S. 1062. A bill to amend the Fair Labor Standards Act of 1938 to provide for an increase in the Federal minimum wage; read the first time.

By Mr. NELSON of Florida (for himself, Mr. BURNS, and Mrs. CLINTON):

S. 1063. A bill to promote and enhance public safety and to encourage the rapid deployment of public safety telecommunication services; to the Committee on Commerce, Science, and Transportation.

By Mr. COCHRAN (for himself, Mr. KENNEDY, Mr. WARNER, Ms. CANTWELL, Ms. COLLINS, and Mr. DAYTON):

S. 1064. A bill to amend the Public Health Service Act to improve stroke prevention, diagnosis, treatment, and rehabilitation; to the Committee on Health, Education, Labor, and Pensions.

By Mr. THUNE (for himself and Mrs. CLINTON):

S. 1065. A bill to amend title 10, United States Code, to extend child care eligibility to the Armed Forces who die in the line of duty; to the Committee on Armed Services.

By Mr. VOINOVICH (for himself, Ms. STABENOW, Mr. BUNNING, Mr. LEVIN, Mr. ALEXANDER, Mr. DEWINE, Mr. MCCONNELL, and Mr. FREITJ):

S. 1066. A bill to authorize the States (and subdivisions thereof), the District of Columbia, territories, and possessions of the United States to provide tax incentives to any person for economic development purposes; to the Committee on Finance.

By Mrs. LINCOLN (for herself, Mr. BROWNSTEIN, Mr. JEFFORDS, and Mr. DODGIAN):

S. 1067. A bill to require the Secretary of Health and Human Services to undertake activities to provide the provision of services under the PACE program to frail elders living in rural areas, and for other purposes; to the Committee on Finance.

By Mrs. LINCOLN (for herself, Mr. BROWNSTEIN, Mr. JEFFORDS, and Mr. DODGIAN):

S. 1068. A bill to provide for higher education affordability, access, and opportunity; to the Committee on Health, Education, Labor, and Pensions.

By Mrs. FEINSTEIN:

S. 1069. A bill to suspend temporarily the duty on certain cases or containers for toys; to the Committee on Finance.

By Mrs. FEINSTEIN:

S. 1070. A bill to suspend temporarily the duty on certain cases for toys; to the Committee on Finance.

By Ms. DOLÉ (for herself and Mr. BAUCUS):

S. 1071. A bill to extend the temporary suspension of duty on certain bags for toys; to the Committee on Finance.

By Mrs. FEINSTEIN:

S. 1072. A bill to extend the temporary suspension of duty on certain children’s products; to the Committee on Finance.

By Mrs. FEINSTEIN:

S. 1073. A bill to extend the temporary suspension of duty on certain children’s products; to the Committee on Finance.

By Mr. HARKIN:

S. 1074. A bill to improve the health of Americans and reduce health care costs by requiring the Nation’s health care system toward prevention, wellness, and self care; to the Committee on Finance.

By Mr. THUNE (for himself, Ms. SNOWE, Mr. BINGAMAN, Mr. COLLINS, Mr. DOMENICI, Mr. GREGG, Mr. JOHNSON, Mr. LOTT, Ms. MURkowski, Mr. STEVENS, and Mr. SUNUNU):

S. 1075. A bill to postpone the 2005 round of defense base closure and realignment; to the Committee on Armed Services.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

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

S. Res. 146. A resolution designating June 2005 as “National Safety Month”; to the Committee on the Judiciary.

By Ms. CANTWELL (for herself, Mrs. MURRAY, Mr. STEVENS, and Mr. FRYER):

S. Res. 147. A resolution designating June 2005 as “National Internet Safety Month”; considered and agreed to.

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

S. Res. 148. A resolution to authorize the display of the Senate Leadership Portrait Collection in the Senate Lobby; considered and agreed to.

ADDITIONAL COSPONSORS

S. 471. At the request of Mr. SPECTER, the names of the Senator from Minnesota (Mr. DAYTON), the Senator from North Dakota (Mr. DODGAN), the Senator from Wisconsin (Mr. FEINGOLD) and the Senator from Hawaii (Mr. AKAKA) were added as cosponsors of S. 471, a bill to amend the Public Health Service Act to provide for human embryonic stem cell research.

S. 484. At the request of Mr. WARNER, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 484, a bill to amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pretax basis and to allow a deduction for TRICARE supplemental premiums.

By Mr. DODD, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 499, a bill to amend the Consumer Credit Protection Act to ban abusive credit practices, enhance consumer disclosures, protect underage consumers, and for other purposes.

S. 537. At the request of Mr. BINGAMAN, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 537, a bill to increase the number of well-trained mental health service professionals (including those based in schools) providing clinical mental health care to children and adolescents, and for other purposes.

S. 603. At the request of Ms. LANDRIEU, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 603, a bill to amend the Consumer Credit Protection Act to assure meaningful disclosures of the terms of rental-purchase agreements, including disclosures of all costs to consumers under such agreements, to provide certain substantive rights to consumers under such agreements, and for other purposes.

S. 635. At the request of Mr. SANTORUM, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 635, a bill to amend title XVIII of the Social Security Act to improve the benefits under the medicare program for beneficiaries with kidney disease, and for other purposes.

S. 662. At the request of Ms. COLLINS, the name of the Senator from New Mexico (Mr. BINGAMAN) was added as a cosponsor of S. 662, a bill to reform the postal laws of the United States.

S. 792. At the request of Mr. DORGAN, the name of the Senator from Massachusetts (Mr. KERRY) was added as a co-sponsor of S. 792, a bill to establish a National sex offender registration database, and for other purposes.

S. 881. At the request of Ms. CANTWELL, the name of the Senator from North Dakota (Mr. DORGAN) was added as a co-sponsor of S. 881, a bill to provide for equitable compensation to the Spokane Tribe of Indians of the Spokane Reservation for the use of tribal land for the production of hydropower by the Grand Coulee Dam, and for other purposes.

S.J. RES. 18

At the request of Mr. McCONNELL, the name of the Senator from Florida (Mr. MARTINEZ) was added as a co-sponsor of S.J. Res. 18, a joint resolution approving the renewal of import restrictions contained in the Burmese Freedom and Democracy Act of 2003.

At the request of Mrs. FEINSTEIN, the names of the Senator from New Jersey (Mr. CORZINE), the Senator from Maryland (Ms. MIKULSKI) from Wisconsin (Mr. KOHL) and the Senator from Wisconsin (Mr. FEINGOLD) were added as cosponsors of S.J. Res. 18, supra.

S. RES. 104

At the request of Mr. FEINGOLD, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. Res. 104, a resolution expressing the sense of the Senate encouraging the active engagement of Americans in world affairs and urging the Secretary of State to take the lead and coordinate with other governmental agencies and non-governmental organizations in creating an online database of international exchange programs and related opportunities.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. COLEMAN (for himself, Mr. SMITH, Ms. SNOWE, Mr. DAYTON, and Mr. HARKIN):
S. 1060. A bill to amend the Internal Revenue Code of 1986 to allow a credit against income tax for the purchase of hearing aids; to the Committee on Finance.

Mr. COLEMAN. Mr. President, today I am introducing legislation to help millions of Americans enjoy the gift of sound. I am pleased to be joined by Senators GORDON SMITH, OLYMPIA J. SNOWE, MARK DAYTON, and Tom HARKIN, who I know care as deeply about these issues as I do.

Hearing loss is one of the most common and widespread health problems affecting Americans today. In fact, thirty-three babies are born each day with hearing loss, making deafness the most common birth defect in America. According to the National Council on Aging, as many as 70 percent of our elderly experience hearing loss. All told, 31.5 million Americans currently suffer from some form of hearing loss.

