) and is secured by such real property,

"(ii) is incurred or assumed to acquire, construct, reconstruct, or substantially improve such real property, and

"(iii) with respect to which such taxpayer makes an election to have this paragraph apply.

"(B) REFINANCED INDEBTEDNESS.—Such term shall include indebtedness resulting from the refinancing of indebtedness under subparagraph (A)(ii), but only to the extent the refinanced indebtedness does not exceed the amount of the indebtedness being refinanced.

"(C) EXCEPTIONS.—Such term shall not include qualified farm indebtedness or qualified real property business indebtedness."

(c) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 108(a) of the Internal Revenue Code of 1986 is amended—

(A) in subparagraph (A) by striking "and (D)" and inserting "(D), and (E)", and

(B) by amending subparagraph (B) to read as follows:

"(B) INSOLVENCY EXCLUSION TAKES PRECEDENCE OVER QUALIFIED FARM EXCLUSION, QUALIFIED REAL PROPERTY BUSINESS EXCLUSION, AND QUALIFIED RESIDENTIAL SHORTFALL EXCLUSION.—Subparagraphs (C), (D), and (E) of paragraph (1) shall not apply to a discharge to the extent the taxpayer is insolvent."

(2) Paragraph (1) of section 108(b) of such Code is amended by striking "or (C)" and inserting "(C), or (E)".

(3) Subsection (c) of section 121 of such Code is amended by adding at the end the following new paragraph:

"(3) SPECIAL RULE RELATING TO DISCHARGE OF INDEBTEDNESS.—The amount of gain which (but for this paragraph) would be excluded from gross income under subsection (a) with respect to a principal residence shall be reduced by the amount excluded from gross income under section 108(a)(1)(E) with respect to such residence."

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges after the date of the enactment of this Act.

By Mr. KENNEDY (for himself, Mr. SPECTER, Mr. JEFFORDS, Mr. LIEBERMAN, Mr. DASCHLE, Mr. AKAKA, Mr. BAUCUS, Mr. BAYH, Mr. BIDEN, Mr. BINGAMAN, Mrs. BOXER, Ms. CANTWELL, Mr. CARPER, Mr. CHAFFEE, Mr. CLELAND, Mrs. CLINTON, Mr. CORZINE, Mr. DAYTON, Mr. DODD, Mr. DURBIN, Mr. EDWARDS, Mr. FEINGOLD, Mrs. FEINSTEIN, Mr. HARKIN, Mr. INOUE, Mr. KERRY, Mr. KOHL, Ms. LANDRIEU, Mr. LEAHY, Mr. LEVIN, Ms. MIKULSKI, Mrs. MURRAY, Mr. NELSON of Florida, Mr. REED, Mr. REID, Mr. SARBANES, Mr. SCHUMER, Mr. SMITH of Oregon, Ms. STABENOW, Mr. TORRICELLI, Mr. WELLSTONE, and Mr. WYDEN):

S. 1284. A bill to prohibit employment discrimination on the basis of sexual orientation; to the Committee on Health, Education, Labor, and Pensions.

Mr. KENNEDY. Mr. President, it's a privilege to introduce the Employment Non-Discrimination Act.

Civil rights is the unfinished business of the Nation. The Civil Rights Act of 1964 has long prohibited job discrimination based on race, ethnic background, gender, or religion. It is long past time to prohibit such discrimination based on sexual orientation, and that is what the Employment Non-Discrimination Act will do.

Its provisions are straight-forward and limited. It prohibits employers from discriminating against individuals because of their sexual orientation when making decisions about hiring, firing, promotion and compensation. It does not require employers to provide domestic partnership benefits, and it does not apply to the armed forces or to religious organizations. It also prohibits the use of quotas and preferential treatment.

Too many hard-working Americans are being judged today on their sexual orientation, rather than their ability and qualifications. For example, after working at Red Lobster for several years and receiving excellent reviews, Kendall Hamilton applied for a promotion at the urging of the general manager who knew he was gay. The application was rejected after a co-worker disclosed Kendall's sexual orientation to the management team, and the promotion went instead to an employee of nine months whom Kendall had trained. Kendall was told that his sexual orientation "was not compatible with Red Lobster's belief in family values," and that being gay had destroyed his chances of becoming a manager. Feeling he had no choice, Kendall left the company.

Fireman Steve Morrison suffered similar discrimination. His co-workers saw him on the local news protesting

an anti-gay initiative, and incorrectly assumed he was gay. He soon lost workplace responsibilities and was the victim of harassment, including hate mail. After lengthy administrative proceedings, he was finally able to have the false charges removed from his record, but he was transferred to another station.

