

Starr's grand jury in Arkansas or before a grand jury here, they do not know what is happening. They do not know if they need an attorney or not. They do not know in most cases whether they are a target of an investigation or not. They are having to produce mountains of information. They are having to produce file drawers full of documents. For many of those documents, they do not know where they are. But in most cases they are trying to comply in good faith and with good intentions.

So, Mr. President, that may have been how this rumor started about the Senator from Arkansas putting a hold. I said that I might have an amendment. One amendment might be on the GATT Glaxo issue; one amendment might be to add additional funds so that we could cover those individuals who could not pay attorney's fees who are not targets of an investigation.

I remember hearing the majority leader sometime back. I tell you, I think he was right. I remember him talking about someone who had been hauled—perhaps hauled or subpoenaed—before the Iran-Contra committee. I believe that was the case. The majority leader said then that what he was going to have to do is go out and try to get his reputation back.

Those words rang in my ears, and they ring in my ears again as we continue dragging these people up from especially our State and where it is going to wreak financial devastation on some of these individuals who have had no part in creating this problem but were merely what you might call lower echelon public servants who are going to be financially destitute after all of this is over.

Mr. President, I see the distinguished majority leader is here. I want to thank once again my friend from Iowa, Senator GRASSLEY, for remaining, and he has had to leave the floor now.

Seeing no other Senators seeking recognition, I yield the floor at this time.

Mr. DOLE addressed the Chair.

The PRESIDING OFFICER. The majority leader.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. DOLE. Mr. President, I ask unanimous consent that the Senate immediately proceed to executive session to consider the following nominations on today's Executive Calendar: Executive Calendar nomination Nos. 507 and 508.

I further ask unanimous consent that the nominations be confirmed, en bloc, the motions to reconsider be laid upon the table, en bloc, that any statements relating to the nominations appear at the appropriate place in the RECORD, the President be immediately notified of the Senate's action, and that the Senate then return to legislative session.

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

The nominations were considered and confirmed as follows:

DEPARTMENT OF ENERGY

Thomas Paul Grumbly, of Virginia, to be Under Secretary of Energy.

Alvin L. Alm, of Virginia, to be an Assistant Secretary of Energy (Environmental Management).

LEGISLATIVE SESSION

The PRESIDING OFFICER. Under the previous order, the Senate will resume legislative session.

RYAN WHITE CARE ACT AMENDMENTS OF 1996—CONFERENCE REPORT

Mr. DOLE. Mr. President, I submit a report of the committee of conference and ask for its immediate consideration.

The PRESIDING OFFICER. The report will be stated.

The legislative clerk read as follows:

The committee on conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 641), a bill to reauthorize the Ryan White CARE Act of 1990, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses this report, signed by all of the conferees.

The PRESIDING OFFICER. Without objection, the Senate will proceed to the consideration of the conference report.

(The conference report is printed in the House proceedings of the RECORD of April 30, 1996.)

Mrs. KASSEBAUM. Mr. President, I rise in support of the conference report on the Ryan White CARE Act Amendments of 1996, S. 641. This bipartisan legislation 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 conference report, which has already moved through the House with near-unanimous support.

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.

Achieving a compromise on the Ryan White CARE Act reauthorization bill has been a long process, and I am delighted to see it come to a completion. The give-and-take involved in the conference rarely leaves everyone satisfied with every aspect of the final agreement. I believe, however, that the compromise bill offers constructive change, and I am particularly pleased that it provides greater equity for rural states through changes in the funding formulas.

The present distribution formulas have led to disparity in funding for in-

dividuals living with AIDS based on where they live. 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. Our agreement ensures that the amount of Federal AIDS support for an individual in a rural State more closely approximates the support for an individual living in a high AIDS population area. This agreement ensures that any individual living with AIDS, regardless of where he or she lives, will have similar support from the Federal Government.

