had to argue with and convince his principal to change these requirements because they were not fair.

They told Ed he could not attend the University of California at Berkeley because they had never had a student in a wheelchair, one who used a respirator, or one who slept in an iron lung. Ed fought all that too, and convinced the university to admit him. ''Helpless Cripple Goes to College'' was one of the headlines marking Ed's entrance to college.

They made him live in the infirmary. But Ed was not helpless. By the time Ed left UC Berkeley, he and fellow student activists who called themselves the Rolling Quads had organized funding to begin transforming the campus into a model of physical accessibility for students with disabilities.

As Ed said, ''We realized that we could change some things, and the first thing we can do is change our own attitudes toward ourselves, be proud of who we were and what we were and go out and change it for others and for ourselves * * * that liberated me when I realized that I can help others. It made me a lot freer to help myself.''

Ed went on to graduate school in political science and taught at UC Berkeley for several years. One of Ed's deans once told him, ''Oh, you'll finish your Ph.D and they you'll live in a nursing home.'' But Ed knew otherwise. He told that dean, ''No, that's not the plan. We're here to change that whole idea.'' And at his memorial service, a representative from the university described him as ''bringing the honor of being the right kind of troublemaker here at Cal.'' Today, over 800 students with many kinds of disabilities attend UC-Berkeley where there are scholarships in his name for undergraduate, graduate, and postdoctoral students with disabilities.

After his university years, Ed went on to establish the first Center for Independent Living in the country. Where was it was located? Where else? Berkeley. Today there are over 300 independent living centers all across the country. Independent living is a philosophy which defines independence as full inclusion of people with disabilities in all aspects of community life. Ed lived this philosophy, and he helped others live it as well. His colleague Doug Martin, ADA and 504 compliance officer for UCLA, recently described Ed during the CIL years when he said, ''He believed in us before we believed in ourselves.''

Ed's philosophy of independent living, and his ability to get the money and the people behind it changed our lives. It changed the lives of millions of people in this country and abroad—people with disabilities, their families, their friends and many others who began to see the universality of his approach. As Ed put it, ''I'm paralyzed from the neck down, but I'm completely in control of my own life. I can make decisions about what I want.''

Early on, they told Ed he was unable to be rehabilitated. However, this rehab failure went on to become director of the California State Department of Vocational Rehabilitation. You see, Ed loved to turn barriers upside down, rendering each one a challenge in his own slalom course toward empowerment and independence. And by the end of his tenure in Sacramento, Ed knew he wanted to be a full-time rabble-rouser. Ed told his friend Stephen Hofman, ''I don't want to work. It prevents you from raising hell, and I like to raise a lot of hell * * * After all, if raising hell doesn't work, the only solution is to raise even more hell, and then, they give up!''

As Joe Shapiro wrote in U.S. News & World Report the week after Ed died, ''He knew that it was the paternalism of others, more than his own disability that held him back.''

In 1984, Ed was awarded a MacArthur Genius Fellowship, which he used to live on as he started The World Institute on Disability, a disability policy think tank located in Oakland, CA. Ed testified before committees in Congress numerous times, and many of us grew to know him well. But Ed was not content to be a solo rabble-rouser. He wanted to join forces, debate the issues, hammer out policy and see it implemented in his lifetime. WID was the crucible Ed fashioned with his colleagues for stoking fires and building community.

Ed's vision was exemplified in the way he lived his own life, but he also very much believed in empowering others. As one of his colleagues at WID said, ''Part of his star quality was that he always talked about 'we'. He always would come up and say 'we've got to do that,' 'we need people,' 'we need to work on this together,' 'we can make this happen.''' Ed blew people's minds when he took to the streets of Moscow in his motorized chair in 1993. There, he has become a symbol of freedom, a household word to millions of people with disabilities.

But Ed was more than a civil rights hero. He was a man with heart, a man whose love and sense of humor were tools just as powerful as his keen mind and his passion for justice. Ed always took the time to find out how you were doing.

He took the time to encourage young students with disabilities to study public policy.

He took time to talk with personal assistants about the powerlessness of being underpaid.