The overwhelming majority of Americans oppose this kind of flagrant discrimination. Businesses of all sizes, labor unions, and a broad religious coalition all strongly support the Employment Non-Discrimination Act. America will not achieve its promise of true justice and equal opportunity for all until we end all forms of discrimination.

Mr. LIEBERMAN. Mr. President, I am delighted to join with Senators KENNEDY, SPECTER, JEFFORDS and many other colleagues as an original cosponsor of this important legislation, the Employment Non-Discrimination Act of 2001. By guaranteeing that American workers cannot lose their jobs simply because of their sexual orientation, this bill would extend the bedrock American values of fairness and equality to a group of our fellow citizens who too often have been denied the benefit of those most basic values.

Two hundred and twenty-five years ago this month, Thomas Jefferson laid out a vision of America as dedicated to the simple idea that all of us are created equal, endowed by our Creator with the inalienable rights to life, liberty and the pursuit of happiness. As Jefferson knew, our society did not in his time live up to that ideal, but since his time, we have been trying to. In succeeding generations, we have worked ever harder to ensure that our society removes unjustified barriers to individual achievement and that we judge each other solely on our merits and not on characteristics that are irrelevant to the task at hand. We are still far from perfect, but we have made much progress, especially over the past few decades, guaranteeing equality and fairness to an increasing number of groups that traditionally have not had the benefits of those values and of those protections. To African-Americans, to women, to disabled Americans, to religious minorities and to others we have extended a legally enforceable guarantee that, with respect to their ability to earn a living at least, they will be treated on their merits and not on characteristics unrelated to their ability to do their jobs.

It is time to extend that guarantee to gay men and lesbians, who too often have been denied the most basic of rights: the right to obtain and maintain a job. A collection of one national survey and twenty city and State surveys found that as many as 44 percent of gay, lesbian and bisexual workers faced job discrimination in the workplace at some time in their careers. Other studies have reported even greater discrimination, as much as 68 percent of gay men and lesbians reporting employment discrimination. The fear

in which these workers live was clear from a survey of gay men and lesbians in Philadelphia. Over three-quarters told those conducting the survey that they sometimes or always hide their orientation at work out of fear of discrimination.

The toll this discrimination takes extends far beyond its effect on the individuals who live without full employment opportunities. It also takes an unacceptable toll on America's definition of itself as a land of equality and opportunity, as a place where we judge each other on our merits, and as a country that teaches its children that anyone can succeed here as long as they are willing to do their job and work hard.

This bill provides for equality and fairness, that and no more. It says only what we already have said for women, for people of color and for others: that you are entitled to have your ability to earn a living depend only on your ability to do the job and nothing else.

This bill would bring our Nation one large step closer to realizing the vision that Thomas Jefferson so eloquently expressed 225 years ago when he wrote that all of us have a right to life, liberty and the pursuit of happiness. I urge my colleagues to join me in supporting this important legislation.

Mr. SMITH of Oregon. Mr. President, I rise today to give my support for the Employment Non Discrimination Act of 2001 or ENDA. I believe that every American should have the opportunity to work and should not be denied that opportunity for jobs they are qualified to fill. In both my private and public life I have hired without regard to sexual orientation and have found both areas to be enriched by this decision.

ENDA would provide basic protection against job discrimination based on sexual orientation. Civil Rights progress over the years has slowly extended protection against discrimination in the workplace based on race, gender, national origin, age, religion and disability. It is time now to extend these protections to cover sexual orientation, the next logical step to achieve equality of opportunity in the workplace.

As a Republican, I do not believe that this discrimination in the workplace can be categorized as a conservative/liberal issue. Barry Goldwater once wrote:

I am proud that the Republican Party has always stood for individual rights and liberties. The positive role of limited government has always been the defense of these fundamental principles. Our Party has led the way in the fight for freedom and a free market economy, a society where competition and the Constitution matter, and sexual orientation should not . . .

Indeed my Republican predecessor in this seat, Mark Hatfield was also a strong supporter of ENDA and viewed discrimination as a serious societal injustice, in both human and economic terms:

As this Nation turns the corner toward the 21st century, the global nature of our economy is becoming more and more apparent. If

we are to compete in this marketplace, we must break down the barriers to hiring the most qualified and talented person for the job. Prejudice is such a barrier. It is intolerable and irrational for it to color decisions in the workplace.

I believe that ENDA is a well thought-out approach to rectifying discrimination in the workplace. ENDA contains broad exemptions for religious organizations, the military and small businesses. It specifically rules out preferential treatment or "quotas" and does not affect our nation's armed services. I am confident that this bill will pass this Senate by a bipartisan majority.