Mr. President, with any formula change, there is always concern about the potential for disruption of services to individuals now receiving them. To address this concern, the bill maintains hold-harmless floors designed to assure that no entity receives less than 95 percent of its 1995 allocation over the next 5 years, and all entities are held harmless in fiscal year 1996.

The Senate-House HIV testing compromise shifts the emphasis from mandatory testing of infants to voluntary testing of pregnant women. It provides \$10 million to help States meet CDC guidelines for voluntary HIV counseling, testing, and treatment for pregnant women. I believe the emphasis on voluntary testing for pregnant women makes sense and is an appropriate compromise. Medical technology today enables us to greatly reduce the chance that a HIV-positive mother will pass HIV to her newborn if she receives proper treatment prior to delivery. This is why I felt it was so critical to focus our Federal resources on voluntary testing of mothers rather than testing newborns, when it would be too late to try to prevent most HIV transmission.

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. I particularly appreciate the constructive and cooperative approach which the Senate conferees, Senators JEFFORDS, FRIST, KENNEDY, and DODD, lent to the development of this legislation. I wish to thank both the Senate and the house conferees for their efforts in crafting the compromises reflected in this conference bill.

I also wish to thank their staffs, including Sharon Winn, Susan Ramthun, Jonelle Rowe, M.D., Joe Musker, Michael Iskowitz, Seth Kilbourn, Jane Loewenson—as well as Marty Ross, M.D., James Wade, M.D. and Kent Bradley, M.D. of my staff—for their hard work in reaching this agreement.

Mr. KENNEDY. Mr. President, it is a privilege to join Senator KASSEBAUM in

bringing to the Senate floor the conference report for the Ryan White CARE Reauthorization Act of 1996. This is critically important legislation and I am pleased that after months, an agreement has finally been reached.

For 15 years, America has been struggling with the devastating effects of AIDS. More than 1 million citizens are infected with the virus. AIDS itself has now become the leading killer of all young Americans from ages 25 to 44. AIDS is killing our brothers and sisters, parents and children, friends and loved ones—all in the prime of their lives. This epidemic knows no walls and has no mercy.

More than 500,000 Americans have been diagnosed with AIDS. Over half have already died—while the epidemic marches on unabated.

The epidemic is now a decade and a half old, but almost 40 percent of the AIDS cases in this country have been diagnosed in the last 2 years. Another American gets the bad news every 6 minutes. Each day, 100 more of our fellow citizens die of AIDS.

As the crisis continues, it becomes more and more difficult for anyone to pretend that AIDS is someone else's problem. There are few of us who do not know someone who is either infected or affected by AIDS. In a very real way, we are all living with AIDS.

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

In response, and in the name of Ryan White and all the other Americans who had lost the battle against AIDS, Congress passed the Comprehensive AIDS Resources Emergency Act, called the CARE Act. With broad bipartisan support, we put people before politics, and took constructive action that has made a world of difference.

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

The act contains a series of provisions that have reduced inpatient hospitalization and emergency room visits—and allowed more than 300,000 Americans with HIV disease to live longer, healthier, and more productive lives.

Title 1 of the act provides emergency relief for cities hardest hit by AIDS.

Title 2 provides funding for all 50 States to organize and operate HIV care consortia, to offer home care services and lifesaving therapeutics, and to continue private insurance coverage for those who would otherwise fall onto the public rolls.

Title 3 funds community health centers and family planning clinics which offer primary care and early intervention services to those living with HIV in underserved urban and rural commu-

nities face an increasing demand for care.

Title 4 links cutting-edge pediatric AIDS research with family centered health and support services to meet the unique needs of children, youth, and families with HIV.

Title 5 funds national demonstration projects for HIV populations with special needs, including teenagers, minorities, the homeless, and Native Americans.

Together, these titles put in place a strong national response with a proven track record of success that has saved both money and lives.

In Boston, the act has led to dramatically increased access to essential services. Because of the act, 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.

While our response has changed significantly 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 5 years, that number has more than tripled.

This crisis is no longer 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. This reality challenges us to move forward together in the best interest of all people living with HIV. And that is what this conference report seeks to do.

