geographical areas, and in some cases lack of transportation to those services.

Behaviors, and the need to accept individual responsibility for one's health has often been cited as an important determinant, but the investigation done by the Commission clearly shows that although behaviors such as smoking, diet, alcohol, and others can be correlated to poor health status, they only account for a modest portion of health disparities which exist across age, sex and race and ethnic categories.

What is often not taken into account is the social and economic environment in which personal choice is limited by opportunities. I am referring to issues such as low income, the unavailability of nutritious foods, and lack of knowledge about healthy behaviors.

So while we help those most affected to understand more about healthy behaviors and make the appropriate lifestyle changes, it is the work of this Congress to improve the educational and housing environment, and to bring the economic growth being experienced by most of America to our more rural and ethnic communities.

What are some of the other changes that the Commission recommends be implemented to meet this important challenge? Not surprisingly they go to the heart of the congressional black caucus initiative.

One of the disparities the Commission found is that although there is an effort to eliminate racial and ethnic health disparities, I quote—there has not been any systematic effort by the steering committee at the Department of Health and Human Services or Office of Civil Rights to monitor or report on the Department's progress.

This is precisely what the funding of the offices of minority health within the agencies would address. It would give these offices a line item budget, and build into the system a process whereby minority interests and expertise would be brought to bear in decision and policy making within the Department.

The Commission stated in its transmittal letter to the President and leaders of Congress that the offices of women and minority health throughout HHS should take a more proactive role in the incorporation of these populations' health issues in HHS. Treated as peripheral, these offices are forced to operate under the constraints of extremely limited budgets. HHS must recognize the potential impact of these offices and increase funding accordingly.

This we feel is critical to creating the internal changes and departmental culture that is necessary to effect the change which must be achieved in the health of people of color.

The report cites the importance of physician diversity and cultural competence in the delivery of health services. It found that within the context of patient care it is necessary to open up medical knowledge to include multicultural and gender perspectives to health, health care, and patient-provider interaction. It further states that a major finding of their research is that clearly more minorities are needed as health care professionals.

The current appropriations committee report indicates a reduction in funding below the President's request for programs that would make this happen. These funds need to be reinstated and I ask the House's support in doing so.

The Commission also stated that their research indicated that minorities and women—particularly minority and poor women—have been excluded from clinical trials for decades.

Again in their transmittal letter the Commission states: another focus of the Office of Secretary, OCR and minority health should be the lack of medical research by and about minorities. HHS must take the lead in enforcing the mandated inclusion of females and minorities in health related research both as participants in and recipients of Federal funds for research.

The CBC, under the leadership of Jesse Jackson, Jr., is supporting the creation of a center of disparity health research which would elevate the current Office of Minority Health to center status.

This is an important measure to achieving diversity which is important in both research and researchers.

Lastly, the CBC initiative is about making resources available to our communities so that they themselves can be the agents of the necessary change and improvement in our health status.

The Commission states that "to be effective in reducing disparities and improving conditions for women and people of color, they must be implemented at the community level, particularly in conjunction with community based organizations.

THE NORWOOD-DINGELL BILL OFFERS REAL HMO REFORM

The SPEAKER pro tempore (Mr. COOKSEY). Under the Speaker's announced policy of January 6, 1999, the gentleman from New Jersey (Mr. PALLONE) is recognized for 30 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, I yield to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

THE HIV-AIDS CRISIS IN THE AFRICAN-AMERICAN COMMUNITY

Mrs. CHRISTENSEN. Mr. Speaker, I really appreciate the gentleman's generosity.

Mr. Speaker, I yield to the gentlewoman from Texas, Ms. EDDIE BERNICE JOHNSON.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I thank the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) and the gentleman from New Jersey (Mr. PALLONE) for yielding.

Mr. Speaker, I join the Members here representing the Black Caucus, and I plead for more attention and funding to be given for prevention and treatment of the HIV virus and the AIDS disease.

Mr. Speaker, somehow I think that back in 1980, 1981, and 1982, when many of the leaders from the gay community were speaking out against this virus, that much of the other parts of the community simply ignored it because they thought it was just a disease of the gay and lesbian population.