The good news is that 95 percent of individuals with hearing loss can be successfully treated with hearing aids. Unfortunately, however, only 22 percent of Americans suffering from hearing loss can afford to use this technology. In other words, over 24 million Americans will live without sound because they cannot afford treatment.

That is why we are introducing the Hearing Aid Assistance Tax Credit Act. This legislation provides help to those who need it most, our children and seniors, by providing a tax credit of up to $500, once every 5 years, toward the purchase of any 'qualified hearing aid' as defined by the Federal Food, Drug, and Cosmetic Act.

Hearing aids are not just portals to sound, but portals to success in school, business, and life. That is why a number of diverse organizations, including the Hearing Industries Association, Self Help for Hard of Hearing People, the International Hearing Society, the American Speech-Language-Hearing Association, and the American Academy of Audiology support the Hearing Aid Assistance Tax Credit Act.

I ask unanimous consent that their letters of support be printed in the Record.

Hearing loss may be one of the most common health problems in the United States, but it doesn't have to be. We can tackle the problem head on with the Hearing Aid Assistance Tax Credit Act.

I look forward to working with my colleagues this Congress to approve this commonsense solution to a serious problem.

There being no objection, the materials were ordered to be printed in the Record, as follows:

**Diaper and Hard of Hearing Alliance: A Coalition of Consumer and Professional Organizations,**

May 18, 2005.

Hon. Norm Coleman, U.S. Senate, Washington, DC.

Dear Senator Coleman: We, the undersigned, representing both consumer and health professional organizations of the Deaf and Hard of Hearing Alliance (DHHA), write to express our strong support for the ‘Hearing Aid Assistance Tax Credit Act’ you are introducing today. While we support and encourage more comprehensive solutions, we believe your legislation can aid some who presently have no options but to pay out of pocket for hearing devices.

Enactment of your legislation will provide a tax credit of up to $500 per hearing aid, available once every five years, toward the purchase of hearing aids for individuals age 55 and over, or those purchasing a hearing aid for a dependent.

As you pointed out with the introduction of this bill, special tax treatment would improve access to hearing aids since only 22 percent of Americans who could benefit from hearing aids actually use them.

Approximately 1 million children under the age of 18 and nearly 10 million Americans over the age of 54 have a diagnosed hearing loss but are not currently using a hearing aid.

The expense of the hearing aid is an important factor why Americans with hearing loss go without these devices. Some 40 percent of individuals with hearing loss have incomes of less than $30,000 per year. Nearly 30 percent of those with hearing loss cite financial constraints as a core reason they do not use hearing aids. In 2002, the average cost for a hearing aid was over $1,400, and almost two-thirds of individuals with hearing loss require two devices, thereby increasing the average cost to over $2,800.

The new tax credit you propose will assist many who might otherwise do without and have limited options.

Hearing aids are presently not covered under Medicare, or under the vast majority of state mandated benefits. In fact, 71.4 percent of hearing aid purchases do not involve third party payments, placing the entire burden of the hearing aid purchase on the consumer.

The need is real. Hearing loss affects 2-3 infants per 1,000 births. For adults, hearing loss usually occurs more gradually, but increases dramatically with age. Ten million older Americans experience age-related hearing loss. For workers, noise induced hearing loss is the second most self-reported occupational injury. Ten million young adults and working aged Americans have noise-induced hearing loss.

Enactment of your bill will make a difference in the lives of some people with hearing loss. Currently, 1.28 million Americans of all ages purchase hearing aids each year, with many individuals requiring two devices, bringing the total number of hearing aids purchased across all age groups to approximately 2 million. This number has remained constant over recent years. While the legislation is not intended to cover the full cost of hearing aids, some measure of financial assistance to the groups who are in need of these devices but are unable to afford them.

Thank you for your leadership on this important issue. We look forward to working with you to seek enactment of your legislation during the 109th Congress.

Sincerely,

Alexander Graham Bell Association for the Deaf & Hard of Hearing (AGBell), American Academy of Audiology (AAA), American Speech-Language-Hearing Association (ASHA), Conference of Educational Administrators of Schools and Programs for the Deaf (CEASD), Cued Language Network of America (CLNA), Media Access Group at WGBH, National Association of the Deaf (NAD), National Court Reporters Association (NCRA), National Cued Speech Association (NCSA), Self Help for Hard of Hearing People (SHHH), Telecommunications for the Deaf, Inc. (TDI), TECHunit.


Hon. Norm Coleman, Hart Senate Office Building, Washington, DC.

Dear Senator Coleman: On behalf of the International Hearing Society (IHS), I write to enthusiastically endorse the Hearing Aid Assistance Tax Credit Act. IHS represents 118,000 audiologists, speech-language pathologists, and hearing, speech, and language specialists qualified to meet the needs of the estimated 49 million (or 1 in 6) children and adults in the United States with communication disorders, we thank you for introducing this important piece of legislation and look forward to working with you and your staff.

Sincerely,


Sincerely,

Harlan S. Cato, President.
Hon. NORM COLEMAN, 
U.S. Senate, Washington, DC.,

DEAR SENATOR COLEMAN: On behalf of the Hearing Industries Association (HTA) and the individuals with hearing loss served by our members, I want to thank you for introducing the Hearing Aid Assistance Tax Credit Act, and offer HTA’s strong endorsement and support for this worthwhile legislation.

The Hearing Industries Association (HTA) is dedicated to providing information about, promoting the use of, and enhancing access to amplification devices in the United States. These devices include, but are not limited to, worn hearing aids, implantable hearing aids (cochlear, middle ear and brain stem) and an array of assistive listening devices (both personal and communication-based) and items used in auditoriums, theaters, classrooms and public buildings. Our members work with the medical community and hearing aid professionals to treat hearing loss in children and adults, and we have seen firsthand the dramatic benefit that hearing aids can provide in terms of greater safety, increased mobility and access, and overall significantly enhanced quality of life.

For the 31.5 million Americans who have some degree of hearing loss, the vast majority (95%) of whom use hearing aids. Yet only 20% of those with hearing loss use hearing aids, while a full 30% cite financial constraints as the reason they do not use hearing devices. The greatest need is in the elderly, where almost one third of the individuals surveyed cite financial constraints. The benefits, in terms of reducing special education costs, as well as reduced special education costs for children, as well as reduced care costs associated with hearing loss in older adults, are immense.

Among the proponents of HIA and the individuals with hearing loss whom we serve, we applaud your leadership in introducing the Hearing Aid Assistance Tax Credit Act, and look forward to working with you to pass the bill in the 109th Congress.

Sincerely,
CAROLIE ROGIN,
Hearing Industries Association.

DEAR SENATOR COLEMAN: On behalf of Self Help for Hard of Hearing People, the nation’s largest consumer group for people with hearing loss, we would like to express our support of the Hearing Aid Assistance Tax Credit Act.

More than 28 million Americans at all stages of life have some form of hearing loss. When left untreated, hearing loss can severely reduce the quality of one’s personal and professional life. A landmark study conducted by the National Council on Aging (NCOA) concluded that hearing loss was associated with, among other things: depression, impaired memory, social isolation and reduced general health. For infants and children left untreated, the educational cost for special education and other programs can exceed $42,000, with additional lifetime costs of $1 million in lost wages and other health complications, according to a respected 1986 study published in the International Journal of Pediatric Otorhinolaryngology.

While fully 95 percent of individuals with hearing aid could be successfully treated with hearing aids, only 22 percent currently use them, according to the largest national consumer survey on hearing loss in America. Almost half of individuals surveyed report financial constraints as a core reason they do not use hearing aids, which is not surprising since hearing aids are not covered under Medicare. According to the National Academy of Sciences, individuals with hearing loss need access to hearing aids in order to maintain or improve quality of life.

This bipartisan initiative is endorsed by virtually the entire spectrum of organizations and institutions in the hearing health community. We view this legislation as an effective and responsible means to encourage individuals to treat their hearing so that they may reduce the quality of life that hearing loss can bring.

