

The inspector general, who is about as independent as you can be within the Federal branch—has been looking into the FBI laboratory. We have these inspector generals in a variety of departments. My legislation brought the inspector general to the CIA, the only reform legislation coming out of the Iran-Contra affair. Inspectors general are not perfect because it is hard to be totally independent. But to the extent you can have independence, the IGs are independent. They report directly to Congress. They are as good a mechanism as you can have for that sort of an investigation, unless you have congressional oversight. There ought to be more of that.

But, at any rate, Director Freeh did what was possible by recusing himself and referring the matter to the inspector general, who brought in five independent scientists. He has been out of the case, and he is prepared to make whatever changes are necessary within the FBI laboratory.

The FBI is currently conducting a very sensitive investigation on campaign irregularities, which may go to the highest levels of Government. Not a great deal can be said about that investigation at this time. But from what I have observed Director Freeh has been independent, has been forthright, and has done his job in a professional way. In that kind of an investigation there are inevitable pressures, either express or implicit. I have some familiarity with what the Bureau is doing and what the Director is doing. I have confidence in him. I do so with some understanding of investigative work on grand juries and criminal matters and the kind of sensitivity which is involved. There are matters on which I consult with him with some frequency in terms of oversight.

As of this moment, I am not yet satisfied with what has been done on Ruby Ridge. The Department of Justice has conducted an investigation on a number of the FBI agents, one of whom was the former Deputy Director, Larry Potts. It may well be as I said, in those hearings, that Director Freeh did not exercise the best judgment with respect to Deputy Director Potts. But at the same time I have said publicly that Deputy Director Potts and others are entitled to have the matter resolved, and that the Department of Justice has been investigating that since the fall of 1995—some 18-month lapse—which is unwarranted. I know that case thoroughly because of the hearings we had. I know investigative practice. That matter should have been concluded. That is not a matter under Director Freeh's purview. It is in the Department of Justice.

I recently wrote to the Attorney General complaining about the delays and got an unresponsive response saying that the investigation will take several more months due to the complicated nature of this matter. It is not all that complicated. We have the Atlanta pipe bomber case where I have

been trying to get an oversight hearing since October-November. I am not delighted with what the FBI has done on that in terms of not being as responsive as I think they might be. They have internal investigations which are really very difficult and which delay congressional oversight. But overall my view is that Director Freeh has done a good job. And when you pick up some of these matters on the FBI laboratory, I think he has provided appropriate management and appropriate oversight.

Mr. President, I think my time has probably lapsed. But in the absence of any other Senator on the floor, I ask unanimous consent for an additional 10 minutes to proceed as if in morning business.

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

The Senator from Pennsylvania is recognized.

Mr. SPECTER. I thank the Chair.

#### HEALTHY CHILDREN'S PILOT PROGRAM ACT OF 1997

Mr. SPECTER. Mr. President, today I am introducing legislation directed at providing health coverage to children who lack health insurance in America.

This issue has been recognized as one of the leading—if not the leading—problems on incremental health coverage in America today. I am glad that President Clinton's health care plan proposed in 1993 was not adopted. That was a matter that was fought out on the Senate floor in some great detail in 1994. I participated in that debate. When I read President Clinton's health plan, I was amazed by the number of agencies, boards, and commissions, and asked an assistant to make a list of all of them. My assistant made a chart instead of a list. I had that chart on this floor and many other places, and I shall spare you the chart today. Bob Woodward of the Washington Post said that chart was the key factor in defeating the Clinton health care plan because it showed on one page in red more than 100 new agencies, boards, and commissions, and in green about 50 existing bureaus giving new jobs. Then we proceeded, I think wisely, with the Kassebaum-Kennedy bill on incremental health coverage. Now I think we need to go ahead and provide for coverage for children in America.

Very briefly, let me summarize my proposal before going into specifics. It is said that there are 10 million children who lack health insurance. My analysis shows that there is a critical group, perhaps the most critical group, of some 4 million children which my bill addresses in an incremental way; 3 million other children are eligible for Medicaid coverage but not enrolled, and 3 million other children are in families which would not be eligible for health insurance under my plan because their family income levels are too high. My legislation will provide a pilot program which would provide

vouchers to States for families which earn up to 235 percent of the poverty level to purchase health insurance in the marketplace.

Later today I am going to have a news conference with the Brandt family from Pennsylvania, because they are illustrative of this issue. I would now like to discuss the key elements of my proposal and why I have asked the Brandts to travel to Washington today.

Mr. President, it is no less true for being a commonplace that nothing could be more important to our Nation than our children. I am introducing today legislation aimed at beginning to fill an enormous and unacceptable gap in our country's support for the health and well-being of our children.