Even at that time, I knew a virus did not know the sexual practices of people, and I felt it was a communicable disease that had the capacity of infecting almost anyone. That has proven to be true. Back in 1980 and 1981, when we were having meetings at home, I was getting warnings that it was dangerous to be talking about this kind of virus that is affecting just the gay community.

We now find that is not the case. It is a communicable disease that will affect all persons that are subjected or exposed to this virus in the workplace, in the health facilities, anywhere that persons can be exposed to this virus.

Mr. Speaker, we now plead for this money to follow where it is. We know that we have had reductions, and we are always pleased about having reductions in any kind of communicable disease. We have seen almost a wipe-out of diphtheria and all the various viruses and bacterial communicable diseases we have had in the past. Hopefully we will speak of this disease as one of the past, but we cannot ignore the education that must taken to prevent this devastating virus.

With our young people and our youth groups, they must understand what causes the exposure and how to prevent that exposure. Far too many people are dying of AIDS. Even though it is much less than what it was some years ago, any death from this virus is too many, because it means that someone has ignored or not known what exposes them to this deadly virus.

People are living longer, which is costing more for care, and we are always pleased to have good results, but nothing surpasses preventing diseases of this sort. For that reason, I hope we would give real attention to educating especially our younger people.

We are finding that our older women in heterosexual relationships have an increase in the incidence of the HIV-AIDs virus because of loneliness, all kinds of other activities that would lead them to be exposed to this virus. That must be given attention. No matter what the profile of the individual might be or might seem to be, caution is advised.

We have gone a long way in attempting to keep people alive with the various drugs that are very, very costly, and causing them to live longer lives. But nothing yet has come along for us to see the real end to this deadly virus. The best thing we can do is prevent it. We find that the persons who are the most sometimes uneducated are the ones who least believe that they can be exposed to this virus, and they are the ones who are becoming more exposed all the time. No one, absolutely no one, is safe when they take part in any activity that exposes them to this virus, no matter what.

I am eternally grateful for the leaders in the gay community for continuing to talk about this virus, and not allowing the rest of us to forget it just because they had a larger incidence. That incidence has gone down tremendously in that community, but the leadership continues almost to come from the concentration of their community.

I am grateful for them continuing to bring forth the leadership in educating the people, but there is an element

missing. When people think it is only in the gay community, they simply think they are over and above this exposure. This is the myth we must break down. This is a virus that absolutely anyone can be exposed to. It only takes one exposure, so the education must go forth in all communities, young and old, heterosexual or not. We must not stop educating, because that is the only thing that is going to prevent this virus. It is costly, the treatment is very costly, the suffering is costly. We must really focus on prevention and not just paying for the illness.

I want to thank the leadership of the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN). As an M.D., she is fully aware of all of the factors involved, and I appreciate the leadership that she has brought forth.

Mrs. CHRISTENSEN. I thank the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON). I want to thank her for her leadership as a health care professional, as well as Vice-Chair of the caucus.

Mr. Speaker, I yield to the gentleman from New Jersey (Mr. PAYNE).

Mr. PAYNE. Mr. Speaker, first of all, let me thank the gentleman from New Jersey (Mr. PALLONE) for yielding.

I commend the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) for her perseverance, and the persistence and leadership she has shown by being a physician, and we are so happy to have her.

But I also would like to add that we are in good company, because the Speaker pro tempore tonight is also a person who has done work on river blindness, and has donated his time and effort and resources to try to help people who are much worse off in another part of the world. I commend him for his work.

Mr. Speaker, we are in a crisis. The issue of HIV and AIDS in this country is one of the most serious problems we must grapple with. Since the AIDS epidemic began in 1981, more than 640,000 Americans have been diagnosed with the disease, and more than 385,000 men, women, and children have lost their lives.

I have been at the forefront of fighting against AIDS since the 1980s, when it was not quite as acceptable to talk in public about this dread disease. In 1989, when I was first elected to Congress, I called a congressional hearing in my district of Newark, New Jersey, to sound the alarm on the epidemic that everyone was ignoring.

