have lobbyists pay for Members to be there with our spouses and with our families—and, by the way, playing golf and tennis at the same time—is inappropriate.

We ought to be letting go of this. I do not understand why Senators, regardless of their party, do not understand that if we want people to believe in the political process, and we do not want to see bashing of public service, we all believe in public service, we ought to let go of this.

This Dole-McConnell initiative, again, has a huge loophole. Likewise, Senators can set up legal defense funds and lobbyists can make contributions to those defense funds. That was prohibited in the original bill that we passed. Likewise, Senators can ask lobbyists to make contributions to different foundations. That was prohibited. Likewise, Senators can set up contributions and have lobbyists contribute money.

Mr. President, this is not reform. This is not a step forward. This is a step backward. This is an attempt to make an end run around reform. I just want people in the country to know about it. I do not understand what happened between last year and this year.

Last year, before the November election, the Senate voted 95–4 for the gift ban legislation, virtually identical to S. 101. Mr. President, 85 of those who voted for the measure have returned to the Senate. Three new Senators voted for a similar gift ban in the House. Now we see this effort to essentially eviscerate—if that is the right word—reform through this, through this measure to be introduced as a substitute by Senator MCCONNELL and Senator DOLE which, quite frankly, is unconscionable. It passes no credibility test.

Mr. President, last October 5, the majority leader said, ''I support gift ban provisions. No lobbyist lunches, no entertainment, no travel, no contributions to legal defense funds, no fruit baskets, no nothing.''

What has happened? Mr. President, I just come to the floor because I want people in the country to know about this. The debate starts Monday. I think, given this substitute that I gather is going to be laid out sometime on the floor—no question but it will—there is going to be, I think, really a historic, very intense debate, because 99.9999 percent of the people want comprehensive gift ban reform. That is what I think many are determined to make happen.

I yield the floor.

Mrs. KASSEBAUM. Mr. President, in response to the Senator from Minnesota, I say I am sure there will be a thorough debate once the facts of the legislation are down and before the Senate. I think we all share some similar goals.

RYAN WHITE CARE REAUTHORIZATION ACT

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of S. 641, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 641) to reauthorize the Ryan White CARE Act of 1990, and for other purposes.

The Senate proceeded to consider the bill.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, I rise today to offer to the Senate for its consideration S. 641, the Ryan White CARE Reauthorization Act. This bipartisan legislation, which cleared the Labor and Human Resources Committee on a voice vote, is cosponsored by the ranking member of the Labor and Human and Resources Committee, Senator KENNEDY, and 63 other colleagues. The act reauthorizes critical health care programs which provide services for individuals living with HIV and AIDS. Accordingly, I urge the Senate to move expeditiously to pass this reauthorization legislation.

Mr. President, if I will just describe what this legislation is all about. The Ryan White CARE Act plays a critical role in improving the quality and availability of medical and support services for individuals living with HIV disease and AIDS. As the HIV epidemic continues, the need for this important legislation remains.

Title I provides emergency relief grants to eligible metropolitan areas [EMA's] disproportionately affected by the HIV epidemic. Just over one-half of the title I funds are distributed by formula; the remaining amount is distributed competitively.

Title II provides grants to States and territories to improve the quality, availability, and organization of health care and support services for individuals with HIV disease and their families.

Sometimes I think we do not think, when we are doing legislation such as this, about the stress that the families are under with such a tragic disease. This is why this initially came about, Mr. President, and this is why I think it does fill an enormously important niche.

The funds are used: to provide medical support services; to continue insurance payments; to provide home care services; and to purchase medications necessary for the care of these individuals. Funding for title II is distributed by formula.

Title III(b) supports early intervention services on an out-patient basis—including counseling, testing, referrals, and clinical, diagnostic, and other therapeutic services. This funding is distributed by competitive grants.

Finally, title IV provides grants for health care services and the coordination of access to research for children and families.

This legislation also includes many important changes to take into account the changing face of the HIV epidemic. When the CARE Act was first authorized in 1990, the epidemic was primarily a coastal urban area problem. Now it reaches the smallest and most rural areas of this country. In addition, minorities, women, and children are increasingly affected.

Chief among these improvements are changes in the funding formulas which are based on General Accounting Office [GAO] recommendations. The purpose of these changes is to assure a more equitable allocation of funding. These formula changes would better allocate funding based on where people currently live with this illness, rather than where people with AIDS lived in highest proportion in the past. In addition, the funds are better targeted based on differences in health care delivery costs in different areas of our country.

Based on a request from Senator BROWN and myself, the GAO has identified large disparities and inequities in the current distribution of CARE Act funding. This is due to: a caseload measure which is cumulative, the absence of any measure of differences in services costs, and the counting of EMA cases by both the titles I and II formulas.