Mr. President, as President Clinton discussed during the State of the Union Address last month, there are today approximately 10 million American children who have no health insurance coverage from any source—private or public—and who therefore lack access to the kinds of preventive and primary care services which can be the difference between staying healthy and getting sick or between minor illness and serious, disabling or even mortal illness.

Now, let me say at the outset that this is not a Republican or Democrat issue. Our two parties do have different approaches to the roles and the cost of our Federal Government but there is not one party that cares about kids and one party indifferent to our children's health. Let us work constructively on this and actually address the problem rather than just trying to wrack up political points.

As with most statistics conjured up for social policy debates, the President's figure of 10 million uninsured children needs further discussion to get to the heart of the matter. Of these 10 million uninsured, approximately 3 million children live in families with incomes which make them eligible for Medicaid. I support outreach efforts by the States to enroll these children in Medicaid but, because coverage is accessible to these families if they avail themselves of it, this problem is not the gaping hole in our health care system of which I spoke a moment ago.

Likewise, of the 10 million uninsured children, another approximately 3 million live in families with incomes greater than the median household income. There are even uninsured children in more than a few high income families.

Those numbers are deeply disturbing, but I see them as a clarion call for greater parental responsibility, rather than for legislative or governmental action. I know it is easy for those of us with substantial incomes and employer-paid health benefits—such as we here in the Senate—to preach to families without these protections, but I cannot imagine any higher priority for a family with any more than just enough income to keep food on the table and a roof over their heads than

to provide health insurance for their kids. And I see it as clearly inappropriate—despite some proposals on the other side of the aisle to do so—to spend tax dollars to subsidize health insurance for higher income families. The cutoff level I propose in this bill, approximately \$38,000 for a family of four is already a bit higher than median household income in the United States—\$34,076—\$34,524 in my own State of Pennsylvania. In other words, taken together, Medicaid and the new initiative I am proposing would allow eligibility by income for more than half of the households in our country. To go beyond that is to do what too many Government programs already do—tax those who have less for the benefit of those who have more, Robin Hood in reverse.

This leaves approximately 4 million children, ineligible for Medicaid but living in families without the resources to obtain coverage on their own. This is an American tragedy—the tragedy of the working poor. Mom, Dad, or both going to work every day, often more than 5 days per week, but being paid low wages, without health benefits. These are honest taxpaying citizens, but their kids' futures are in jeopardy. They are falling through a crack in our health care system which must be sealed off.

Some States, including my own State of Pennsylvania, are attempting to address this problem. In Pennsylvania, a public/private partnership, combining a publicly funded program called BlueCHIP, the Children's Health Insurance Program, on which Governor Ridge will spend \$39 million this year, and a private initiative called the Caring Program for Children are reaching 60,000 out of the estimated 300,000 uninsured Pennsylvania children who are not eligible for Medicaid.

But, as this statistic indicates, even generous State and private resources are wholly inadequate to meet the need. And this need, this hole in our health care system, is not a statistic. It is real.

I would like to speak to you today about some Pennsylvanians whose stories demonstrate both the real need for action on the matter of uninsured children and the effectiveness of a program, such as the one I am proposing today, in helping real people face life's storms. These good people have been helped by Pennsylvania's existing efforts to provide health coverage to children and their story is the best argument which can be made for a national effort to solve this problem.

Here with me today is the Brandt family, from Tarentum, PA, in Allegheny County: mother, Scarlett; father, Richard; daughter, Lindsay, age 11; and son Chad, age 7.

First, I would like to thank the Brandts very deeply for their willingness to be here today, not only because it involves a precious day off from work for both Scarlett and Richard, a day out of school for both Lindsay and

Chad and a long car ride to Washington and back, but even more so because it involves a family decision to put pride aside and to be willing to face the press as symbols for a policy debate. This is not an easy position for people to put themselves in—and even less so their children—but the Brandts believe in the need to tell America about this too long ignored problem of uninsured children and about the way life brightens with just a little help to fill this basic need. I am very grateful to them for putting their desire to help others ahead of their own privacy.

Scarlett and Richard both have full time jobs; Scarlett is a hairdresser and Richard is a truck driver. But neither of their employers offer health benefits and this hard working, taxpaying family simply doesn't earn enough money to go out and purchase private health insurance on their own. Before the Pennsylvania programs began helping the Brandts in 1993, Lindsay had lived the first 7 years of her life without any health insurance coverage and her little brother Chad had gone without coverage from birth until he was 3 years old.

Here, then, are counter examples for the think tank commentators who argue against Federal action on children's health insurance by pointing to examples of children who are only uninsured for transitional periods of months as their parents change jobs. Here, in Lindsay and Chad, are examples of the heart of this problem—the long-term uninsured children of the working poor.