In 1991, I introduced the abandoned infants bill, which was approved in the House. This was a bill to protect abandoned infants, some of whom were infected with HIV virus, and for other programs to assist them. I was outraged at the lack of attention being paid to this disease, a disease that was and still is killing people every day in every community.

This past reluctance to address the problem that was staring us in the face is one reason why we have such a grave situation today. While we have advanced in that respect, we cannot rest on our laurels because the problem still exists and it is growing stronger with every passing day, especially with regard to people of color.

For example, African-Americans make up only 12 percent of the population, but account for 45 percent of all reported HIV–AIDS cases. African-American women account for 56 percent of women living with HIV–AIDS, and to me, the most sobering statistic, African-American children account for 58 percent of children living with the disease.

The bottom line, Mr. Speaker, is that we are dying, and something must be done. The Clinton administration has worked with the Congressional Black Caucus to address the disproportionate burden of AIDS in racial minorities by funding money to those communities most affected. Together, we fought a hard battle with the majority party to secure an additional $156 million on targeted initiatives to address racial and ethnic minorities. A local Newark group fighting against AIDS with drama is Special Audiences, which recently received one of these grants.

This increase in funding is a good start, but it is simply not enough. Right now AIDS is the leading cause of death of African-American males between the ages of 25 and 44, the leading cause of death. This is unacceptable. Our young black men represent our future, and this terrible disease is killing them off.

In order to address the AIDS issue effectively, we need to tackle the problem at all levels. First, we need to increase awareness of the disease. The difference in response from my first hearing on AIDS to this forum tonight is like the difference between night and day. The awareness of the disease has increased dramatically, and that is a good indication that people want to be helped.

Secondly, we have to educate people on the dangers of this disease. This means everyone. AIDS is a killer that affects every segment of our population and every age group, from children to elderly adults. Without properly educating people, we will find ourselves in a much worse situation down the road than we are today.

Finally, we must encourage better treatment and health care for those who have the disease. The disproportionate number of AIDS cases in the African-American population is not due to the lack of medical technology or advancements. Rather, it points to the limitations that African-Americans face in access to health care. The medicines and treatments are out there. They are effective, but we do not have access to them. That is wrong.

Let me conclude by saying there is a common bond between all of these strategies. They are all contingent on increasing the Federal funding, and ensuring that these funds are targeted to the population that needs it the most.

Our struggle against AIDS and the AIDS epidemic is far from over. Our efforts now are extremely important to the future of each and every citizen of the country. Every concerned individual needs to take an active role in the fight against AIDS. We must wake up, and we must make a concerted effort at both the Federal and grassroots level if we are truly determined to defeat the AIDS crisis.

Mr. PALLONE. Mr. Speaker, I wanted to spend some time tonight, because this is the week when managed care reform, HMO reform, will come to the floor for the first time. I just wanted to spend about 15 or 20 minutes talking about why the Patients' Bill of Rights, the bipartisan Norwood-Dingell bill, is the right measure, and why every effort that may be made by the Republican leadership over the next few days to try to stop the Norwood-Dingell bipartisan bill, either by substituting some other kind of HMO so-called reform or by attaching other amendments or poison pills that are unrelated and sort of mess up, if you will, the clean HMO reform that is necessary, why those things should not be passed, and why we should simply pass the Norwood-Dingell bill by the end of this week.

I do not want to take away from the fact that the Republican leadership has finally allowed this legislation to come to the floor, but I am very afraid that the Committee on Rules will report out a procedure that will make it very difficult for the bill to finally pass without having poison pill or other damaging amendments added that ultimately will make it difficult for the Patients' Bill of Rights to move to the Senate, to move to conference between the two Houses, and ultimately be signed by the President.

A word of warning to the Republican leadership. This is a bill, the Norwood-Dingell bill, the Patients' Bill of Rights, that almost every American supports overwhelmingly. It is at the top of any priority list for what this Congress and this House of Representatives should be doing in this session. I think it would be a tragedy if the Republican leadership persists and continues to persist in its efforts to try to stall this bill, damage this bill, and make it so this bill does not ultimately become law.