We are pleased to offer you our support.

Respectfully,
TERRY PORTIS, 
Executive Director, Self Help for Hard of Hearing People.

AMERICAN ACADEMY OF AUDIOLOGY,
Hon. NORM COLEMAN, 
U.S. Senate, Hart Senate Office Building, Washington, DC.

DEAR Senator Coleman: The American Academy of Audiology, the largest organization of audiologists representing over 9,700 audiologists, commends you on your leadership in hearing health care issues and championing policies that benefit individuals with hearing loss.

The Academy supports the Hearing Aid Assistance Tax Credit Act which would provide a tax credit of up to $500 per hearing aid, available once every five years, towards the purchase of a hearing aid(s) for individuals age 55 or older, or those purchasing a hearing aid for a dependent. As you have pointed out with the introduction of this bill, special tax treatment would improve access to hearing aids since only 22 percent of Americans who could benefit from hearing aids are currently using them. Approximately, 1 million children under the age of 18 and nearly 10 million Americans over the age of 54 have diagnosed hearing loss but are not currently using a hearing aid.

Hearing aids are presently not covered under Medicare, or under the vast majority of state mandated benefits. In fact, 71.4 percent of hearing aid purchases involve no third party payments, thereby placing the entire burden of the purchase on the consumer.

The Hearing Aid Assistance Tax Credit Act offers a practical, low cost, and common sense solution to help older individuals who may not otherwise be able to afford to purchase a hearing aid, or those purchasing a hearing aid for their child. The bill is not intended to cover the full cost of hearing aids, but would simply provide some measure of financial assistance to the populations who are most in need of these devices but may not be able to afford them, those approaching or in retirement, and families with children.

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We are pleased to offer you our support.

Respectfully,
Terry Points, 
Executive Director, Self Help for Hard of Hearing People.

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Hon. NORM COLEMAN, 
U.S. Senate, Hart Senate Office Building, Washington, DC.

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We are pleased to offer you our support.

Respectfully,
Terry Points, 
Executive Director, Self Help for Hard of Hearing People.

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Hon. NORM COLEMAN, 
U.S. Senate, Hart Senate Office Building, Washington, DC.

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This bipartisan initiative is endorsed by virtually the entire spectrum of organizations and institutions in the hearing health community. We view this legislation as an effective and responsible means to encourage individuals to treat their hearing so that they may reduce the quality of life that hearing loss can bring.

We are pleased to offer you our support.

Respectfully,
Terry Points, 
Executive Director, Self Help for Hard of Hearing People.
shall have the sole responsibility for the proper design, operation, and function of the 911 and E911 access capabilities offered to the provider’s customers.

(g) PROVIDER PARITY FOR PROVISION OR USE OF IP-ENABLED VOICE SERVICE.—

(1) PROVIDER PARITY.—If a provider of an IP-enabled voice service offers 911 or E911 services in compliance with the rules required by subsection (a), that provider, its officers, directors, employees, vendors, and agents, shall have immunity or other protection from liability that is not less than the scope and extent of immunity or other protection from liability that any local exchange company, and its officers, directors, employees, vendors, and agents, have under the applicable Federal and State law (whether through statute, judicial decision, tariffs filed by such local exchange company, or otherwise), including in connection with an act or omission involving the release of subscriber information related to the emergency calls or emergency services to a public safety answering point, emergency medical service provider, or emergency dispatch provider, public safety, fire service, or law enforcement official, or liability to a person using an IP-enabled voice service that is not provided through an IP-enabled voice service.

(2) USER PARITY.—A person using an IP-enabled voice service that offers 911 or E911 services pursuant to this subsection shall have immunity or other protection from liability of a scope and extent that is not less than the scope and extent of immunity or other protection from liability under applicable law in similar circumstances of a person using 911 or E911 service that is not provided through an IP-enabled voice service.

(h) DELEGATION PERMITTED.—The Commission may, in the regulations prescribed under this section, provide for the delegation of its authority to State or other appropriate government entities to implement and enforce the requirements of this section and the regulations thereunder.

SEC. 3. MIGRATION TO IP-ENABLED EMERGENCY NETWORK.

Section 158 of the National Telecommunications and Information Administration Organization Act (as added by section 104 of the ENHANCE 911 Act of 2004) is amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c) the following:

"(d) MIGRATION PLAN REQUIRED.—

(1) NATIONAL PLAN REQUIRED.—No more than 18 months after the date of the enactment of the ENHANCE 911 Act of 2004, the Office shall develop and report to Congress on a national plan for migrating to a national IP-enabled emergency network capable of receiving and responding to all citizen activated emergency communications.

(2) CONTENTS OF PLAN.—The plan required by paragraph (1) shall—

(A) outline the potential benefits of such a migration;

(B) identify barriers that must be overcome and funding mechanisms to address those barriers;

(C) include a proposed timetable, an outline of costs and potential savings;"
Mr. KENNEDY. Mr. President, the month of May is Stroke Awareness Month, and it is a privilege to join Senators COCHRAN, WARNER, CANTWELL, COLLINS, and DAYTON in introducing the Stroke Treatment and Ongoing Prevention Act of 2005. The STOP Stroke Act will help build a national network of effective care to diagnose and quickly treat victims of stroke and improve the quality of care for stroke patients across America. For over 20 years, stroke has been the third leading cause of death in our country, affecting about 700,000 Americans a year and killing approximately 163,000 a year. Every 45 seconds, another American suffers a stroke. Every 3 minutes, another American dies. Few families today are untouched by this cruel, debilitating, and often fatal disease that strikes indiscriminately, and robs us of our loved ones. Even for those who survive, a stroke can have devastating consequences. Over half of all stroke victims are left with a disability or even full recovery following a stroke. Prompt treatment with clot-dissolving drugs within three hours of a stroke can dramatically improve these outcomes. Yet, only 2-3 percent of all stroke patients are treated with such a drug within that crucial first three hours. Few Americans recognize the symptoms of stroke, and crucial hours are often lost before a patient receives treatment. Emergency room staffs are often not trained to recognize and manage the symptoms, which further adds to the delay in treatment. Patients at hospitals with primary stroke centers have nearly five times greater chance of receiving clot-dissolving drugs.

Modern medicine is generating new scientific advances that increase the chance of survival and at least partial or even full recovery following a stroke. Physicians are learning to manage strokes more effectively, and they are also learning how to prevent them in the first place. But science doesn’t save lives and protect health by itself. We need to do more to bring new discoveries to the patient and new awareness to the public. That means educating as many people as possible about the warning signs of stroke, so that they know enough to seek medical attention. It means training doctors and nurses in the best techniques of care. It means finding ways to treat victims quickly and as effectively as possible—so that they have the best chance of full recovery.

Our bill provides grants to States to implement statewide systems of stroke care that will give health professionals the equipment and training they need to treat this disorder. It also establishes a continuing education program to make sure that medical professionals are well trained and well aware of the newest treatments and prevention strategies. This bill also emphasizes the critical point of contact between a stroke patient and medical care is usually an emergency medical technician. Grants under this bill may be used to train these personnel to provide more effective care to stroke patients in the crucial first few moments after an attack.

The bill directs the Secretary of Health and Human Services to conduct a national media campaign to inform the public of the signs of stroke, the Stroke Treatment and Ongoing Prevention Act of 2005. The bill also authorizes the Secretary of HHS, acting through CDC, to operate the Paul Coverdell National Stroke Regis-

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try, which will collect data about the care of stroke patients and assist in the development of more effective treatments.

The bill also provides new resources for states to improve the standard of care for stroke patients in hospitals, and to increase the quality of care in rural hospitals through improvements in telemedicine.