ENDA is a simple, narrowly-crafted solution to a significant omission in our civil rights law. I strongly believe that no one should be denied employment on the basis of sexual orientation or any other factor not related to ability to do a particular job. I look forward to working with my colleagues to pass ENDA and strengthen fundamental fairness in our society.

By Mr. CORZINE:

S. 1285. A bill to provide the President with flexibility to set strategic nuclear delivery system levels to meet United States national security goals; to the Committee on Armed Services.

Mr. CORZINE. Mr. President, today I am introducing legislation, the Strategic Arms Flexibility Act of 2001, that would restore the President's authority to manage the size of our Nation's nuclear stockpile by repealing an obsolete law that now prevents him from reducing the number of nuclear weapons. The Strategic Arms Flexibility Act of 2001 would reduce the risk of a catastrophic accident or terrorist incident, reduce tensions throughout the world, and save substantial taxpayer dollars.

We have far more nuclear weapons than would ever be necessary to win a war. Based on START counting rules, we have 7,300 strategic nuclear weapons. Yet, as Secretary of State Colin Powell has said, we could eliminate more than half of these weapons and still, "have the capability to deter any actor." Furthermore, the U.S. nuclear arsenal is equipped with sophisticated guidance and information systems that make our nuclear weapons much more accurate and effective than those of our adversaries. This is one reason why we should not be overly influenced by calls for maintaining strict numerical parity.

While the huge number of nuclear arms in our arsenal is not necessary to fight a war, maintaining these weapons actually presents significant risks to national security.

First, it increases the risk of a catastrophic accident. The more weapons that exist, the greater chance that a sensor failure or other mechanical problem, or an error in judgment, will lead to the detonation of a nuclear weapon. In fact, there have been many times when inaccurate sensor readings or other technical problems have

forced national leaders to decide within minutes whether to launch nuclear weapons. In one incident, a Russian commander deviated from standard procedures by refusing to launch, even though an early detection system was reporting an incoming nuclear attack, a report that was inaccurate.

The second reason why maintaining excessive numbers of nuclear weapons poses national security risks is that it encourages other nations to maintain large stockpiles, as well. The more weapons held by other countries, the greater the risk that a rogue faction in one such country could gain access to nuclear weapons and either threaten to use them, actually use them, or transfer them to others. Such a faction could obtain weapons through force. For example, there are many poorly guarded intercontinental ballistic missiles that are easy targets for terrorists. Senator BOB KERREY, who introduced this legislation in the last Congress, speculated that a relatively small, well-trained group could overtake the few personnel who guard some of the smaller installations in Russia.

Alternatively, a hostile group might be able simply to purchase ballistic missiles on the black market. This risk may be especially relevant in Russia, where many military personnel are poorly paid and a few may feel financial pressure to collaborate with those hostile to the United States. In addition, some have speculated that the high cost of maintaining a large nuclear stockpile could encourage some nuclear powers themselves to sell weapon technologies as a mean of financing their nuclear infrastructure.

By reducing our own stockpile, we can encourage Russia to reduce its stockpile and discourage other nuclear states from expanding theirs. In particular, Russia is faced with the exorbitant annual cost of maintaining thousands of unnecessary ICBMs. The present state of Russia's economy leaves it ill-equipped to handle these costs, a fact readily admitted by Russian Defense Minister Igor Sergeev. Russia has expressed an interest in reducing its stockpile dramatically, from about 6,000 weapons to fewer than 1,000. However, Russia is unlikely to make such reductions without a commensurate reduction by the United States. If the United States takes the first step, it would provide Russia with a face-saving way to do the same, without waiting for START II, which now appears unlikely to be ratified in the short term.

Beyond the benefits to national security of reducing our nuclear stockpile, such a reduction also would save taxpayers significant amounts of money. According to the Center for Defense Information, in FY 01, the United States spent \$26.7 billion on operations, maintenance, and development related the United States' nuclear program. Of that \$26.7 billion, \$12.4 billion, just under half, goes to build, maintain, and operate our arsenal of tactical and

strategic nuclear weapons. Although a precise cost estimate is not available, it seems clear that reducing the stockpile of nuclear weapons would provide major cost savings.