□ 2130

I just want to say very briefly, Mr. Speaker, because I have mentioned it so many other times on the floor of the House of Representatives, the reason the Patients' Bill of Rights is a good bill and such an important bill basically can be summed up in two points; and that is that the American people are sick and tired of the fact that when they have an HMO, too many times decisions about what kind of medical care they will get is a decision that is made by the insurance company, by the HMO, and not the physician and not the patient. That is point number one.

Point number two is that if an HMO denies a particular operation, a particular length of stay in the hospital, or some other care that a patient or physician feels is necessary, then that patient should be able to take an appeal to an independent outside review board that is not controlled by the HMO and, ultimately, to the courts if the patient does not have sufficient redress. Right now, under the current Federal law, that is not possible because most of the HMOs define what is medically necessary, what kind of care an individual will receive themselves. And if an individual wants to take an appeal, they limit that appeal to an internal review that is basically controlled by the HMO itself.

So the individual cannot sue. If an individual is denied the proper care, they cannot take it to a higher court, to a court of law, because under the Federal law, ERISA preempts the State law and makes it impossible to go to court if an individual's employer is in a self-insured plan, which covers about 50 percent of Americans, who get their health insurance through their employer, who is self-insured, and those people cannot sue in a court of law.

We want to change that. The bipartisan Norwood-Dingell bill would change that. It would say that medical decisions, what kind of care an individual gets has to be made by the physician and the patient, not by the HMO. The definition of what is medically necessary is essentially decided by the physicians, the health care professionals.

And, secondly, if an individual is denied care that that individual and their physician thinks they need, under the Patients' Bill of Rights, the bipartisan bill, what happens is that that patient has the right to an external review by an independent review board not controlled by the HMO. And, failing that, they can go to court and can sue in a court of law.

Now, those are the basic reasons this is a good bill. There are a lot of other reasons. We provide for emergency services, we provide access to specialty care, we provide protection for women and children. There are a lot of other specific provisions that I could talk about, but I think there is an overwhelming consensus that this is a good bill. This is a bill that almost every Democrat will support and enough Republicans on the other side of the aisle will join us against their own Republican leadership in support of this bill.

But there have been a lot of falsehoods being spread by the insurance industry over the last few days and the last few weeks and will continue until Wednesday and Thursday when this bill comes to the floor, and I wanted to address two of them because I think they are particularly damaging if people believe them. And they are simply not true.

One is the suggestion that the patient protection legislation, the Norwood-Dingell bill, would cause health care premiums to skyrocket. That is simply not true. If we look at last week's Washington Post, September 28, there was an article that surveyed HMO members in Texas, where there is a very good patient protection law that has been in place for the last 2 years. That survey showed dramatically that in Texas they could not find one example where the Texas patient protection law forced Texas HMOs to raise their premiums or provide unneeded and expensive medical services. The Texas law, which has been on the books for 2 years, shows that costs do not go up because good patient protections are provided.

In addition, we are told by the insurance companies that costs are going to go up because there will be a lot more suits and that will cost people more money and their premiums will have to go up. Well, the 2-year Texas law that allows HMOs to be sued for their negligent medical decisions has prompted almost no litigation. Only five lawsuits out of the four million Texans in HMOs in the last 2 years, five lawsuits, which is really negligible.

It is really interesting to see the arguments that the insurance companies use. The other one they are using, and they are trying to tell every Member of Congress not to vote for the Patients' Bill of Rights, not to vote for the Norwood-Dingell legislation, is this myth that employers would be subject to lawsuits simply because they offer health benefits to their employees under ERISA. What they are saying is, if we let the patient protection bill pass, employers will be sued and they will drop health insurance for their employees because they do not want to be sued.

Well, that is simply not true. Senior attorneys in the employee benefits department in the health law department at some of the major law firms, and I will cite a particular one here from Gardener, Carton and Douglas, which basically did a legal analysis of the Norwood-Dingell bill, claim that this is simply not correct. Section 302 of the Norwood-Dingell bill specifically precludes any cause of action against an employer or other plan sponsor unless the employer or plan sponsor exercises discretionary authority to make a decision on a claim for covered benefits that results in personal injury or wrongful death.