To correct these problems, the new equity formulas will include an estimate of living cases of AIDS and a cost-of-service component. The AIDS case estimate is calculated by applying a different weight to each year of cases reported to the Centers for Disease Control and Prevention over the most recent 10 year period. The cost index uses the average Medicare hospital wage index for the 3 year period immediately preceding the grant award.

In addition, the new title II formula includes an adjustment to offset the double-counting of individuals by states, when such States also include title I cities.

Mr. President, with any formula change, there is always the concern about the potential for disruption of services to individuals now receiving them.

There is also a concern that someone will be getting more or someone will be getting less than they had before.

To address this concern, the bill maintains hold-harmless floors designed to assure that no entity receives less than 92.5 percent of its 1995 allocation over the next 5 years.

This reauthorization legislation also establishes a single appropriation for title I and title II. The appropriation is divided between the two titles based on the ratio of fiscal year 1995 appropriations for each title. Sixty-four percent is designated for title I in fiscal year 1996. This is a significant change which should help unify the interests of grantees in assuring funding for all individuals living with AIDS—regardless of whether these persons live in title I cities or in States.

Because the face of the AIDS epidemic is changing so rapidly, the Secretary is authorized to develop and implement a method to adjust the ratio of funding for title I and title II. This method should account for new title I cities and other relevant factors. If the Secretary does not implement such a method, separate appropriations for titles I and II are authorized, beginning in fiscal year 1997.

In an effort to target resources to the areas in greatest need of assistance, the bill also limits the addition of new title I cities to the program. The current designation criteria for title I cities was developed to target emergency areas. Five years after the initial enactment of the Ryan White CARE Act, the epidemic persists. However, the needs of potential title I cities are not the same as the original cities.

This is so because title II funding has been used to develop infrastructure in many of these metropolitan areas. This decreases the relative need for new cities to receive emergency title I funding.

The growth of new title I cities would be slowed beginning in fiscal year 1998. At that time, current provisions which establish eligibility for areas with a cumulative AIDS caseload in excess of 2,000 will be replaced with provisions offering eligibility only when over 2,000 cases emerge within a five-year period.

I believe this change will truly allow us to target these limited resources to areas where the real emergencies exist. As I talked with public health experts about this proposal, they indicated a rapid growth of AIDS cases over a five year period would truly stretch the limits of their existing public health infrastructure.

Mr. President, the legislation makes a number of other important modifications:

First, it moves the Special Projects of National Significance program to a new title V, funded by a 3 percent setaside from each of the other four titles. In addition, it adds Native American communities to the current list of entities eligible for projects of national significance.

Second, it creates a statewide coordination and planning process to improve coordination of services, including services in title I cities and title II states.

Third, it extends the administrative expense caps for title I and II to subcontractors.

Fourth, it authorizes guidelines for a minimum state drug formulary.

Fifth, it modifies representation on the title I planning councils to reflect more accurately the demographics of the HIV epidemic in the eligible area.

Sixth, for the title I supplemental grants, a priority is established for eligible areas with the greatest prevalence of co-morbid conditions, such as tuberculosis, which indicate a more severe need.

I believe that the changes proposed by this legislation will assure the continued effectiveness of the Ryan White CARE Act by maintaining its successful components and by strengthening its ability to meet emerging challenges. Putting together this legislation has involved the time and commitment of a wide variety of individuals and organizations. I want to acknowledge all of their efforts.

Mr. President, I would also like to say that this is a controversial bill. It has been ever since it was approved and became law in 1990. I think this is so largely because of the fear of AIDS, the concern about HIV, where it may strike next, and as I mentioned earlier, the changing face of this tragic disease, particularly when it strikes children. I think we wonder how can this be.

We have in the past had infected blood transmitted by blood transfusions. We are beginning to try to gain control over that so that the frequency of that does not occur. But it becomes a ripple effect that goes down through families.

It is a tragic disease, and it is one for which I think we all want to be able to help provide some support for a population that is viewed with great uncertainty and great concern, and as I said, great fear. That is why we always have a hard time with this legislation, Mr. President. We have a hard time making the case, even though there are 63 cosponsors, that this is an important piece of legislation; it will help a large number of people.

I am particularly appreciative of the constructive and cooperative approach which the ranking member of the Labor and Human Resources Committee, Senator KENNEDY, has lent to the development of this legislation. I also wish to thank the other 63 cosponsors of this bill for assisting me in bringing this important legislation to the floor. I am not without an understanding of those who oppose this legislation and their concerns. These are about our limited resource dollars, our limited support of those in need in the health care area, and the question of why we are targeting this money to this particular arena.

I hope that the Senate can act promptly and approve this measure.