On Monday, the Wall Street Journal published an article about the inadequate treatment that stroke patients often encounter when ambulances bring them to hospitals with staffs not trained in the early treat-

ment of stroke or lacking the needed equipment to intervene early. Over twenty years ago, the survival of trauma victims was very much dependent on whether the ambulance took them to a hospital with a trauma care center, or to a hospital not equipped to treat traumatic injury. Congress passed the Trauma Care System Planning and Development Act of 1990 that revolutionized the treatment for accident victims. Now in 2005, it is long past time to see that state of the art care is made available to stroke pa-

tients as quickly as possible.

Stroke is a national tragedy that leaves no American community unscarred. Fortunately, if the right steps are taken during the brief win-

dow of time available, effective treatment can make all the difference between life and disability or death. We need to do all we can to see that those precious few hours are not wasted. The STOP Stroke Act is a significant step in reaching that goal.

May is Stroke Awareness Month, and I urge Congress to act quickly on this legislation, and give stroke victims a far better chance for full recovery.

I ask unanimous consent that the full text of a Wall Street Journal artic-

cle of May 9 on this issue be printed in the RECORD. There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Wall Street Journal, May 9, 2005]

STROKE VICTIMS ARE OFTEN TAKEN TO WRONG HOSPITAL
(By Thomas Burton)

Christina Mei suffered a stroke just before noon on Sept. 2, 2001. Within eight minutes, an ambulance arrived. Her medical fate may have been sealed by where the ambulance took her.

Ms. Mei’s stroke, caused by a clot blocking blood flow to her brain, occurred while she was driving with her family south of San Francisco. Her car swerved, but she was able to pull over before slumping at the wheel. Paramedics saw the classic signs of a stroke: 45-year-old driver can’t speak or move the right side of her body.

Had Ms. Mei’s stroke occurred a few miles to the south, she probably would have been taken to the Stanford University Medical Center, one of the world’s top stroke hospitals. There, a neurologist almost certainly would have seen her quickly and administered an intravenous drug to dissolve the clot. Stanford was 17 miles away, across a county line. But paramedics, following county ambulance rules that stress proximity, took her 13 miles north, to Kaiser Permanente’s South San Francisco Medical Center. There, despite her sudden inability to talk or walk and her facial droop, an emergency-room doctor concluded she was suffering from depression and stress. It was six hours before a neurologist saw her, and she never got the intravenous clot-dissolving drug.

In a legal action brought against Kaiser on Ms. Mei’s behalf, an arbitrator found that her care had been negligent, and in some aspects, incomprehensible. Ms. Mei can’t dress herself and walks unsteadily, says her lawyer, Richard C. Bennett. The fi-
gers on her right hand are curled closed, and she had to give up activities like calligraphy, ceramics and other types of art. Kaiser declined to comment beyond saying that it settled the case under confidential terms that it settled the case under confidential terms.

There is no objection, the article was ordered to be printed in the RECORD.

Stroke is the nation’s No. 1 cause of disability and No. 3 cause of death, killing 164,000 people a year. But far too many stroke victims, like Ms. Mei, get inadequate care thanks to deficient medical training and outdated ambulance rules that don’t send stroke patients to the best stroke hospitals.

Over the past decade, American medicine has learned how to save stroke patients’ lives and keep them out of nursing homes. New techniques offer a better chance of complete recovery by dissolving blood clots and treating even more lethal strokes caused by burst blood vessels in the brain. But few patients receive this kind of treatment because most hospitals lack specialized staff and knowledge, stroke experts say. State and county ambulance rules generally limit how to take stroke patients to the nearest emergency room, regardless of that hospital’s level of expertise with stroke. That was the case patently clearly roughly where trauma care was a quarter-century ago. By 1975, surgeons expert at treating victims of car crashes and other major accidents realized that taking severely injured patients to the nearest emergency room could mean death. So the surgeons led a push to make selected regional hospitals into specialized trauma centers and to overhaul ambulance protocols so that paramedics would speed the most severely injured to those centers. Now, in many areas of the U.S., accident victims get sent to a trauma center. Experts say this change has saved lives and lessened disability.

Eighty percent or more of the 700,000 strokes that Americans suffer annually are “ischemic,” meaning they are caused by blockage of an artery feeding the brain, usually a blood clot. Most of the rest are “hemorrhagic” strokes, resulting from burst blood vessels in or near the brain. Although they have different causes, both result in brain tissue dying by the millions.

Several factors have combined to prevent improvement in stroke care. In some areas, hospitals have resisted movement toward a system of specialized care because nondonated institutions couldn’t lose business, according to neurologists who favor the
In full view of other holiday travelers, Ms. Shelton, then 66, slumped over, and an ambulance was called. It was 4:45 p.m. By 5:35 p.m., she arrived at what now is called Centinela Freeman Medical Center, four miles away in Marina del Rey. Hospital records show that doctors thought Ms. Shelton had suffered an “acute stroke” and recommended an initial step, until 9 p.m. By then, she was already outside the three-hour window for safely administering intravenous tPA. Records also show she didn’t receive the drug “due to unavailability of neurologist until after the patient had been outside the three-hour window.” Ms. Shelton’s daughter, Sandi Shaw, was until recently nurse-manager of the prestigious stroke unit at the University of Texas Health Science Center at Houston. Ms. Shaw says that at her unit, her mother would have had a CT scan within five minutes of arriving, and tPA probably would have been administered 30 or 35 minutes after that.

Today, according to her daughter, Ms. Shelton often can’t come up with words or relatives’ names, can’t take care of her finances, and must have certain basic commands in neurological tests.

Kent Shoji, an emergency-room doctor at Centinela Freeman who handled Ms. Shelton’s case, says, “She was a possible candidate for tPA.” But a CT scan was required first. “The order was put in for a CT scan,” Dr. Shoji says, “I can’t answer why it took so long.”

A Centinela Freeman spokeswoman says, “We did not have 24/7 coverage with our CT scan, and we had to call, a technician to come in. That’s pretty common with a community hospital.” The hospital has since been acquired by a larger health system and now does have the required 24/7 coverage.

**PAROXAL INTERESTS**

A hospital-accrediting group has begun designating hospitals as stroke centers, but that is only part of what is needed, stroke experts assert. They say hospitals typically have to come together to create local political momentum to change state or county rules to that ambiguous actually take stroke patients to stroke centers, not the nearest ER. New York, Maryland and Massachusetts are moving toward creating stroke-care systems, and Florida recently passed a law creating one. But in many places, short-term economic interests impede change, some doctors say.

“There are still very parochial interests by hospitals and neurologists to keep patients locally even if they’re not equipped to handle them,” says neurosurgeon Robert A. Solomon of New York Presbyterian Hospital/Weill Cornell. “Hospitals don’t want to give up patients.”

The University of California at San Diego runs one of the leading stroke hospitals in the country. It is in an area that is well prepared to treat stroke patients have sought for a decade to set up a regional system, but there has been little progress, says Patrick D. Lyden, UCSF’s chief of neurology. “Some hospitals are resisting losing stroke business,” he says. “We have the same political crap as in most communities. Paramedics still take people to the local ER.”

Among the opponents of the stroke-center concept during the 1990s was Richard Mansfield, former president of the Valley Hospital south of San Diego. In various public debates, Dr. Stennes recalls, he argued that many apparent stroke patients would be misdiagnosed as brain injuries or other artery blockage, cause symptoms such as muscle weakness or paralysis on one side, slurred speech, facial droop, severe dizziness, unsteady gait and vision loss. With this kind of stroke are sometimes mistaken for being drunk. In addition to intense head changes, in addition, stroke treatment has lacked an organized lobby to galvanize popular and political interest in the ailment.

**DOCTOR IGNORANCE**

A big reason for the backwardness of much stroke treatment, many doctors say, is how little about it. Even emergency physicians and interns likely to see stroke victims tend to receive scant neurology training in their internships and residencies according to stroke specialists.