While a reduction in the nuclear stockpile would improve national security and reduce costs, the 1998 defense authorization act now prevents the President from reducing such weapons until the Russian Duma approves the START II treaty. The Bush Administration has made it clear that it wants this law repealed, and would like the authority to unilaterally reduce the nuclear stockpile. In hearings before various Senate Committees, Secretary of Defense Donald Rumsfeld and Deputy Secretary of Defense Paul Wolfowitz, have expressed the Administration's desire to retire immediately 50 unnecessary MX peacekeeper missiles with some 500 warheads. The Administration is still conducting a more comprehensive review and may well propose additional reductions. However, as Secretary Wolfowitz has testified, "we will need the support of the Congress to remove the current restrictions that prohibit us from getting rid of a nuclear system that we no longer need."

Some might question whether it is appropriate to reduce the United States stockpile without a direct assurance that other nations would reduce theirs by the same amount. However, this is flawed Cold War thinking. As Secretary Powell has stated, we have far more weapons than necessary to devastate any opponent, real or imagined, many times over. Clearly, we can reduce our stockpile without in any way reducing our nuclear deterrent, or our national security.

Having said this, reducing the stockpile is not enough. We also need to encourage and assist others in doing so. In particular, it is important that we help Russia by providing aid for dismantling weapons and by offering other economic assistance. We also need to continue to negotiate arms reductions and non-proliferation agreements with other countries, including, but not limited to Russia. Unilateral action can provide many benefits, but we need multilateral agreements to more fully reduce the nuclear threat, and prevent the spread of nuclear technology. Ultimately, the nuclear threat is a threat to all of humanity, and all nations need to be part of a coordinated effort to reduce that threat.

In recent months, we have renewed a long-standing debate about whether to deploy a national missile defense. Proponents of such a system argue that it would reduce the threat posed by nuclear weapons by giving us the capacity to deflect incoming nuclear weapons. However, many have raised serious concerns about this approach, and the risk that it actually could reduce our national security by creating a new arms race and heightening international tensions.

The bill I am introducing today offers a proven way to reduce the nuclear

threat that can be accomplished quickly and without the controversy associated with a national missile defense system.

There are few issues more important than reducing the risks posed by nuclear weapons. For the past half century, the world has lived with these weapons, and it is easy to underestimate the huge threat they represent. Yet it is critical that we remain vigilant and do everything in our power to reduce that threat. The fate of the world, quite literally, is at stake.

I urge my colleagues to support this simple but powerful measure.

#### STATEMENTS ON SUBMITTED RESOLUTIONS

#### SENATE RESOLUTION 142—EX- PRESSING THE SENSE OF THE SENATE THAT THE UNITED STATES SHOULD BE AN ACTIVE PARTICIPANT IN THE UNITED NATIONS WORLD CONFERENCE ON RACISM, RACIAL DISCRIMI- NATION, XENOPHOBIA AND RE- LATED INTOLERANCE

Mr. DODD submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 142

Whereas racial discrimination, ethnic conflict, and xenophobia persist in various parts of the world despite continuing efforts by the international community;

Whereas in recent years the world has witnessed campaigns of ethnic cleansing;

Whereas racial minorities, migrants, asylum seekers, and indigenous peoples are persistent targets of intolerance and violence;

Whereas millions of human beings continue to encounter discrimination solely due to their race, skin color, or ethnicity;

Whereas early action is required to prevent the growth of ethnic hatred and to diffuse potential violent conflicts;

Whereas the problems associated with racism will be thoroughly explored at the United Nations World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, to be held in Durban, South Africa from August 31 to September 7, 2001;

Whereas this conference will review progress made in the fight against racism and consider ways to better ensure the application of existing standards to combat racism;

Whereas the conference will increase the level of awareness about the scourge of racism and formulate concrete recommendations on ways to increase the effectiveness of the United Nations in dealing with racial issues;

Whereas the conference will review the political, historical, economic, social, cultural, and other factors leading to racism and racial discrimination and formulate concrete recommendations to further action-oriented national, regional, and international measures to combat racism;

Whereas the conference will draw up concrete recommendations to ensure that the United Nations has the resources to actively combat racism and racial discrimination; and

Whereas the United States is a member of the United Nations: Now, therefore, be it

*Resolved*, That it is the sense of the Senate that—

(1) the United States should attend and participate fully in the United Nations World Conference on Racism, Racial Discrimination, Xenophobia and Related Intolerance;

(2) the delegation sent to the conference by the United States should reflect the racial and geographic diversity of the United States; and

(3) the President should support the conference and should act in such a way as to facilitate substantial United States involvement in the conference.

Mr. DODD. Mr. President, I rise today to discuss the possibility that the United States will not send a full delegation to the United Nations World Conference Against Racism, Racial Discrimination, Xenophobia, and Related Intolerance. I believe this is both a worthwhile and important endeavor, and I am greatly troubled by the prospect that the United States may not attend.