I yield the floor, Mr. President.

Mr. KENNEDY. Mr. President, let me say at the outset how much I think all of us on this side of the aisle appreciate the leadership of Senator KASSEBAUM and her colleagues, our colleagues on the Labor and Human Resources Committee and in the Senate, in support of this legislation, the Ryan White CARE Reauthorization Act of 1995.

The fact is, Mr. President, at times of human suffering or great national tragedies or epidemics, it has always been the leadership of the Federal Government that has helped our fellow citizens deal with difficulties. It is in that very important tradition that this legislation was created and I urge the Senate to accept it today. This is critically important legislation. I am pleased that it is the first Labor Committee initiative to reach the full Senate.

For 15 years, America has been struggling with the devastating effects of AIDS. More than a million citizens are infected with the AIDS virus. AIDS itself has now become the leading killer of all young Americans ages 25 to 44. AIDS is killing brothers and sisters, children and parents, friends and loved ones—all in the prime of their lives.

From the 10,000 children orphaned by AIDS in New York City alone, to the 18-year-old gay man with HIV living in the Ozarks of Oklahoma, this epidemic knows no geographic boundaries and has no mercy.

Nearly 500,000 Americans have been diagnosed with AIDS. Over half have already died—and yet the epidemic marches on unabated.

The epidemic is a decade-and-a-half old—almost 40 percent of the AIDS cases in the country have been diagnosed in the last 2 years. One more American gets the bad news every 6 minutes. And each day, we lose another 100 fellow citizens to AIDS.

As the crisis continues year after year, it has become more and more difficult for anyone to claim that AIDS is someone else's problem. In a very real way, we are all living with AIDS. There are few of us, even here in the Senate, who do not know someone who is either infected with AIDS or directly touched by AIDS.

The epidemic has cost this Nation immeasurable talent and energy in young and promising lives struck down long before their time. And our response to this plague—and the challenges it presents—will surely document in the pages of history what we stood for as a society.

Five years ago, in the name of Ryan White and all the other Americans who had lost their battle against AIDS, Congress passed and President Bush signed into law the Comprehensive AIDS Resources Emergency Act. In dedicating this bill to the memory of Ryan White, the Senate Labor and Human Resources Committee stated in its report:

> Beginning at the age of 13, Ryan White valiantly fought not only the AIDS virus, but also fear and discrimination based on ignorance. With dignity, patience and unwavering good cheer, Ryan White introduced America and the world to a face of AIDS that caring human beings could not turn their back upon. First through his courageous fight to go to school with his peers, then through his tireless efforts to educate others about the realities of his illness, young Ryan White changed our world. By dedicating this legislation to Ryan, the Labor Committee affirms its commitment to providing care and compassion and understanding to people living with AIDS everywhere. Ryan would have expected no less.

America can take satisfaction that—in these difficult times—sometimes we get it right. In the case of the CARE Act—I think we have.

AIDS has imposed demands on our health care system that were totally unanticipated a decade ago. In 1980, no Federal, State, or local public health

agency could possibly have foreseen the introduction of a novel and lethal infectious disease into 20th century society. Yet without warning, communities across this country were faced with an ever-expanding epidemic—creating the need for essential health and support services for hundreds of thousands of Americans who previously had little contact with the health care system.

In preparing to respond, the committee heard horror stories of people with AIDS waiting 10 or 12 days in overflowing emergency rooms—only to die before they were seen. I visited these hospitals and I talked with these families. We held hearings across the Nation. We took testimony in an old school house in a southern rural town, where we heard from a person with AIDS who traveled for many hours to reach an urban clinic—for fear that if anyone in his home town knew his HIV status, he would be banished, or killed. The human tragedy brought about by AIDS was staggering, even unfathomable—and cried out for national relief.

In 1990, advocates, organizations, and frontline service providers gave us the sound advice that the development and operation of community-based AIDS care networks could help shore up the Nation's overburdened health care delivery system, while improving the quality of life and efficiency of services for individuals and families with AIDS.

These principles were affirmed in recommendations made by two successive commissions on AIDS—one appointed by President Reagan and chaired by Adm. James Watkins, the other created by Congress and chaired by Dr. June Osborn.

In a report to President Bush, the National Commission on AIDS stated:

> Federal disaster relief is urgently needed to help states and localities provide the HIV treatment, care, and support services now in short supply. The Commission strongly supports the efforts in Congress to address this need. The resources simply must be provided now or we will pay dearly later.

With broad bipartisan support, and 95 votes in the U.S. Senate, we passed the landmark Ryan White CARE Act. We joined together in the interest of the Nation. We put people before politics. We took constructive action that has made a world of difference.