“Surprisingly, you could go through your entire internal medicine rotation without training on strokes, and in emergency medicine it hasn’t been emphasized,” says James C. Grotta, director of the stroke program at the University of Texas Health Science Center at Houston.

Many hospitals don’t have a neurologist ready to deal with emergencies. As a result, strokes aren’t treated urgently there, even though short delays increase chance of severe disability or death. Even if doctors do react quickly, recent research has shown that many aren’t sure what treatment to provide.

For example, a survey published in 2000 in the journal Stroke showed that 66 percent of hospitals in New York State in the 1990s showed that patients with ruptured blood vessels in the brain were more than twice as likely to die—16% versus 7%—in hospitals doing few such procedures compared with those doing them regularly. A national study published last year in the Journal of Neurosurgery showed a similar disparity.

A major economic of most stroke treatment, according to many neurologists, is the failure to use the genetically engineered clot-dissolving drug known as tPA. Short for tissue plasminogen activator, tPA, which is made by Genentech Inc., has been shown to be a powerful treatment that can dissolve a clot that has led to a stroke within the first 90 minutes after suffering a stroke, according to many neurologists, and internists likely to see stroke victims now do these procedures, compared with those doing them regularly. A national study published last year in the Journal of Neurosurgery showed a similar disparity.

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pain, a hemorrhagic stroke often leads to nausea, vomiting or loss of balance or consciousness. Still, many people with some of these symptoms merely go to bed in hopes of improving, or doctors say, instead, they should go immediately to a hospital and demand a CT scan as a first diagnostic step.

The well-funded American Heart Association, established in 1924, has made many people aware of heart attack symptoms and thereby saved many lives. In contrast, the American Association for the Study of Bleeding has started only in 1998 as a subsidiary of the heart association. The stroke association spent $126 million last year out of the heart association’s $1 billion.

Justin Zevin, another University of California at San Diego stroke expert, says the stroke association “is a terribly ineffective bunch. When it comes to actual public education, I haven’t seen anything.”

The stroke association counters that it is buying television and radio ads promoting awareness, similar to ones produced in 2003 and 2004. The group also sponsors research and education, including an annual national stroke-medicine conference.

It’s a rival public that fails to recognize stroke symptoms. Often, emergency-room doctors and nurses don’t either. Greg Donnelly, a suburban Detroit began suffering headaches last May, for the first time in her life. “She wasn’t one to complain, but she said, ‘I can’t even lift my head off the pillow,’” recalls her daughter. Erika Mazer, Ms. Thiele, 57, nearly passed out from the pain one night and suffered blurred vision. When the pain recurred in the morning, she went to the emergency room at nearby St. Joseph’s Mercy of Macomb Hospital. Ms. Mazer says that during the six hours her mother spent there, she was given a CT scan with the wrong label, which could potentially have shown she had a leaking brain aneurysm, meaning a ballooned and weakened artery in her brain. After the CT, Ms. Thiele was given a muscle relaxant and pain medicine and sent home, her daughter says.

Two months later, the blood vessel burst. Neurosurgeons at William Beaumont Hospital in Royal Oak, Mich., did emergency surgery, but Ms. Thiele suffered massive bleeding and died. All Bydon, one of the neurosurgeons who operated on Ms. Thiele, says the procedure often is inadequate and that her condition could have been detected earlier with a spinal tap, also called a lumbar puncture. “Had she had a puncture and a spinal tap earlier, it might have saved her life,” says Dr. Bydon. “In general, a person who tells you, ‘I usually don’t get headaches, and this is the worst headache of my life,’ is something that should alarm you.”

In addition, he says Ms. Thiele “absolutely” was experiencing smaller-scale bleeding in a small blood vessel that could have led to a more serious rupture. If doctors identify this kind of bleeding early, he says, chances of death are minimal. But when a rupture occurs, he says, “it’s either just make it to the hospital, 25% die in the hospital and 25% are severely disabled.”

A St. Joseph’s hospital spokeswoman says the hospital has “very aggressive standards for treatment, and we met this standard.”

DETERMINED NURSE

Paramedics did the right thing after Chuck Toeniskoetter, 55, was on a ski trip, Dec. 23, 2000, at Bear Valley, near Los Angeles. He skied a run at 3:30 p.m. when, in the snowmobile shop, he began slurring his words and nearly fell over. Kathy Snyder, the nurse in the ski area’s first-aid room quickly diagnosed stroke. She called a helicopter and an ambulance.

Ms. Snyder says she knew the closest hospital was 35 miles away in Roseville Medical Center in Roseville, CA. The helicopter pilot was planning to take Mr. Toeniskoetter to a closer ER, but Ms. Snyder says he needed to see the right person, demanding the patient go to Sutter. The pilot eventually relented. Mr. Toeniskoetter went to Sutter, where he promptly received tPA. Toda pilot was planning to run a real estate-development business in the San Jose area. “Trauma patients go to trauma centers, not the nearest hospital,” he says, “so we don’t even need a real specialized sort of care.”

One-third of all strokes are suffered by people under 60, and hemorrhagic strokes in particular often strike young adults and children. Vance Bowers of Orlando, Fla., was 9 when he woke up screaming that his eyes hurt, shortly after 1 a.m. on Jan. 8, 2001. Malformed blood vessels in his brain were bleeding. He was in a coma by the time an ambulance delivered him at 1:57 a.m. to the nearest emergency room, at Florida Hospital East Orlando.

Emergency-room doctors soon realized Vance had a hemorrhagic stroke. But neurosurgeons say surgery isn’t performed at that hospital. A sister hospital, 14 minutes away by ambulance, Florida Hospital Orlando, did have neurosurgical capability. But in part because of administrative tangles, Vance didn’t get to the second hospital until 4:37 a.m., more than two hours after his arrival. Surgery began at 6:18 a.m. “This delay may have cost this young man the possibility of a functional survival,” says Paul D. Sawin, the neurosurgeon who operated on Vance, said in a letter to the hospital’s joint administration.

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Vance’s stroke, not the care he received, caused his injuries, she said. Vance, now 13, survived but is mentally handicapped. His mother, Brenda Bowers, says. Once a star baseball player, he goes by wheelchair to a class for disabled children. He speaks very slowly and has trouble explaining. Many people can understand. “He remembers playing baseball with all of his friends,” his mother says but they rarely come around any more. “He really misses all that.”

By Mr. VOINOVICH (for himself and Mrs. CLINTON):

S. 1066. A bill to amend title 10, United States Code, to extend child care eligibility for children of members of the Armed Forces who die in the line of duty to the Committee on Armed Services.

Mr. THUNE. Mr. President, today I rise to introduce legislation to extend child care eligibility for children of members of the Armed Forces who die in the line of duty. I am determined to provide as much help as possible to those who have borne the burden of loss, particularly those with young children. By providing two years of child care eligibility, our goal is to ensure that a surviving spouse has the time and tools necessary to make a healthy adjustment to life after her husband’s death. Many decisions face survivors, most importantly, how to make a living. Often that means having to re-enter the work force after years of being a working mother. The question of how to adequately care for young children while trying to find employment or restart a career should not be an issue. Further, we have expanded this eligibility to include access to child care centers in other Federal facilities. This will aide surviving spouses with children when they are in the process of relocating to an area of the county without a military base nearby, but in the proximity of a local Federal building. I am honored that Senator CLINTON is working with me on this legislation and I encourage my colleagues to support this important measure.

S. 1066. A bill to authorize the States (and subdivisions thereof), the District of Columbia, territories, and possessions of the United States to provide certain tax incentives to any person for economic development purposes; to the Committee on Finance.

Mr. VOINOVICH. Mr. President, I rise to introduce legislation to authorize the Economic Development Act of 2005 to authorize States to provide tax incentives for economic development purposes.