This bill acknowledges that the HIV epidemic has expanded its reach, but we have not forgotten its roots. While new faces and new places are now 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 desperately needed resources available to cities and States, based on the number of people living with HIV disease. These changes will increase the availability of medical care and the support services to individuals with HIV in many cities, including Boston, and in many States.

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

Finally, the compromise includes a provision promoting voluntary HIV counseling, testing, and treatment for pregnant women as part of comprehensive prenatal care.

Thanks to recent research advances, we now know that this sound public health approach will save countless young lives. Doctors, nurses, public health officials and AIDS organizations have all called for this responsible action.

This aspect of the bill is a dramatic departure from the provisions contained in the House bill, which focused on mandatory testing of newborns. That approach is both too little and too late. In addition, it is likely to prove counterproductive for achieving the goal of preventing HIV in newborns or prolonging the lives of children infected with HIV.

The participation and cooperation of parents and physicians is essential if children are to receive the care they need. Mothers must be involved in the health care system, not alienated from it. Mandatory testing programs threaten to drive women away from essential services, for fear of losing their health care or the custody of their children. This is especially true for poor women and IV drug users who are at high risk for HIV, but who are also often highly mistrustful of the health care system.

An HIV test by itself does not guarantee needed participation, and does not ensure access to care. It does not provide access to health insurance or to necessary followup treatment. It does not mean that a mother will be able or willing to follow a complex treatment schedule.

Doctors, nurses, patients, and all those on the front lines of this epidemic agree that to maximize the potential for appropriate care, the relationship between a woman and her health provider must be based on compassion, confidence, and trust.

Coercive, mandatory procedures are hostile to such a relationship and hostile to the American tradition of respect for the doctor-patient relationship.

The compromise contained in the conference report focuses on the promising strategy of offering voluntary HIV counseling, testing, and treatment to pregnant women. States are given the time and the resources to implement the CDC guidelines and to begin to save lives.

Medical professional and public health officials have expressed serious concerns about Congress withholding funds unless they implemented a program which they do not believe is in the best interest of those they serve. Under this bill, no doctor or State will be forced to implement a program of mandatory HIV testing of newborn during this reauthorization cycle.

No State will be forced to implement a mandatory testing program at all unless, first, the Secretary of HHS decides that such a program has become the standard of practice; and second,

the State is unable to achieve a significant reduction in HIV transmission from mother to child by the year 2000. This compromise allows States to keep their eyes on the goal, rather than divert their attention or resources to a strategy they believe is wrong.

If States do implement mandatory testing programs, this provision requires that States have in place protection against insurance discrimination based on HIV status or based on the fact that an individual has undergone HIV testing. This protection adds to the protection already provided under the Americans With Disabilities Act [ADA].

Under the ADA, an insurance company or an employer cannot place different requirements or restrictions on people with HIV or AIDS than they place on people with diseases of similar financial risk. This protects against insurance discrimination based on fears and myths, rather than objective actuarial and financial considerations.

The requirements in this provision add to those of the ADA, and prohibit insurance discrimination against individuals who have simply undergone HIV testing. The ADA has an important provision which protects people who are perceived to have HIV or AIDS. Many people who have undergone HIV tests, and are subsequently discriminated against, may be perceived as having HIV and are thus protected by the ADA. But this provision makes clear that such individuals may not be discriminated against in insurance, whether or not they are perceived as having HIV.

The reason for this provision is clear. As I have noted, I do not believe mandatory testing is appropriate. But if a State ultimately chooses to fulfill its obligations under this law by enacting such testing, it must also ensure that comprehensive insurance protection is in place. Congress has already ensured significant protection when we passed the ADA. These State laws or regulations will complement such protection.

Like most compromises, it is not perfect and it will not please everyone. But on balance, it is a fair one. We have sought sound policy. We have listened to those on the frontlines. And we have attempted to support their efforts, not tie their hands.