The CARE Act contains a series of carefully crafted components that together form the strategy that has reduced inpatient hospitalization and emergency room visits—and allowed more than 300,000 Americans with HIV disease this year to live longer, healthier, and more productive lives.

Let me for a minute mention the various aspects of the program that form the CARE Act.

Title I provides emergency relief for cities hardest hit by AIDS.

Basically, we establish a threshold of 2,000 cases. Once the cities reach that threshold in terms of diagnosed AIDS cases, they will be eligible for help and assistance. That is why a continued expansion of the program is necessary, as more and more cities are reaching that 2,000 level.

As more and more reach that 2,000 level and become eligible, we will need additional resources to meet this growing need.

Title II provides funding for all 50 States to organize and operate care consortia, to offer home care services and lifesaving therapeutics, and to assist in the continuation of private insurance coverage for those who would otherwise be bankrupted.

We have a funding stream targeted to the areas hardest hit by HIV. We also have grants that go to all 50 States to permit the States to develop programs to meet their growing need. As Senator KASSEBAUM pointed out, we are seeing an increasing incidence in many of the rural areas of this country.

The basic thrust of these programs is to develop humane and compassionate ways to provide essential services to individuals and families with HIV. This approach is also cost-effective and reduces pressure on the health care systems in these seriously impacted communities.

Title III provides funding for community health centers and family planning clinics to offer primary care and early intervention services to men, women, and children with HIV in underserved urban and rural communities which face an increasing demand for care.

Title IV links cutting-edge pediatric AIDS research with family center health and support services to meet the unique needs of children, youth, and families with HIV.

One of the great human tragedies is the number of babies born HIV positive, infants born into this world with HIV. We are providing help and assistance to those children as well.

There has been some enormously significant and important research that has been done that has offered great hope and opportunity with early intervention of freeing these infants from transmission by providing their mothers with AZT during pregnancy and delivery.

There has been important progress made. It is the kind of research that is also being done out of NIH in a coordinated way. We want to be able to be responsive to the needs of children, youth and families that have been affected and infected. This is enormously important.

I had the opportunity to visit a center at Boston City Hospital. It was really one of the most moving and tragic visits I have ever made. But the people who are working with these infants, the volunteers that go in there and give care and attention to these babies is one of the most inspiring examples of selflessness. We want to try and at least maintain, as title IV does, cutting edge pediatric research with family centers in our country.

Title V provides funds for national demonstration projects targeted to HIV populations with special needs, including minorities, the homeless, and Native Americans.

Together these titles function to put in place a strong national response with a proven track record of success. In a very real way, the CARE Act has saved both money and lives.

In Boston, the CARE Act has led to dramatically increased access to essential services. This year, because of Ryan White, 15,000 individuals are receiving primary care, 8,000 are receiving dental care, and 9,000 are receiving mental health services. An additional 700 are receiving case management services and nutrition supplements.

This assistance is reducing hospitalizations, and is making an extraordinary difference in people's lives.

In Newark, pediatric admissions at Children's Hospital decreased by 33 percent and the length of stay has decreased by half because of the coordinated family-based care offered through the act.

I think primarily San Francisco, which experimented with a variety of ways of providing community based care, has been a model from which other cities have drawn and made a very important difference. San Francisco has increased the quality of life of people living with HIV and also has diminished, in a very significant way, the financial cost of treatment.

In Denver, emergency room visits have been reduced by 90 percent and hospitalizations by 60 percent as a result of a home care program for the uninsured paid for by the CARE Act.

In Florida, Minnesota, and Wisconsin; the State saved more than $1 million—or nearly $10,000 for each person with AIDS—by using CARE dollars to help individuals continue their private health insurance coverage.

While much has changed since 1990, the brutality of the epidemic remains the same. When the Act first took effect, only 16 cities qualified for ''emergency relief''. In the past five years, that number has more than tripled—and by next year it will have quadrupled.

This crisis is not limited to major urban centers. Caseloads are now growing in small towns and rural communities, along the coasts and in America's heartland. From Weymouth to Wichita, no community will avoid the epidemic's reach.

We are literally fighting for the lives of hundreds of thousands of our fellow citizens. These realities challenge us to move forward together in the best interest of all people living with HIV. And that is what Senator KASSEBAUM and I have attempted to do.

The compromise in this legislation acknowledges that the HIV epidemic has expanded its reach. But we have not forgotten its roots. While new faces and new places are affected, the epidemic rages on in the areas of the country hit hardest and longest.

The pain and suffering of individuals and families with HIV is real, widespread, and growing. All community-

based organizations, cities, and States need additional support from the Federal Government to meet the needs of those they serve.

The revised formulas in this legislation will make these desperately needed resources available based on the number of people living with HIV disease—and the cost of providing these essential services.