This legislation is crucial to preserving tax incentives as an important tool for State and local governments to promote economic development in the wake of last year’s decision by the Sixth Circuit Court of Appeals in Cuno v. DaimlerChrysler.

In its decision in Cuno, the Sixth Circuit struck down Ohio’s manufacturing machinery and equipment tax credit, which I helped enact while I was Governor of Ohio, on grounds that it violated the “dormant” Commerce Clause of the U.S. Constitution. The court ruled that the tax incentive violated the Commerce Clause of the U.S. Constitution because it granted preferential tax treatment to companies that invest within the State rather than in other States.

The Cuno decision had severe repercussion across the country. The decision immediately cast doubt on the constitutionality of tax incentives presently offered by all fifty States. As
a result, States and businesses have been reluctant to go forward with new projects that depend on the availability of tax incentives out of concern that the Cuno decision may be used to invalidate those incentives. This legal uncertainty has hindered and continues to challenge the economic environment. Furthermore, the decision threatens to undermine federalism by dramatically restricting the ability of States to craft their tax codes to promote economic development in the manner they determine is best. If left standing, this decision will handcuff the States in the Sixth Circuit, as well as States in other circuits where the court chooses to follow Cuno, in their efforts to promote economic growth and create jobs. Additionally, it will cripple their ability to compete internationally. In today’s competitive economic environment, we cannot afford to unilaterally discard the use of tax incentive to attract business to this country. As a former Governor who had to compete against Japan, Canada, China and Europe for new business projects, I know the important role tax incentives can play in attracting new businesses. I can assure you that our competitors have not stopped using tax incentives. Neither should we.

Fortunately, the U.S. Constitution gives Congress the power to determine which State actions violate the Commerce Clause. The Economic Development Act of 2005 is designed to have Congress override the decision in Cuno by authorizing States to provide tax incentives for economic development purposes. The legislation would remove the legal uncertainty surrounding tax incentives created by the Cuno decision and preserve the States’ power to design their tax codes to promote economic development.

The history of the tax incentive system demonstrates the important role tax incentives can play in promoting economic development. When I was Governor of Ohio, at my request and as part of my jobs incentive package, the Ohio Legislature enacted the industrial development machinery and equipment tax incentive to encourage businesses to expand their operations in Ohio and to help draw new businesses to Ohio. It worked. Between 1993 and 1997, Ohio was ranked number one in the nation for industrial development. The Success of the jobs incentives was critical to our success in making the often complex policy decisions regarding whether a tax incentive truly discriminates against interstate commerce and hinders the creation of a national market, or whether a tax incentive encourages innovation and job growth. Such decisions necessarily involve a careful weighing of competing and often mutually exclusive interests, and therefore should be made by Congress. Moreover, judicial decisions often fail to provide bright lines on which incentives run afoul of the dormant Commerce Clause, injecting uncertainty about the validity of certain tax incentives that makes businesses weary of relying on them and reduce their effectiveness. Indeed, the Supreme Court itself has called its dormant Commerce Clause jurisprudence a “quagmire.” Hence, it is time that Congress provide some clear rules on the treatment of tax incentives under the Commerce Clause.

As Supreme Court Justice Felix Frankfurter stated nearly a half-century ago:

At best, this Court can only act negatively; it can determine whether a specific enactment is imposed in violation of the Commerce Clause. Such decisions must necessarily depend on the application of rough and ready legal concepts. We cannot make a detailed inquiry into the standards for dividing up national revenue on the basis of more or less abstract principles of constitutional law, which cannot be responsive to the necessities of the interrelated economies of Nation and State. The problem calls for solution by devising a congressional policy. Congress alone can perform for a full and searching of the multitudinous and intricate factors which compose the problem of the taxing
freedom of the States and the needed limits on such state taxing power. Congressional committees can make studies and give the claims of the individual States adequate hearing before the ultimate legislative formulation of policy is made by the representatives of all the States. . . . Congress alone can formulate policies founded upon economic development.

The Economic Development Act of 2005 is a good first step toward providing the prudent and carefully considered legislation that Justice Frankfurter urged the Congress to pass nearly a half-century ago. The National Conference of Mayors, the National Conference of State Legislatures, the National Governors Association, the National Federation of Tax Administrators, the Teamsters, and many important projects have been put on hold as we await the court’s further action. The bill has also been endorsed by Governor Bob Taft of Ohio, the National Governors Association, and the National Conference of State Legislatures, acting on behalf of their citizens, make choices and set priorities. This has allowed government policy to reflect the diversity of interests in our great republic and results in better and more responsive government. Allowing states to choose to use tax incentives to promote economic development, then that is not a violation of the interstate commerce clause, that’s simply their choice. It is called federalism, and it should not be thwarted by the courts.

There are a couple of points about this legislation that I would like to discuss. First, this legislation is carefully crafted to protect the most common and benign forms of tax incentives, but not to authorize those tax incentives that truly discriminate against interstate commerce. I believe this bill strikes the right balance between protecting States’ tax rights and preserving long-established protections against truly discriminatory State tax practices. Second, this legislation does not invalidate any tax incentives. It only authorizes tax incentives. Any tax incentive not covered by the legislation’s authorization is simply subject to the traditional dormant Commerce Clause review by the courts. Third, the legislation does not require any state to provide tax incentives. Although I had success using tax incentives to foster economic growth in Ohio while I was Governor, I recognize that some states have concerns about whether a state government can say no to such tax incentives and therefore believe it should be left to the states to resolve these concerns.

I am pleased that this legislation is being co-sponsored by all of the Senators representing States in the Sixth Circuit. We all realize that the right of states to make their own decisions about the programs and services they offer within their boundaries is their own and should not be taken away. Moreover, if the Supreme Court fails to review the Cuno decision, then our States, the States in the Sixth Circuit, will be at a competitive disadvantage in attracting businesses against other states which are not affected by the Cuno decision and can offer tax incentives.

The bill has also been endorsed by Governor Bob Taft of Ohio, the National Governors Association, the National League of Cities, the National Conference of Mayors, and the Federation of Tax Administrators, as well as by broad-based business coalitions and the Teamsters.

I am hopeful that the seriousness of this issue, and the severity of the ruling’s possible ramifications, will allow us to see quick and positive consideration of my bill. The States are in a crisis mode because of this ruling. In Ohio, as I’m sure is the case across the country, many important projects have been put on hold as we await the court’s further action.

The challenges that manufacturers and workers face today are daunting but surmountable. The last thing we need is an artificial hurdle that threatens to trip us up. I urge my colleagues to support the Economic Development Act of 2005 so that we can preserve the ability of the States to foster economic development and help put our economy, and especially our manufacturing industries, back on the road to recovery and prosperity.

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. 1066

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 “Economic Development Act of 2005”.

SEC. 2. AUTHORIZATION.

Congress hereby exercises its power under Article I, Section 8, Clause 3 of the United States Constitution to regulate commerce among the several States by authorizing any State to provide to any person for economic development purposes tax incentives that otherwise would be the cause or source of discrimination against interstate commerce under the Commerce Clause of the United States Constitution, except as otherwise provided by law.

SEC. 3. LIMITATIONS.

(a) TAX INCENTIVES NOT SUBJECT TO PROTECTION UNDER THIS ACT.—Section 2 shall not apply to any State tax incentive which—

(1) is dependent upon State or country of incorporation, commercial domicile, or residence of an individual;

(2) requires the recipient of the tax incentive to agree to one taxable presence, such as占有, license, use, or property services to property produced, manufactured, generated, assembled, developed, fabricated, or created in the State;

(3) is reduced or eliminated as a direct result of an increase in out-of-State activity by the recipient of the tax incentive;

(4) is reduced or eliminated as a result of an increase in out-of-State activity by a person other than the recipient of the tax incentive or as a result of such other person not having a taxable presence in the State;

(5) results in loss of a compensating tax system, because the tax on interstate commerce exceeds the tax on intrastate commerce prescribed in this section.