So the other HMO myth is that an employer's decision to provide health insurance for employees would be considered an exercise of discretionary authority. Well, again, that is simply not true. The Norwood-Dingell bill explicitly excludes from being construed as the exercise of discretionary authority decisions to, one, include or exclude from the health plan any specific benefit; two, any decision to provide extracontractual benefits; and, three, any decision not to consider the provisions of a benefit while internal or external review is being conducted.

What this means is that we precluded all these employer suits. The employer basically cannot be sued under the Norwood-Dingell bill. And I would defy anyone to say that that is the case, that an employer can be sued effectively.

I wanted to mention one last thing about the poison pills, and then I would like to yield to the gentlewoman from Texas, because she is representing the State of Texas. And she knows firsthand how this law has worked so effectively in her home State of Texas, and this is a law I use over and over again as an example of why we need the Federal laws. So I would like to hear her speak on the subject.

Let me just say, though, that the other thing that we are going to see over the next few days here in the House is an effort by the Republican leadership to load down the Patients' Bill of Rights, the Norwood-Dingell bill, with what I call poison pills. I say they are poison because they do not really believe that these are good things. But they think if they pass them and add them to the Patients' Bill of Rights that, ultimately, that will defeat the bill. They cannot defeat the bill on its merits because they know that that will not work, so they try to add some poison pills.

Basically, what they are trying to do, and this is the same stuff we have had in previous years, a few days ago the GOP leadership announced its intention to consider a number of provisions it claims will expand access to health insurance along with managed care. Again, this is a ruse. There is no effort here to really expand access for the uninsured. It is just that they have no other way to counter the growing momentum behind the Norwood-Dingell bill. But based on the statement released by the gentleman from Illinois (Mr. HASTERT), the Speaker of the House, we can expect to see the following poison pills: The worst of them are: Medical Savings Accounts, Associated Health Plans, or MEWAs, and Health Marts.

All three of these measures would fragment the health care market by dividing the healthy from the sick. This fragmentation will drive up costs in the traditional market, making it more difficult for those most in need of health insurance to get it. As a result, these measures would exacerbate the problem of making insurance accessible to more people.

And that is not all they do. MSAs take money out of the treasury that could be used more effectively to increase access to health insurance through tax benefits. The Health Marts and the MEWAs would weaken patient protections by exempting even more people from State consumer protection and benefit laws.

There is no doubt about what is going on here with the Republican leadership. The opponents of the Norwood-Dingell bill are cloaking their fear of the bill's strength in a transparent costume. They are trying to add these poison pills to kill the bill. We should not

allow it, and I do not think my colleagues will.

Mr. Speaker, I yield to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, I could not help but listen to the gentleman as he was making both an eloquent but very common-sense explanation of what we are finally getting a chance to do this week in the United States Congress. First, let me applaud the gentleman from New Jersey for years of constant persistence about the crumbling and, unfortunately, weakened health care system in America.

I was just talking with my good friend the Speaker, and I think none of us have come to this Congress with any great adversarial posture with HMOs. I remember being a member of the Houston City Council and advocating getting rid of fraud and being more efficient with health care. So none of us have brought any unnecessary baggage of some predestined opposition to what HMOs stand for. I think what we are committed to in the United States Congress and what the gentleman's work has shown over the years, and what the Norwood-Dingell bill shows, is that we are committed to good health care for Americans, the kind of health care that Americans pay for.

I would say to our insurance companies, and I will respond to the State of Texas because it is a model, but shame, shame, shame. The interesting thing about the State of Texas, and might I applaud my colleagues, both Republicans and Democrats alike in the House and Senate in Texas, it was a collaborative effort. It was a work in progress. It was all the entities regulated by the State of Texas who got together and sacrificed individual special interests for the greater good.