How did Scarlett and Richard make due without health insurance for their kids? They scrounged what services they could from community health clinics and they used emergency rooms in ways that, when multiplied by all those who act similarly, damage and drain our entire health care system. They also restricted the activities of their children—and recent studies indicate this is a common coping strategy for parents in their shoes—cracking down on sports and even bike riding to try to avoid injuries. When Chad became ill as a toddler, with recurring ear infections, the family had to rotate payments to their creditors—some months skipping a utility bill, some months cutting back on groceries—just to be able to afford the prescription medicines for their little boy.

Even with all of these ways of dealing with their situation, the Brandts lived every day under a cloud of fear about their children's health and their family's future and Lindsay and Chad lived with unmet health care needs—for physician care, for vision care, and for dental care.

In 1993 the Brandt family got help from the programs operated by Western Pennsylvania's Caring Foundation for Children. It turned out that this assistance proved even more necessary than they knew at the time.

In April 1996, Lindsay Brandt was diagnosed with hemiplegic migraines.

This condition causes stroke-like symptoms. When an incident occurs, Lindsay suffers paralysis on the side of her body opposite from the headache, her speech slurs, her vision is blurred, and she becomes confused. Although she has needed five ambulance trips to the hospital since developing this condition, Lindsay is now on medication to prevent further episodes.

Obviously, all of this care has been expensive. Obviously, the sort of problem the Brandts feared in their uninsured years came to pass. It might well have destroyed this family had it happened before they got health insurance coverage for their kids. Thank God, it did not.

The legislation I am introducing today is a measured response to this major problem. We must react with both compassion and consideration.

Here is my proposal:

A 5-year pilot program funded with discretionary dollars—rather than a permanent entitlement—to provide block grants to the States in support of health insurance for uninsured children who are not eligible for Medicaid or for employer-based private health insurance and whose families have incomes up to 235 percent of the poverty level, \$37,718 for a family of four.

States which are already providing health insurance coverage to children eligible under this bill, such as under their own Medicaid plans, would be required to maintain their efforts but would, in effect, receive credit from the Federal Government in the form of dollars equal to the costs of the coverage they are providing to children in families up to the bill's cutoff level of 235 percent of poverty.

My bill would offer full vouchers, with the level determined by the Secretary of HHS based on costs for an insurance policy covering preventive, primary, and acute care services for a child, for families earning up to approximately \$29,700 per year for a family of four and partial subsidies from that income level until phased out at approximately \$38,000 for a family of four.

By limiting eligibility to children who do not have access to employer-based private health insurance, we avoid creating a disincentive to private coverage. We should all applaud the employers who are covering their employees, including lower wage employees, with family health insurance. Indeed, there are approximately 10 million American children in families earning between the poverty line and 235 percent of poverty who do receive private health insurance coverage, compared to the 4 million who do not. This is another example of the overall effectiveness of our market-based health care system even as it is also the most striking example of a particular case of market failure.

By making this a 5-year pilot program, we admit the complexity of the health care system and the task of health care reform. This approach,

with block grants and vouchers, may well prove to be the best way to cover kids who need health insurance, but we all know about the unintended consequences of social policy initiatives and we all know how hard it is to reform an entitlement, even if it has truly perverse effects, and so I am proposing a 5-year demonstration of this approach in the appropriately humble spirit of "trial and correction" which I have many times before said on this floor should inform our entire project of health reform.

By making this program subject to appropriations, we ensure that we undertake this important effort in a fiscally responsible manner.

Specifically, to provide sufficient funds to properly test this approach to children's health coverage in a way that does not bust the budget, my bill establishes the "Healthy Kids Trust Fund," on budget, funded through the sale of available broadcast and non-broadcast spectrum assets. I am not wedded to this offset but offer it to make clear my intention to see this program paid for with hard dollars, not confederate money.

Furthermore, my proposal provides that:

The first year of the program, fiscal year 1998, would be devoted to HHS and State planning, with the new insurance coverage commencing on or about October 1, 1998.

Coverage would be phased in, beginning with children 0-5 years old in fiscal year 1999 and expanding in subsequent years to cover children 6-9, 10-12, and 13-17.

In the 104th Congress, I was pleased to cosponsor the Health Insurance Portability and Accountability Act of 1996, better known as the Kassebaum-Kennedy bill (S. 1028). There is no question that Kassebaum-Kennedy made significant steps forward in addressing troubling issues in health care. The bill's incremental approach to health care reform is what allowed it to generate consensus support in the Senate; we knew that it did not address every single problem in the health care delivery system, but it would make life better for millions of American men, women, and children.