The new formula will increase the medical care and support services available to individuals with HIV in many cities, including Boston, Los Angeles, Philadelphia, and Seattle, and in many States.

Equally important, the compromise will ensure the ongoing stability of the existing AIDS care system in areas of the country with the greatest incidence of AIDS. The HIV epidemic in New York, San Francisco, Miami, and Newark is far from over—and in many ways, the worst is yet to come.

This legislation represents a compromise, and like most compromises, it is not perfect and it will not please everyone. But on balance, it is a good bill—and its enactment will benefit all people living with HIV everywhere in the Nation.

We have sought common ground. We have listened to those on the frontlines. And we have attempted to support their efforts, not tie their hands.

Congress must now once again put aside political, geographic, and institutional differences to face this important challenge squarely and successfully. The structure of the CARE Act—affirmed in this reauthorization—and its well-documented effectiveness provide a sound and solid foundation on which to build that unity.

Hundreds of health, social service, labor, and religious organizations helped to shape the reauthorization's provisions. The reauthorization has been praised by Governors, mayors, county executives, and local and State AIDS directors and health officers. It has required all levels of government to join together in providing services and resources. And success stories of this coordination are now plentiful.

Community-based AIDS service organizations and people living with HIV have had critically important roles in the development and implementation of humane and cost-effective service delivery networks responsive to local needs.

Although the resources fall far short of meeting the growing need, the Act is working. It has provided life-saving care and support for hundreds of thousands of individuals and families affected by HIV and AIDS. Through its unique structure, it has quickly and efficiently directed assistance to those who need it most.

The Ryan White CARE Reauthorization Act, however, is about more than Federal funds and health care services. It is also about the caring American tradition of reaching out to people who are suffering and in need of help. Ryan White would be proud of what has happened in his name. His example, and the hard work of so many others, are bringing help and hope to our American family with AIDS.

The CARE Act has been a model of bipartisan cooperation and effective Federal leadership. Today that tradition continues. Sixty-three Senators join Chairman KASSEBAUM and me in presenting this bill to the Senate. It has been unanimously reported by both the Labor and Human Resources Committee in the Senate and the Commerce Committee in the House.

We must do more and do it better to provide care and support for those trapped in the epidemic's path. And with this legislation, we will.

Mr. President, again, I thank our chairperson, Senator KASSEBAUM, for her leadership and for working through a number of recommendations and changes. There have been changes in the way the funding will be distributed, and any time you engage in that, there will always be some winners and some losers.

It is a compromise which I support. It took a good deal of time to work this through, but I commend her for her diligence and for her ability to bring us all together on to some common ground.

Finally, I think those individuals who are looking to this legislation for some hope ought to find it as we go forward. It has broad bipartisan support. We expect that, as the majority leader has indicated, we will pass this in the very near future —certainly in the period of time before the August recess. If you take the progress being made in this area, the progress being made in the Office of AIDS research at the NIH, and the progress we have made with the Americans With Disabilities Act in the not too recent past, I think what Americans can take some satisfaction in is that we are trying to deal with this issue as a public health issue. We are trying to deal with it in a humane fashion. We are putting aside, during this debate, ideology and rhetoric in dealing with the facts at hand. We should follow scientific, and medical judgements and reflect caring and compassionate leadership, which we are about when we are at our best.

So this is really a hopeful piece of legislation. It will make a difference to tens of thousands of our fellow citizens. It is an area of important need. It is building on solid records of achievement and accomplishment. It reflects a number of the recommendations that have been made by Republicans and Democrats alike. It is a reflection of many of our colleagues' good recommendations and suggestions. We are very grateful to all of those that have been a part of this legislation. I am very hopeful that the Senate will pass it in the very near future.

I yield the floor.

Ms. MIKULSKI. Mr. President, I rise today in strong support of the Ryan White Comprehensive AIDS Resources Emergency [CARE] Act reauthorization. This act that honors the memory of a teenager who touched the lives of all Americans by bringing to the public's consciousness the need to respond to people living with AIDS. I am proud to be a cosponsor of this legislation and I urge my colleagues to join me in keeping the ''care'' in the Ryan White CARE Act.

My home State of Maryland, and Baltimore in particular, has benefited greatly from the services funded under the Ryan White CARE Act. Many Marylanders with AIDS would have gone without care or received substandard care if this law was not in existence. The CARE Act has provided primary care services and specialized HIV/AIDS care specifically for children, adolescents, women, men, and families through cost-effective community-based, family-centered comprehensive systems. In Maryland alone, the number of reported AIDS cases has increased every year since 1990 when the Ryan White CARE Act was first passed. In 1990, the number was 923, in 1992 it was 1,242, in 1993 it was 2,483, and last year it was 2,810.