He took the time to visit other respirator users in the hospital when they were despairing over living independent lives.

He took the time to stop on the street and talk with homeless people, people with disabilities that the ''system'' has forsaken.

He took the time to laugh, to have an adventure, and always to eat a good meal!

Ed did just about everything a person could dream of doing. He got married. He fathered a son—his absolute pride and joy. Ed swam with the dolphins, practiced karate, was almost eaten by a shark, threw tremendous dinner parties, and travelled all over the world. As WID vice president and one of Ed's former proteges, Debby Kaplan said recently, ''He had a determined exuberance for life.''

We are all fortunate to live in this world which Ed so deeply touched, so richly celebrated.

Mr. President, I yield the floor.

MESSAGES FROM THE HOUSE

At 11:58 a.m., a message from the House of Representatives, delivered by Ms. Goetz, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1045. An act to amend the Goals 2000: Educate America Act to eliminate the National Education Standards and Improvement Council, and for other purposes.

H.R. 1266. An act to provide for the exchange of lands within Admiralty Island National Monument, and for other purposes.

MEASURES REFERRED

The following bill was read the first and second times by unanimous consent and referred as indicated:

H.R. 1266. An act to provide for the exchange of lands within Admiralty Island National Monument, and for other purposes; to the Committee on Energy and Natural Resources.

MEASURES READ THE FIRST TIME

The following measure was read the first time:

H.R. 1045. An act to amend the Goals 2000: Educate America Act to eliminate the National Education Standards and Improvement Council, and for other purposes.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mrs. KASSEBAUM, from the Committee on Labor and Human Resources, with an amendment in the nature of a substitute:

S. 454. A bill to reform the health care liability system and improve health care quality through the establishment of quality assurance programs, and for other purposes (Rept. No. 104–83).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

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

By Mr. HATFIELD:

S. 806. A bill to amend the Public Health Service Act to provide grants to entities in rural areas that design and implement innovative approaches to improve the availability and quality of health care in such rural areas, and for other purposes; to the Committee on Finance.

By Mr. LIEBERMAN:

S. 807. A bill to amend the Internal Revenue Code of 1986 to provide that individuals who have attained age 59 1/2 may contribute to individual retirement accounts without regard to their compensation; to the Committee on Finance.

By Mr. BREAUX:

S. 808. A bill to extend the deadline for the conversion of the vessel M/V TWIN DRILL, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. LAUTENBERG (for himself, Mr. HELMS, and Mr. BRADLEY):

S. 809. A bill to amend the Trade Act of 1974 to limit the eligibility for treatment under the generalized system of preferences in the case of countries that support international acts of terrorism, and for other purposes; to the Committee on Finance.

By Mr. HOLLINGS (for himself and Mr. THURMOND):

S. 810. A bill to direct the Secretary of the Interior to remove from the Coastal Barrier Resources System a tract of land in South Carolina that was added to the System without notice to the county in which the tract is located, and for other purposes; to the Committee on Commerce, Science, and Transportation.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. HATFIELD:

S. 806. A bill to amend the Public Health Service Act to provide grants to entities in rural areas that design and implement innovative approaches to improve the availability and quality of health care in such rural areas, and for other purposes; to the Committee on Finance.

THE RURAL HEALTH IMPROVEMENT ACT OF 1995

● Mr. HATFIELD. Mr. President, during the last several years, Americans have heard a lot about the need to reform our health care system. Health care costs are soaring out of control—far outpacing the rate of inflation—and nearly 38 million Americans are without health care insurance. Solutions for reform are complex and will go through much debate and consensus building before implemented on a national level.

While local and regional health care systems have rushed to consolidate and integrate their services and resources over the last decade, rural entities, due to their shortage of physicians, the vulnerability of their hospitals, their geographical and technical isolation, and the demographics of their patient populations, have been largely unable to adjust in a similar way. As public concern over the national health care crisis grows and legislative bodies and policymaking agencies scramble to devise and implement far-reaching health care reform, the special health care needs of rural America must not be neglected.