(b) NO INFRINGEMENT.—Nothing in this section shall be construed to create any inference with respect to the validity or invalidity of any commerce clause of the United States Constitution of any tax incentive described in this section.

SEC. 4. DEFINITIONS; RULE OF CONSTRUCTION.

(a) DEFINITIONS.—For purposes of this Act—

(1) COMPENSATING TAX SYSTEM.—The term “compensating tax system” means compensatory taxes imposed in both interstate and intrastate commerce where the tax on interstate commerce does not exceed the tax on intrastate commerce where taxes are imposed on substantially equivalent events.

(2) ECONOMIC DEVELOPMENT PURPOSES.—The term “economic development purposes” means all legally permissible for attracting, retaining, or expanding business activity, jobs, or investment in a State.

(3) IMPOSED ON APPORTIONED INTERSTATE ACTIVITIES.—The term “imposed on appor tioned interstate activities” means, with respect to a tax, a tax levied on values that can arise out of interstate or foreign transactions or operations, including income, sales, use, gross receipts, net worth, and value added taxable bases. Such term shall not include taxes levied on property, transactions, or operations that are taxable only if they exist or occur exclusively inside the State, including any real property and severance taxes.

(b) RULE OF CONSTRUCTION.—It is the sense of Congress that the authorization provided in section 2 should be construed broadly and the limitations in section 3 should be construed narrowly.

SEC. 5. SEVERABILITY.

If any provision of this Act or the application of any provision of this Act to any person, committee, or governmental entity is held unconstitutional, the remainder of this Act and the application of the provisions of this Act to any
By Mr. HARKIN:

S. 1074. A bill to improve the health of Americans and reduce health care costs by reorienting the Nation’s health care system toward prevention, wellness, and self care; to the Committee on Finance.

Mr. HARKIN. Mr. President, for more than a decade, I have spoken out about the need to fundamentally reorient our approach to health care in America—reorient it towards prevention, wellness and self care.

I don’t think you’ll find too many people who would argue with the statement that if you get sick, the best place in the world to get the care you need is here in America. We have the best trained, highest-skilled health professionals in the world. We have cutting-edge, state-of-the-art equipment and technology. We have world-class health care facilities and research institutions.

But, when it comes to helping people stay healthy and stay out of the hospital, we fall woefully short. In the United States, we fail to make an up-front investment in prevention. If you get sick, the best care in the world can’t make up for lost time.

Consider the cost of major chronic diseases—diseases that, as I said, are so preventable. In 2002, 46 million American adults regularly smoked cigarettes—that 26 percent of our population. Nearly 40 percent of college-aged students smoke. That means it’s that after decades of education and efforts to stop tobacco use, more than one in every four Americans is still addicted to nicotine and smoking.

Mental health is another enormous challenge that we are grossly neglecting. Mental health and chronic disease are intertwined. One will not affect another. It is about time we stop separating the mind and body when discussing health. Prevention and mental health promotion programs should be integrated into our schools, workplaces, and along with physical health screenings and education.

As of the outset of the 21st century, it’s time to move beyond the lingering shame and stigma that often attend mental health.

Seventy percent of all deaths in the United States are linked to chronic conditions such as heart disease, cancer, and diabetes. In so many cases, these chronic diseases are caused by poor nutrition, physical inactivity, tobacco use, and untreated mental illness. This is unacceptable.

After many months of meetings and discussions with Iowans and experts across the nation, today I am introducing comprehensive legislation designed to transform America’s “sick care” system into a true health care system—one that emphasizes prevention and health promotion.

I am calling this bill the HeLP America Act, with HeLP as an acronym for Healthy Lifestyles and Prevention. The aim is to give individuals and communities the information and tools they need to take charge of their own health.

Because we are serious about getting control of health-care costs and health insurance, then we must give people access to preventive care . . . and we must give people the tools they need to stay healthy and stay out of the hospital.

This will take a sustained commitment from government, schools, communities, employers, health officials, and the tobacco and food industries.

But a sustained effort can have a huge payoff—for individuals and families, for employers, for society, for government budgets, and for the economy at large.

As I said, the HeLP America Act is comprehensive legislation. It is a very complex, multifaceted bill. But, this afternoon, I’d just like to outline the bill’s major elements:

The first component addresses healthy kids and schools. Prevention and the development of a healthy habit and lifestyle begin in the early years, with our children. Unfortunately, today, we are heading in exactly the wrong direction. More and more children across America are suffering from poor nutrition, physical inactivity, mental health issues, and tobacco use.

For example, just since the 1980s, the rates of obesity have doubled in children and tripled in teens. Even more alarming is the fact that a growing number of children are experiencing what used to be thought of primarily as adult health problems. Almost two-thirds—60 percent—of overweight children have at least one cardiovascular disease risk factor. Recent studies of children have shown that increasing waist measurements come from fast food, and poor eating habits have contributed to the rise in blood pressure, higher cholesterol levels, and a shockingly rapid increase in adult-onset diabetes.

The HeLP America Act will not only double funding for the successful PEP program, which promotes health and physical education programs in our public schools, I find it disturbing that more than one in three of America’s children do not regularly engage in adequate physical activity. This is a shame, because studies show that regular physical activity boosts self-esteem and improves health.

The HeLP America Act will also expand the Harkin Fruit and Vegetable Program to provide more fresh fruits and vegetables in more public schools. The bill will also encourage schools to incentivize the creation of healthier environments, including goals for nutrition education and physical activity.

The HeLP America Act would also establish a grant program to provide mental health screenings and prevention programs in schools, along with training for school staff to help them recognize children exhibiting early warning signs. It will improve access to mental health services for students and their families.

New to the HeLP Act this year is a strong focus on breastfeeding promotion. Sound nutrition begins the moment a baby is born and there is a vast body of scientific evidence that shows beyond a shadow of a doubt that mom’s milk is the ideal form of nutrition to promote child health. But in the U.S. we don’t do enough to encourage breastfeeding. The HeLP America Act seeks to remove some of those barriers and to encourage new mothers to breastfeed.

The second broad component of the HeLP America Act addresses Healthy Communities and Workplaces. For example, the bill aims to create a healthier workforce by providing tax
credits to businesses that offer wellness programs and health club memberships. Studies show that, on average, every $1.00 that is invested in wellness workplace returns $3.00 in savings on health costs, absences from work and so on.

At a field hearing in Iowa last year, I heard from Mr. Lynn Olson, CEO of Ottumwa Regional Health Center. The Center offers a comprehensive wellness program for its employees, including reduced health insurance premiums for those employees who meet individual health goals. The Center has seen tremendous increase in the return on their investment in health promotion.

My bill also creates a grant program for communities, encouraging them to develop localized plans to promote health. These plans will make a big difference to people with disabilities, who often are forced to travel in the street alongside cars because there are no sidewalks or bike lanes available for wheelchair users. And bike lanes are available for only about 5 percent of bike trips.

As my colleagues know, I have been a longstanding advocate for the rights of people with disabilities. So I have given priority attention to health-promotion programs and activities that include this population. I just mentioned the bill’s incentives to create bike lanes and sidewalks on newly constructed roads. This will make a big difference to people with disabilities, who often are forced to travel in the street alongside cars because there are no sidewalks or bike lanes available for wheelchair users.

The Centers for Disease Control has funded a program called Living Well with a Disability, which has actually decreased secondary conditions and led to improved health for participants. The program is an eight-session workshop that teaches individuals with disabilities how to change their nutrition and level of physical activity. The program not only increases healthy activity, but it also reduces the number of secondary conditions that people with disabilities, but has also led to a 10 percent decline in the cost for medical services, particularly emergency-room care and hospital stays.

In addition, my bill includes a Works Program with a Disability program, which will build partnerships between employers and local vocational rehabilitation offices with the aim of developing wellness programs in the workplace.