As we have seen in Maryland, the AIDS epidemic is far from over. The greatest spread of the disease in Maryland has been in the Baltimore metropolitan area. In Baltimore City alone in 1993. there was a 64.4 percent increase in the AIDS caseload. The number of AIDS cases in Baltimore has multiplied more than 21 times since 1985. Sixty-one percent of AIDS cases in Maryland are in Baltimore.

The Federal Government has always responded to national tragedies and epidemics with targeted assistance—AIDS is no different. We must make sure that the Ryan White CARE Act continues to provide community-based care as well as new care and prevention programs. I believe this Act as reauthorized accomplishes this goal.

We cannot ignore the human element of this disease and the individuals whose lives have been affected by it. We cannot forget their personal plights and how this law has affected their lives. We have an opportunity today to do the right thing by reauthorizing this Act. We need to ensure that those affected by HIV and AIDS receive help in coping with the ravages of this dreaded disease.

AIDS is a disease that does not discriminate among children and adults, rich or poor, Democrats and Republicans. It affects everyone. Now is the time to come together in a bipartisan way to show Americans living with AIDS and their families that their elected officials—their Congress—is standing firmly behind them in their time of need. Let's keep the ''care'' in the Ryan White CARE Act.

Mrs. KASSEBAUM. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Ms. MOSELEY-BRAUN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Ms. MOSELEY-BRAUN. Mr. President, I rise in strong support for quick action to approve the funding for the Ryan White CARE Act. The Ryan White CARE Act is an example of Government at its best. It is an initiative that has worked well in spite of the unfortunate and tragic growth in the number of AIDS and HIV. This has been a difficult disease for the country to deal with and an even greater challenge for the individuals and families of individuals stricken with the disease.

When Ryan White was first enacted, about 128,000 Americans were diagnosed with HIV. Now, unfortunately, there are more than 480,000 diagnosed cases.

Unfortunately, Mr. President, and probably predictably so, AIDS is one of those things that none of us like to talk about. It is a subject that brings fear in the hearts of anyone who even raises the question. But it is, I think, vitally important that we talk about it, and it is vitally important that we engage in debate about priorities and how we go about responding to what is truly an American emergency.

AIDS is just such an emergency. HIV is just such an emergency. Ryan White has been there to respond in a comprehensive and sensible way to that emergency. It is cost effective. It is working. It is responsive. And again, it represents the best of America.

Let me say at the outset that Ryan White funding plays a critical role in ensuring that people with HIV and AIDS receive not just health services but case management, home services, housing services, transportation, and it is a comprehensive approach to dealing with the entire individual and the entire community.

The funding goes to State and local governments to deal with HIV-infected populations within that community, as well as to provide support for community initiatives designed to try to provide the kinds of supports that will be responsive to the particular health needs of that community.

One of the things that needs to be talked about during the health care debate is the fact that here in America no one goes without health services.

If you think about it, everyone gets services in one form or another. If somebody falls out in the middle of the street or someone gets sick, somewhere, somehow or another, they will get served. The question becomes, how does it get paid for?

Unfortunately, our health care system is broken—we have the finest health care in the world, but in many ways it is a broken one. The fact is, the way the system works now, uncompensated care costs get shifted back and forth, and so in many instances, people who go to the hospital and pay private pay for health coverage, for health services, wind up paying $100 for aspirin, and that is just an apocryphal example. But the reason aspirin costs $100 is because of uncompensated care provided to people in other points in the system. Hospitals have provided the care. They have to recover that cost in some way and very often those costs get shifted to people who have private insurance and the like.

What Ryan White does, then, if you look at it in the scheme of things, Ryan White says here is a particular population with particular health needs and a community need to have these health needs met. We are going to provide funding to State and local governments, to health care institutions, to research institutions and the like, to try to address this specific problem so these costs will not be shifted and these costs will not be spread and we can be responsive in a comprehensive way.

So Ryan White-funded health care services help not only keep people healthy, and of course I know some of my colleagues have spoken to the human dynamic that is involved with Ryan White, but it also helps to provide a way of providing health care services in a way that does not call for this unaccountable kind of cost shifting that we might see in our health care system overall in the absence of Ryan White.

Mr. President, my State, Illinois, received in Federal funding for AIDS programs a total in 1994 of about $60 million. This is a lot of money. But certainly the fact is that the population is large and is growing and Ryan White has been responsive to a number of different institutions in the State of Illinois to provide for health care services: Emergency funds for care services, funds to the State health departments for support and care services, funds to community-based clinics and migrant health clinics to provide outpatient early intervention and primary medical services, funds to support pediatric, adolescent, and family programs.