In retrospect, I urge my colleagues to note a most important fact—the Kassebaum-Kennedy bill was enacted only after some Democrats abandoned their hopes for passing a nationalized, big government health care scheme, and some Republicans abandoned their position that access to health care is really not a major problem in the United States demanding Federal action.

Although we succeeded in enacting incremental insurance market reforms, there is still much we need to do to improve our health care system. Additional reforms must be enacted if we are serious about our commitment to meet the needs of the American people. I am hopeful that my colleagues understand how important it is to our constituents that we continue to reform

the health care system. Just look at the Brandt children and multiply their need by millions. Looking back at our success with the Kassebaum-Kennedy bill, I am equally hopeful that my colleagues have come to realize that if we are to continue to be successful in meeting our constituents' needs, the solutions to our Nation's health care problems must come from the political center, not from the extremes.

Mr. President, I hope the legislation I am introducing today can be the basis for taking this next, crucial step in our process of bipartisan, incremental health reform. My proposal seeks to achieve incremental expansion of health care through a conservative means—a fully funded program with carefully crafted eligibility rules for a limited period of time, a program based on State administration and personal choice and responsibility. Let us take this step. Let us make this test. Let us see to it that the anguish and Russian roulette endured by all those situated similarly to the Brandt family are stopped and millions more of our Nation's greatest assets are given a basic ingredient for decent and productive lives.

Mr. President, how much time do I have remaining on the additional time which I sought independent of Senator DOMENICI's time?

The PRESIDING OFFICER. The Senator has 7 minutes and 10 seconds remaining. The Senator from New Mexico has 39 minutes remaining in regard to the previous order.

Mr. SPECTER. I thank the Chair.

#### MAMMOGRAMS

Mr. SPECTER. Mr. President, the final subject I wish to address briefly involves the problem of mammograms for women age 40 to 49.

Mr. President, this subject came into sharp focus when a National Institutes of Health panel on January 23 issued a report that mammograms were not warranted for women in the 40 to 49 category. That was immediately met with very widespread criticism, including criticism from Dr. Richard Klausner, the Director of the National Cancer Institute, who said that he was shocked by that conclusion. As the facts later developed, a press release was inadvertently disclosed. Some of the members of the panel had held that mammograms were not warranted. But, as I understand it, that had not been thoroughly analyzed and agreed upon by the panel. But once this press release came out they stood by the release. And there has been enormous confusion in America on this issue of women 40 to 49.

The subcommittee, which I chair and which has jurisdiction over the Department of Health and Human Services, had a hearing on February 5 at which Dr. Klausner restated his shock about the matter. He thought that the advantages of mammograms for women 40 to 49 had not been appropriately empha-

sized, and the disadvantages had been emphasized too heavily. He also said that he was going to await a meeting of the National Cancer Institute later in February—on February 24 and 25. It was my understanding that the matter would be resolved at that time. But, in fact, it was not.

When the Secretary of Health and Human Services testified before our subcommittee on March 4 she said that there would be a 2-month delay, which I said in those hearings was unacceptable. I have since pressed Dr. Klausner as to why there would be such a delay.

I wrote to him on March 5, 1997. I ask unanimous consent that the text of that letter be printed in the RECORD following my statement.

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

(See exhibit 1.)

Mr. SPECTER. Mr. President, when I was dissatisfied with his response, I wrote to Dr. Harold Varmus, Director of the National Institutes of Health, the overall supervisor, on March 6, 1997 asking that there be some acceleration of this determination because no further tests were necessary but only a judgment was needed. What I found was that the matter was being referred to a 7-person subcommittee which was going to deliberate on the issue and then take it up by an 18-person full committee.

I ask unanimous consent that my letter to Dr. Varmus and a subsequent letter to Dr. Klausner be included in the RECORD following my statement.

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

(See exhibit 2.)

Mr. SPECTER. I am concerned that the delays in mammograms could constitute a health hazard for women 40 to 49. And, beyond that, that there is much confusion in America on that subject. The upshot of it has been that there now appears that the subcommittee will render its report to the full committee on this Friday, and there will be a final report rendered next Tuesday which will eliminate the need for accelerated hearings in our subcommittee to try to come to a conclusion on this important matter.

I emphasize that I appreciate the need for an independent medical judgment on this important subject.

It seems to me that where all the tests have been performed and it is a matter of issuing guidelines, coming to closure and judgment on this should not require such a lengthy period of time. I believe that there is not a sufficient sense of urgency generally, and in Government specifically, as this issue has been addressed. My views are expressed more fully in these letters, and I shall not take a greater period of time to elaborate upon them here.

In coming to my own judgment that mammograms are warranted for women 40 to 49, the subcommittee held hearings in Pittsburgh, in Hershey, and in Philadelphia, where we heard from a long array of witnesses. A report has