Mr. President, the third component of the HeLP America Act addresses Responsible Marketing and Consumer Awareness. Having accurate, readily available information about the nutritional value of the foods we eat is the first step toward improving overall nutrition. Unfortunately, because of all the gimmicks and hype that marketers use to entice us to buy their products, determining the nutritional value of the foods we buy can be problematic—especially in restaurants. This is why the HeLP America Act proposes to extend the nutritional labeling requirements of the National Labeling and Education Act, which currently covers only a small percentage of food—primarily the vast majority of retail foods, to restaurants foods as well, which were exempted from the NLEA when it first passed.

You may have heard a marketing of junk food—is out of control. It was estimated that junk food marketers, alone, spent $15 billion in 2002 promoting their fare. And, I don’t have to tell you how much money is being spent on things like broccoli and apples. No, the majority of these ads are for candy and fast food—foods that are high in sugar, salt, fat, and calories.

Children—especially those under 8 years of age—do not always have the ability to distinguish fact from fiction. The number of TV ads that kids see over the course of their childhood has doubled from 20,000 to 40,000. The sad thing is that, way back in the 1970s, the Federal Trade Commission recommended banning TV advertising to kids. And what was Congress’ response? It created an advisory council for the FTC to regulate advertising for children than it is to regulate advertising for adults. My bill will restore the authority of the FTC to regulate marketing to kids, and it encourages the FTC to do so.

The fourth component of the HeLP America Act addresses Reimbursement of Defense Departments. Right now, our medical system is setup to pay doctors to perform a $20,000 gastric bypass instead of offering advice on how to avoid such risky procedures. The bill will reimburse and reward physicians for practicing prevention and screenings. It will also expand Medicaid coverage for counseling for nutrition and physical activity, mental health and smoking cessation programs. It also would establish a demonstration project in the Medicare program, long overdue in my opinion, under which we can learn how best to use tax health care dollars to prevent chronic disease, rather than just manage them once they’ve occurred. Frankly, it’s a little embarrassing that we haven’t done this before.

Finally, let me point out that the HeLP America Act will be paid for by creating a new National Health Promotion Trust Fund paid for through penalties on companies that fail to cut smoking rates among children, by ending the taxpayer subsidy of tobacco advertising, and also by reinstating the top income tax rates for wealthy Americans.

It’s time for the Senate to lead America in a new direction. We need a new health care paradigm—a prevention paradigm. Some will argue that avoiding obesity and preventable disease is a matter of personal responsibility. Well, we all agree that individuals should act responsibly. I’m all for personal responsibility. But I also believe in government responsibility. Government has a responsibility to ensure that people have the information and tools and incentives they need to take charge of their health. And that is what the HeLP America Act is all about.

Of course, this description of my bill just scratches the surface. The HeLP America Act is comprehensive. It is ambitious. And I fully expect an uphill fight in some quarters of Congress.

But just as with the Americans with Disabilities Act 14 years ago, I am committed to doing whatever it takes—and for as long as it takes—to pass this critically needed legislation.

It’s time to heed the Golden Rule of Holes, which says: When you are in a hole, stop digging. Well, we have dug one whopper of a hole by failing to emphasize prevention and wellness. And it’s time to stop digging.

By Mr. THUNE (for himself, Ms. SNOWE, Mr. BINGAMAN, Ms. COLLINS, Mr. DOMENICI, Mr. GREGG, Mr. JOHNSON, Mr. LOTT, Ms. MURKOWSKI, Mr. STEVENS, and Mr. SUNUNU): S. 1075. A bill to postpone the 2005 round of defense base closure and realignment; to the Committee on Armed Services.

Mr. THUNE, Mr. President, I rise today to introduce a bill that would delay the implementation of the 2005 round of the Defense Base Closure and Realignment report issued by the Department of Defense on May 13, 2005. The bill would postpone the execution of any decisions recommended in the report until certain anticipated events, having potentially large or unforeseen implications for our military force structure, have occurred, and both the department and Congress have had a chance to fully study the effects such events will have on our base requirements.

The bill identifies three principal actions that must occur before implementation of BRAC 2005. First, there must be a complete analysis and consideration of the recommendations of the commission on overseas military structures. The overseas base commission has itself called upon the Department of Defense to “slow down and take a breath” before moving forward on basing decisions without knowing exactly where units will be returned and if those installations are prepared or equipped to support units that will return from garrisons in Europe, consisting of approximately 70,000 personnel.

Second, BRAC should not occur while this country is engaged in a major war and rotational deployments are still ongoing. We have seen enough disruption of both military and civilian institutions due to the logistical strain brought about by these constant rotations of units and personnel to Iraq and Afghanistan without, at the same time, initiating numerous base closures and the multiple transfer of units and missions from base to base. This is simply too much to ask of our military, our communities and the families of our
service men and women, already stretched and over-taxed. And frankly, our efforts right now must be devoted to winning the global war on terrorism, not packing up and moving units around the country.

Our bill would delay implementation of the BRAC recommendations without having the benefit of either the Commission or Congress studying the Quadrennial Defense Review, due in 2006, and its long-term planning recommendations seems counter-intuitive and completely out of logical sequence. Therefore, the bill requires that Congress receive the QDR and have an opportunity to study its planning recommendations as one of the conditions before implementing BRAC 2005.

Fourth and Fifth: BRAC should not go forward until the implementation and development by the Secretaries of Defense and Homeland Security of the National Maritime Security Strategy; and the completion and implementation of Secretary of Defense’s Homeland Defense and Civil Support Directive—only now being drafted. These two planning strategies should be key considerations before beginning any BRAC process.

Finally, once all these conditions have been met, the Secretary of Defense must submit to Congress, not later than one year after the occurrence of the last of these conditions, a report that assesses the relevant factors and recommendations identified by the Commission on Review of Overseas Military Facility Structure of the United States; the return from deployment in the Iraq theater substantially all (as determined by the Secretary of Defense) major combat units and assets of the Armed Forces; the receipt by the Committees on Armed Services of the Senate and the House of Representatives of the report on the quadrennial defense review required to be submitted in 2006 by the Secretary of Defense under section 118(d) of title 10, United States Code; the complete development and implementation by the Secretary of Defense and the Secretary of Homeland Security of the National Maritime Security Strategy; the complete development and implementation by the Secretary of Defense of the Homeland Defense and Civil Support directive.

This proposed delay only seems logical and fair. There is no need to rush into decisions, that in a few years from now, could turn out to be colossal mistakes. We can’t afford to go back and rebuild installations or relocate high-cost support infrastructure at various points in this country once those installations have been closed or stripped of their valuable capacity to support critical missions. I, therefore, introduce this legislation today and call upon my colleagues to join us in supporting its passage.

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 1075

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

SECTION 1. REQUIREMENT OF 2005 ROUND OF DEFENSE BASE CLOSURE AND REALIGNMENT.

(a) POSTPONEMENT.—Effective May 13, 2005, the Defense Base Closure and Realignment Act of 1990 (part A of title XXIX of Public Law 101-182, 10 U.S.C. 2687 note) is amended by adding at the end the following:

"(2) The receipt by the Committees on Armed Services of the Senate and the House of Representatives of the report on the quadrennial defense review required to be submitted in 2006 by the Secretary of Defense under section 118(d) of title 10, United States Code;" (b) ACTIONS REQUIRED BEFORE BASE CLOSURE ROUND.—(i) The actions referenced in subsection (a) are required to be submitted before the end of fiscal year 2007; and (ii) the Secretary of Defense shall post a notice in the Federal Register (A) within 30 days after the enactment of this Act; and (B) in each subsequent year that the Secretary of Defense determines has not met the condition established by section 202(c) of the Department of Defense Appropriations Act, 2006, as amended by section 1052 of the fiscal year 2006 supplemental.