All of these are vitally important, particularly given the fact that the AIDS population and HIV population is growing with regard to pediatrics, with regards to the children—that population is expanding. I think we have every obligation to see to it that we respond to the health needs of the community and the health needs of the individuals who are suffering with this dread disease in a way that is efficient. Certainly, Ryan White is that cost-effective, that efficient approach to health care funding for AIDS and HIV.

Finally, I would like to make a special appeal to my colleagues to look at this program and not allow us to get into a tradeoff between diseases, if you will. The fact is, we have a universal interest in seeing to it that the health care of America is something that we respond to as a society, not just because it is good for the individuals but because it is good for our society as a whole.

I do not think it can ever be argued that one disease versus another disease should be competitive. Indeed, if anything, we have, I think, an obligation to provide people with quality health care and access to health care and the availability of funding for that health care in a system of health care that is responsive to our total population needs.

I understand this legislation has broad-based bipartisan support and so this is not a partisan issue. This is certainly not an issue that should be controversial in any way. I hope there will not be any controversy.

I certainly want to applaud Senators KASSEBAUM and KENNEDY for working through the issues surrounding this legislation. Senator KASSEBAUM has been a leader in the health area for a long time and I applaud her for her efforts in this regard and applaud her for this legislation, and I urge its quick passage by the U.S. Senate.

I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. AKAKA. Mr. President, I am pleased that the Senate is now considering S. 641, the Ryan White Comprehensive AIDS Resources Emergency, CARE, Reauthorization Act of 1995. In 1990, Congress enacted the Ryan White CARE Act, named in honor of the young hemophiliac who devoted enormous energy educating Americans about the need for a compassionate response to people living with AIDS.

The Ryan White CARE Act is the cornerstone of Federal funding for AIDS-specific care and has played a critical role in improving the quality and availability of medical and support services for individuals with HIV and AIDS. Since its enactment, the CARE Act has provided life-sustaining services to over 300,000 people with HIV/AIDS, including primary health care, prescription drugs, home health care and hospice care, dental care, drug abuse treatment, counseling, case management, and assistance with housing and transportation.

I commend the sponsors of this legislation, Senators NANCY KASSEBAUM and EDWARD KENNEDY, for their leadership on this issue of national importance. S. 641 would amend the CARE Act and extend authorization of the grant programs, which expire on September 30, 1995. As AIDS is the leading cause of death of young adults, we cannot let reauthorization of the CARE Act be delayed any longer nor diluted through negative amendments. I am a cosponsor of this legislation and believe that it will strengthen the CARE Act and enhance our ability to be responsive to the evolving nature of this epidemic. The measure, which enjoys bipartisan support, was favorably reported out of the Senate Labor and Human Resources Committee by a unanimous vote on March 29, 1995.

The sponsors of this legislation recognize that the changing demographics of the AIDS epidemic require a more

equitable distribution of funding in order to balance the needs of people across this country living with HIV and AIDS. Accordingly, S. 641 builds on the program's strengths and makes significant improvements by modifying the funding formulas to reflect the changing nature of the AIDS epidemic. The legislation before us would assure a more equitable allocation of funding as it restructures formulas based on an estimation of the number of individuals currently living with AIDS and the costs of providing services

I urge my colleagues to support, without amendment, S. 641, the Ryan White Care Reauthorization Act of 1995.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, I thank the Senator from Hawaii and prior to the Senator from Hawaii speaking, the Senator from Illinois, Senator MOSELEY-BRAUN, for their cosponsorship and assistance with this legislation as we have been putting it together and as it is now ready to be considered by the full Senate.

I just wish to thank the Senator from Hawaii for his support.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mr. LEAHY. Mr. President, I am proud to be a cosponsor of the Ryan White CARE Act.

Today, AIDS is the leading cause of death among Americans between the ages of 25 to 44 years. Truly, a staggering statistic.

Since the beginning of the epidemic in 1981 through June of 1994, the number of reported AIDS cases in Vermont is 213. Eighty-two of these cases were reported in the previous year alone. This represents an increase of 242 percent over the reported total in 1991–92.

AIDS knows no gender, sexual orientation, age, or region of the country. AIDS is something that affects all of us.

Since its enactment in 1990, the Ryan White CARE has done so much to help provide health care and services to the growing number of people with HIV/AIDS. I hope that we can work toward a speedy passage.

Mr. President, I ask unanimous consent to be able to proceed as if in morning business.

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

SUPPORT FOR CONGRESSIONAL LEADERSHIP AGAINST LANDMINES

Mr. LEAHY. Mr. President, on June 16 I introduced S. 940, the Landmine Use Moratorium Act. My bill, which calls for a 1-year moratorium on the use of antipersonnel landmines, aims to exert U.S. leadership to address a problem that has become a global humanitarian catastrophe, the maiming and killing of hundreds of thousands of innocent civilians by landmines.