With the enactment of this conference report, Congress has put aside political, geographic, and institutional differences to face this important challenge squarely—and in all likelihood, successfully.

In these times of partisan politics and scarce resources, it is a tribute to the effectiveness of this landmark legislation that Congress voted nearly unanimously to continue this program—and to provide a \$105 million increase for this year.

This action will sustain and expand the act's lifeline. It will provide better care and support for hundreds of thousands of individuals and families caught in the epidemic's path.

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

I am pleased that the House of Representatives passed the conference report earlier this evening by a vote of 402 to 4 and I urge my colleagues to unanimously approve this critically important conference report.

Before we take final action, I would like to thank the committee staff who have worked tirelessly on this legislation and made it possible for us to reach this point. First and foremost, I would like to thank Michael Iskowitz of my staff, who was instrumental in the development of this act in 1990, and who has been indispensable throughout this reauthorization process.

I would also like to thank Seth Kilbourn who, during his detail with the Labor Committee, proved invaluable to our efforts. Finally, I would like to thank Senator KASSEBAUM and her able staff, including Kent Bradley, Jim Wade, and Marty Ross. This has been a solidly bipartisan effort and I am grateful to the chairman and her staff for their cooperation and collaboration.

I ask unanimous consent that my remarks, a summary of the legislation and of the voluntary testing compromise be printed in the RECORD.

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

RYAN WHITE AIDS CARE ACT SUMMARY

TITLE I—DISASTER RELIEF TO CITIES

Provides emergency assistance to metropolitan areas hardest hit by the AIDS epidemic. Urban areas with more than 2,000 diagnosed AIDS cases qualify for such assistance (FY91=16 cities, FY93=24 cities, FY95=42, and FY96=48 projected cities). Funds are used for outpatient health care and support services for individuals and families with HIV disease to enhance quality of life and to reduce inpatient hospitalization. Funds go to mayors who must establish an HIV Planning Council to assess need and allocate resources.

Authorizes such sums as may be necessary in FY96-00. Actual appropriations: FY91=\$87 million; FY92=\$122 million; FY93=\$184.8 million; FY94=\$325.5 million; FY95=\$356.5 million; and FY96=\$391.7 million.

TITLE II—HIV CARE GRANTS TO STATES

Provides for the development, organization, and operation of effective and cost efficient systems for the delivery of essential health care and support services to individuals and families with HIV disease in both urban and rural areas. Eligible uses of funds include:

- (1)—local consortia capable of delivering a comprehensive continuum of care;
- (2)—home health care services;
- (3)—assuring continuity of health insurance coverage; and
- (4)—paying for HIV related therapeutics.

All states must set aside not less than 15 percent of funds for the delivery of health

and support services for infants, children, women and families with HIV disease.

Authorizes such sums as may be necessary in FY96-00. Actual appropriations: FY91=\$87 million; FY92=\$108 million; FY93=\$115.3 million; FY94=\$183.9 million; FY95=\$198.1 million; and FY96=\$260.8 million.

TITLE III—EARLY INTERVENTION CATEGORICAL GRANTS

Provides early intervention services through categorical grants to public and non-profit entities including community and migrant health centers and others which deliver primary health care. Individuals who test HIV(+) receive the diagnostic and therapeutic services in order to benefit from medical advances.

Authorizes such sums as may be necessary in FY96-00. Actual appropriations: FY91=\$44 million; FY92=\$49.8 million; FY93=\$47.9 million; FY94=\$47.9 million; FY95=\$52.3 million; and FY96=\$56.9 million.

TITLE IV—CHILDREN, YOUTH, WOMEN AND FAMILIES

Provides grants to appropriate public and non-profit entities that offer primary care to coordinate the delivery of health care and support services with experimental therapies for women and children with HIV to increase access to services and clinical trials.

Authorizes such sums as may be necessary in FY96-00. Actual appropriation: FY94=\$22 million; FY95=\$26 million; and FY96=\$29 million.