According to a Washington Post article last week, the Bush Administration's reservations about attending the conference stem from concerns regarding certain proposed items on the agenda. The Administration's concerns are legitimate ones, but it is my belief that the Conference organizers are so anxious to have high level U.S. participation in Durban that contentious issues can be resolved prior to the August event, provided the United States signals its genuine interest in participating. Clearly the overarching objectives of the conference are of great importance to the American people and to peoples throughout the planet. As members of the global community, and as a global leader and vocal advocate for human rights, it would be tragic if the United States could not find a way to support the conference's honorable ambitions.

I do not need to list for my colleagues all the many injustices that occur each day, worldwide, that can be attributed to racism and ignorance, racism's frequent collaborator. As we all know, despite the best efforts of the international community, the effects of racial discrimination, ethnic conflict, and xenophobia continue to threaten and victimize people the world over. We have seen the violent devastations of racism in the former Yugoslavia, in Indonesia, and sadly, at home in America as well. The hateful term "ethnic cleansing" is now all too often used to describe violent international conflicts, and, increasingly, international humanitarian relief efforts focus on the tides of refugees fleeing persecution based on skin color, religion, and ethnic heritage. The task that lays before all nations therefore, is to peer deeply into the corners of our societies that we find most distasteful and hurtful, and to shine some light honestly onto the devastation that racism has inflicted.

In my view, the United Nations World Conference on Racism is the place to begin this difficult, but crucial process of racial introspection. It is not enough for the United States to pay lip service to the ideals of racial equality.

We should attend this conference, and lend our full support to this worthy cause. I believe that in the conference we have a unique opportunity to work with other nations, our neighbors and partners, to begin the process of addressing the many crimes caused by racism, and the underlying societal causes of racism itself. This conference has the power to raise awareness about these issues, to form international consensus on best to combat racism, and to educate the international community on the ravages of racially motivated persecution and conflict.

It is my hope, that the Bush Administration will conclude that our presence at the United Nations Conference on Racism, Racial Discrimination, Xenophobia, and Related Intolerance is vital and appropriate, and will work to ensure that problems related to U.S. participation are resolved before the conference convenes next month. I would also hope that the President would designate Secretary of State Colin Powell to lead a racially and geographically diverse delegation from the United States to the conference in South Africa. Toward that end, I am submitting a resolution which urges the active participation of the United States in the conference, and it is my hope that my colleagues will support this resolution.

#### SENATE RESOLUTION 143—EX- PRESSING THE SENSE OF THE SENATE REGARDING THE DE- VELOPMENT OF EDUCATIONAL PROGRAMS ON VETERANS' CON- TRIBUTIONS TO THE COUNTRY AND THE DESIGNATION OF THE WEEK OF NOVEMBER 11 THROUGH NOVEMBER 17, 2001, AS "NATIONAL VETERANS AWARE- NESS WEEK"

Mr. BIDEN (for himself, Mr. CONRAD, Mr. GRAHAM, Mr. LEVIN, Mr. SANTORUM, Mr. AKAKA, Mr. BREAUX, Mr. KENNEDY, Mr. COCHRAN, Mr. DODD, Mr. NELSON of Florida, Mr. BAUCUS, Mr. BAYH, Mr. BUNNING, Mr. DORGAN, Mrs. FEINSTEIN, Mr. DASCHLE, Mr. KERRY, Mr. INOUE, Ms. LANDRIEU, Mr. LEAHY, Mr. MILLER, Mr. MURKOWSKI, Mr. REID, Mr. SARBANES, Mr. BINGAMAN, Mr. BYRD, Mr. DAYTON, Mr. DURBIN, Mr. KOHL, Mr. LIEBERMAN, Mr. MCCAIN, Mr. ROCKEFELLER, Mr. BROWNBACK, Mrs. LINCOLN, Mr. WARNER, Ms. STABENOW, Mr. DOMENICI, Mr. VOINOVICH, Mrs. BOXER, Mr. CHAFEE, Mr. DEWINE, Mr. GRASSLEY, Mr. HAGEL, Mr. INHOFE, Ms. SNOWE, Mr. THURMOND, Ms. COLLINS, Mr. CARPER, Mr. STEVENS, Mr. ENSIGN, Mr. ROBERTS, Mr. SMITH of New Hampshire, and Mr. BOND) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 143

Whereas tens of millions of Americans have served in the Armed Forces of the United States during the past century;

Whereas hundreds of thousands of Americans have given their lives while serving in the Armed Forces during the past century;