Landmines are tiny explosives that are concealed beneath the surface of the ground. There are 100 million of them in over 60 countries, each one waiting to explode from the pressure of a footstep. Millions more are manufactured and used each year. The Russians are scattering them by air in Chechnya. They are being used by both sides in Bosnia, where 2 million mines threaten U.N. peacekeepers and humanitarian workers there, as well as civilians.

In Angola there are 70,000 amputees, and another 10 million unexploded mines threatening the entire population. Mines continue to sow terror in dozens of countries in Asia, Africa, Latin America, and the former Soviet Union.

Again, my bill calls for a 1-year moratorium on the use of antipersonnel mines. Not because the United States uses landmines against civilian populations the way they are routinely used elsewhere, but because without U.S. leadership nothing significant will be done to stop it.

Like the landmine export moratorium that passed the Senate 100 to 0—2 years ago—and like the nuclear testing moratorium, my bill aims to spark international cooperation to stop this carnage. Time and time again we have seen how U.S. leadership spurred other countries to act.

The Landmine Use Moratorium Act has 45 cosponsors—37 Democrats and 8 Republicans. They are liberals and conservatives. They understand that whatever military utility these indiscriminate, inhumane weapons have is far outweighed by the immense harm to innocent people they are causing around the world.

Every 22 minutes of every day of every year, someone, usually a defenseless civilian, often a child, is horribly mutilated or killed by a landmine. It is time to stop this. My bill takes a first step.

Mr. President, in recent weeks, newspapers around the country have published editorials and articles about the landmine scourge and the need for leadership by Congress.

I ask unanimous consent that several newspaper articles about the Landmine Use Moratorium Act from Maine, Oregon, Pennsylvania, and elsewhere, as well as several defense publications, be printed in the RECORD.

I also ask unanimous consent that Senator GORTON be added as a cosponsor to S. 940.

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

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

[From Defense News, July 10–16, 1995]

LAND-MINE BAN WOES

In 1994, about 100,000 land mines were removed from former war zones at a cost of $70 million. At the same time, another 2 million mines were deployed elsewhere.

These and other sobering, frustrating statistics came out of a three-day international conference in Geneva last week on mine-clearing.

The daunting prospect of new mines being sown at a rate 20 times faster than they can be removed is matched by the apparently futile attempts to ban the sale and manufacture of these inexpensive weapons.

There is some momentum to enact an international ban, with 25 nations adopting moratoriums on mine exports and three—Mexico, Sweden and Belgium—calling for comprehensive bans on their sale and manufacture. But in Geneva, it was concluded that banning land mines must be a long-term goal.

Despite the clear evidence that these weapons often can serve as everlasting and deadly vestiges of wars long resolved, some countries demand the right to keep them in their inventories.

The nations that want to have land mines in their inventories typically are not the same 64 countries where collectively 100 million land mines kill or maim 500 persons each week. If they were, perhaps a comprehensive ban would not be so elusive.

BURY MINE VIOLENCE

While international support is growing for a comprehensive ban on the sale and manufacture of antipersonnel mines, Western leaders must speak with one voice in demanding stronger curbs on these weapons that kill about 70 people each day.

Following the U.S. lead, 18 countries have declared moratoriums on the export of antipersonnel land mines and a U.N. conference beginning in September in Vienna will examine how and where antipersonnel land mines may be used.

Despite these and other promising signs, a worldwide ban on these mines that kill or maim 26,000 people each year remains an unlikely outcome of the U.N. meeting.

Even the European Parliament, which is hoping to influence the U.N. decision by soon adopting its own resolution calling for an antipersonnel mine ban, may have trouble achieving consensus.

While Belgium, for instance, banned all production, sale and export of antipersonnel mines last month, officials from other countries, such as Finland, insist that antipersonnel mines are a vital asset in national defense.

Because of these widely divergent views, a strong European Parliament resolution renouncing antipersonnel mines may be an elusive goal.

Even the United States, which had been a leader in the drive to rid the world of antipersonnel land mines, is falling off the pace. Despite a landmark speech by U.S. President Bill Clinton to the U.N. General Assembly in September in which he stressed the elimination of antipersonnel land mines, the government would allow the sale of certain high-tech antipersonnel land mines if the congressionally imposed export ban that ends in 1996 is not extended.

The U.S. military wants to keep high-tech antipersonnel mines that are self-deactivating. And a multilateral mine control regime being touted by U.S. officials concentrates on eliminating long-lived antipersonnel mines that do not self-destruct or self-deactivate.

While the newer high-tech mines offer great improvements over many of their predecessors, they nonetheless are dangerous