HELPING TO REDUCE HIV TRANSMISSION FROM MOTHER TO CHILD

The Senate-House HIV testing compromise contained in the Ryan White conference report shifts the emphasis from mandatory testing of infants to voluntary testing of pregnant women. Focusing on voluntary testing of pregnant women rather than mandatory testing of newborns is the approach supported by medical professionals and public health officials as the most effective means of preventing perinatal transmission of HIV. The compromise contains the following provisions.

Provides \$10 million to assist states in implementing the CDC guidelines which call for voluntary HIV counseling, testing, and treatment for pregnant women. For states to access these funds, they must have adopted the CDC guidelines.

Within 4 months of enactment (Sept. 1996), the CDC, in consultation with states, must develop and implement a system for states to gather data related to perinatal transmission, to document reduction in such transmission.

The Secretary of HHS is directed to contract with the Institute of Medicine to evaluate the extent to which state efforts have been effective in reducing perinatal transmission of HIV and to analyze the existing barriers to further reduction in such transmission. Within two years of enactment (May 1998), the Secretary shall report these findings to Congress along with any recommendations made by the Institute.

After 2 years and 4 months (Sept. 1998), the Secretary of HHS will make a determination of whether mandatory HIV testing of all infants born in the US whose mothers have not undergone prenatal HIV testing has become routine practice in the provision of health care in the US. This determination will be made in consultation with states and experts.

If the Secretary determines that such mandatory testing has become routine practice, after an additional 18 month period (March 2000), a state will not continue to receive Title 2 Ryan White funding unless it can demonstrate one of the following:

- (1). A 50 percent reduction (or a comparable measure for states with less than 10

cases) in the rate of new AIDS cases resulting from perinatal transmission, comparing the most recent data to 1993 data;

(2). At least 95% of women who are received at least two prenatal visits prior to 34 weeks gestation have been testing for HIV; or

(3). A Program for mandatory testing of all newborns whose mothers have not undergone prenatal HIV testing.

Mr. JEFFORDS. Mr. President, I am proud to be an original cosponsor of the Ryan White CARE Act; I am proud to have served on the conference committee for this very vital legislation; and I am proud to be here today to speak in support of the bill's final passage. As most of us are aware, AIDS has become one of the most difficult and complicated public health threats in recent memory. For this reason, the Ryan White CARE Act is important not only for those already infected with HIV or suffering from AIDS—as a public health bill, this legislation is important for all of us.

We've said it a number of times before, but it bears repeating: AIDS is now the leading killer of men and women ages 25 to 44. AIDS has killed over 300,000 people since the beginning of the epidemic in the early 1980's—but half of those people, 154,077, have died in the past 2 years. The Centers for Disease Control estimates that nearly 1 million people are now infected with HIV, the virus that leads to AIDS. Clearly, then, AIDS is challenging our health care system in ways it has not been challenged before.

We discussed this bill at length nearly a year ago, so I want to take a few minutes to remind my colleagues of the valuable programs they will help to support today. As I've already mentioned, the bill provides health services to those already living with AIDS. It also relieves pressure from our critical care units and emergency rooms by utilizing early intervention techniques with AIDS and HIV patients.

The programs we're reauthorizing today work at the local level, and they're cost-effective—two things we've tried hard to stay focused on in this Congress. The Ryan White CARE Act funds community based organizations to provide needed outpatient care at the local level in the most cost effective and efficient ways possible for the populations that need help the most. One study even indicated that a person receiving outpatient managed care spends 8 fewer days in the hospital than a person not receiving such care—resulting in a cost savings of over \$22,000 per person.

Dollars from the CARE Act increase the availability of critical outpatient primary care services; they provide support services; and they improve the quality of life of those living with HIV. In Vermont, CARE Act money is used primarily to provide pharmaceuticals to people with HIV and AIDS who need drugs, but cannot afford them.

Successful outpatient care keeps people out of the hospital, improves their quality of life, and saves money for the

system. When early interventions and primary care are used successfully, the health care system saves untold dollars in unused emergency health services. From a purely fiscal perspective, we cannot afford not to fund these programs.