Today I am reintroducing the Rural Health Improvement Act because I feel, given the current direction of the health care reform debate, that it provides an essential transition into comprehensive health care reform. Now, more than ever, health providers in rural communities are joining with their urban counterparts to create networks to assure that health care is accessible in rural areas. There are a number of obstacles, however, that create a disincentive for providers to participate in these efforts. I believe that the legislation that I am introducing today will remove these obstacles and help rural communities position themselves for comprehensive health care reform.

Mr. President, the Rural Health Improvement Act will help our rural communities in the following ways. First, this legislation provides grants to allow rural and urban providers to develop rural health extension networks to facilitate the delivery of health care in rural communities. It allows existing networks such as area health education centers to compete for these grants in order to prevent needless duplication and to assure that successful programs will have the ability to expand their capabilities. The goal of the rural health extension networks grant is to facilitate resource sharing within the network by providing education and training for health care providers in rural areas, creating linkages between rural and urban providers through the use of telecommunications and other consultative projects, and assisting rural providers in developing cooperative approaches to health care delivery.

Second, my bill provides grants for the creation of rural managed care cooperatives which will enhance the economic viability of health care providers in rural areas. The idea of health cooperatives in rural areas is not new. In 1929, the first health maintenance organization in the United States was developed in rural Elk City, OK, by the Farmers' Cooperative. Since 1929, there have been several attempts to create rural health cooperatives, however, they have suffered because they lacked sufficient startup support. My bill provides this startup support.

These cooperatives will be made up of health providers of all types including, but not limited to, hospitals, physicians, rural health clinics, nurse practitioners, physician assistants, and public health departments. By establishing an effective case management and reimbursement system designed to support the financial needs of rural hospitals and health care systems, cooperatives will provide an effective framework for negotiating contracts with payers and assuring a defined level of quality. The cooperatives will also help rural practitioners with a portion of their payments on malpractice premiums.

Due to the concerns about possible antitrust problems that might arise in the formation of the rural health extension networks and the rural managed care cooperatives, the bill includes language which would protect providers who participate in these entities from antitrust law. This exemption from antitrust law should facilitate the development of network and cooperatives in rural areas.

Third, the bill allows the Secretary of Health and Human Services to award competitive grants to develop and implement mental health outreach programs in rural areas. The bill emphasizes the needs of the elderly and children in rural areas. Grant recipients are encouraged to form relationships with rural managed care cooperatives to enhance the delivery of these services.

Fourth, my bill provides stipend grants under the Area Health Education Centers [AHEC] Program to health care providers and trainees in rural communities as an incentive to provide health care services in those areas. While the stipends envisioned in this legislation will not completely relieve the financial burden young providers face, especially physicians, it is my hope that they will provide enough of an incentive to attract and retain health care providers in rural areas.

It has been 20 years since the AHEC Program was enacted and we now have a network of 48 AHEC Programs in 38 States. In my own State of Oregon, we have an excellent statewide AHEC program with five centers now operating to meet the challenges of both rural and urban areas. State studies have shown that AHEC's have an excellent record in addressing the primary health care profession needs of underserved areas. In fact, since AHEC's inception more than 1.5 million students, residents, and preceptors have been trained in medicine, allied health, dentistry, nursing, and pharmacy.

Finally, this year I have included a nonrefundable tax credit for qualified providers in rural and underserved areas. This tax credit is similar to the tax credit proposed in health care reform legislation last session. Under this provision qualified providers will be eligible for a tax credit if they serve in rural or underserved areas for 5 years. A similar tax credit program in Oregon has enjoyed great success. In a recent survey by the Oregon Office of Rural Health, rural providers indicated that the Oregon Tax Credit Program is the most important program offered that keeps them practicing in rural areas.

Mr. President, our rural communities are facing a crisis in health care delivery. Nationwide, 141 rural community hospitals closed between 1989 and 1993. In Oregon, five rural hospitals have closed since 1986 and several other rural facilities are threatened with imminent closure. These hospitals simply cannot compete with their urban counterparts. I believe my legislation will give rural health care providers the tools to build rural health care delivery systems which meet the health needs of their communities. This is the first step in developing an infrastructure of providers who will support and sustain comprehensive health care reform and provide health care access for all Americans.