Finally, let me remind my colleagues that this is not a disease from which we can remove ourselves so easily as we might expect. Any of us who previously felt confident we could not be touched by HIV or AIDS because AIDS affects other people must now reexamine those assumptions. Soon we will all have friends whose lives have been touched by this disease. I had the honor of hosting one of my friends, David Curtis, at a Labor Committee hearing on this bill. The face of AIDS is changing, it is affecting the people I know and the people we all know.

If we and our loved ones are affected, I know we will want adequate resources to be available to help with prescription drugs, health care and support services. The Ryan White CARE Act is an assurance that help will be available. So for my friend, David Curtis and the millions of other Americans affected by HIV, I hope my colleagues will join me in supporting final passage of the Ryan White CARE Act.

Mr. DOLE. Mr. President, I ask unanimous consent that the conference report be deemed adopted, the motion to reconsider be laid upon the table, and that any statements relating to the conference report be included in the RECORD at the appropriate place.

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

The conference report was agreed to.

ORDERS FOR FRIDAY, MAY 3, 1996

Mr. DOLE. Mr. President, I ask unanimous consent that when the Senate completes its business today it stand in adjournment until the hour of 10 a.m. on Friday, May 3; further, that immediately following the prayer, the Journal of proceedings be deemed approved to date, that no resolutions come over under the rule, the call of the calendar be dispensed with, that the morning hour be deemed expired, that there be a period for the transaction of morning business until the hour of 1 p.m. with Senators to speak for up to 5 minutes each with the following Senators to speak for the designated times: Senator COVERDELL for the first 90 minutes and Senator DASCHLE for the last 90 minutes.

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

PROGRAM

Mr. DOLE. Mr. President, the Senate will have a period for morning business only tomorrow, and no rollcall votes will occur during Friday's session of the Senate.

Following morning business, the Senate will recess until 12 noon on Mon-

day, May 6th. Following morning business on Monday, I ask unanimous consent that the Senate turn to the consideration of Calendar No. 380, H.R. 2937, regarding White House Travel Office.

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

Mr. DOLE. Mr. President, for the information of all Senators, it is my hope that the Senate could dispose of the White House Travel Office bill by the close of business on Monday. I did not hear the debate between the Senator from Arkansas and the Senator from Iowa, but, hopefully, if there are problems, we can work those problems out. We hope there are not any nongermane amendments. We will see what happens. Perhaps we could find that out before or maybe on Monday because I may fill up what we call the amendment tree—I prefer not to do that—in order to keep the Senate germane to the pending issue.

There will be no rollcall votes during Monday's session of the Senate, and the Senate may be asked to consider any other legislative matters that may be cleared for action.

I know there are a number of nominations on the calendar. I have never been one to try to hold up nominations, but I would just say to the White House they have had nominations—Republican nominees have been down there for 6 to 8 months—that have not been sent to the appropriate committees. It seems to me there ought to be some reciprocity here. If they continue at the White House to say, "We are not going to send Republican nominees out," we do not find it very difficult to say, "Why should we clear nominations the White House wants?"—whether judicial nominations or any others.

So I hope we could have some understanding because I have never been one, regardless of who is in the White House, to try to hold up nominations. These nominees have families and obligations but so do the families we have sent down months and months and months ago. They are still waiting for some word from the White House. They cannot have it both ways.

I also hope that we could still work out some agreement—we made a tentative suggestion to our colleagues on the other side with reference to the minimum wage. I will ask Senator LOTT to try to meet again early next week with Senator DASCHLE or his designee to see if we can work out some time to take up that matter, either as a part of something else, which I will not speculate what it might be, or have separate votes, parallel votes on our proposal and a Democratic proposal, because we would like to proceed with the legislation and not have nongermane amendments at every turn. It took us 8 days to complete an immigration bill that probably should have taken 3 days, and I hope that we can catch up. We need to catch up so we can hopefully enjoy a recess or a few days off the end of this month. We have