I might add, and I do not think I am misspeaking, that all of the known physicians in the United States Congress, or at least in the House, let me not stretch myself to the other body, I believe, are on one of the bills. And I think most of them, if they are duly cosponsoring, are on the Norwood-Dingell bill. I think Americans need to know that. All of the trained medical professionals who are Members of the United States Congress are on the Norwood-Dingell bill, or at least cosponsoring it and maybe sponsoring another entity. That says something.

What we should know about the Texas bill is, one, to all those who might be listening, our health system has not collapsed. Many of my colleagues may be aware of the Texas Medical Center, one of the most renowned medical centers in the whole Nation. Perhaps Members have heard of M.D. Anderson or of St. Luke's. Many of our trauma centers, the Hermann Hospital, developed life flight. We have seen no diminishment of health care for Texans because of the passage of legislation that would allow access to any emergency room or that would allow the suing of an HMO.

I was just talking to a physician who stands in the Speaker's chair, if I might share, that if there is liability on a physician who makes a medical decision, the only thing we are saying about the HMOs is if they make a medical decision, if that medical decision does not bear the kind of fruit that it should, then that harmed or injured person should be allowed to sue. That has been going on in the State of Texas now for 2 years. There have been no representation that there has been abuse. I can assure my colleagues in a very active court system, as a former municipal court judge, there has not been any run on the courthouse, I tell the gentleman from New Jersey, because of that legislation.

So I would just simply say, if I might share just another point that I think the gentleman mentioned in terms of a poison pill, that we tragically just heard that 44.3 percent of Americans do not have access to health insurance. We know that we have, as Henry Simmons has said, President of the National Coalition on Health Care, that this report of uninsured Americans is alarming and represents a national disgrace. We know we cannot fix everything with this. And I might say to the gentleman that Texas, alarmingly so and embarrassingly so, is number one in the number of uninsured individuals, but we do know that with this bipartisan effort of a Patients' Bill of Rights, I am supporting the Norwood-Dingell bill, we can address the crisis that many of our friends and our constituents are facing in terms of denied health care because HMOs are superceding the professional advice of physicians who have a one-on-one relationship with patients.

I think we have to stop the hypocrisy in the patient's examination room. We must give back health care to the patient and the physician and the health professional. We must stop this intrusion. And I know the gentleman knows of this, because we have had hearings and heard many tragic stories.

So I would say to the gentleman that I hope this is the week that is, and that is that we can successfully come together in a bipartisan manner to stand on the side of good health care for all Americans by passing the Norwood-Dingell bill, the Patients' Bill of Rights. And I thank the gentleman again for his leadership, and I continue to look forward to working with him. I believe at the end of the week, hopefully, when the cookies crumble, we will stand on the side of victory for that bill.

Mr. PALLONE. Mr. Speaker, I want to thank the gentlewoman. I wanted to say one more thing, because I know we are out of time. Even though Texas and my home State of New Jersey, and now we read California, have all passed good patient protection laws, I do not want any of our colleagues to think that we do not need the Federal law. These State laws still do not apply to 50 percent of the people that are under ERISA where the corporation, their employer, is self-insured.

If we do not pass a Federal law, all of the things that Texas, California, and New Jersey and other States will do are still only going to apply to a minority of the people that have health insurance. So it is crucial, even though we know that States are making progress, and even though we have seen some of the courts now intervene, Illinois last week intervened and is allowing people to sue the HMO under certain circumstances, and the Supreme Court of the United States is taking up a case, even with all that, the bottom line is that most people still do not have sufficient patient protections because of that ERISA Federal preemption.

It is important to pass Federal legislation. And we are going to be watching the Republican leadership to make sure when the rule comes out tomorrow or the next day, that they do not screw this up so that we cannot pass a clean Patients' Bill of Rights.

I want to thank the gentlewoman again for so many times when she has been down on the floor with me and others in our health care task force making the case for the Patients' Bill of Rights. It is coming up, but we are going to have to keep out a watchful eye.

□ 2145

''SEPARATION OF CHURCH AND STATE''

The SPEAKER pro tempore (Mr. COOKSEY). Under the Speaker's announced policy of January 6, 1999, the gentleman from Pennsylvania (Mr. PITTS) is recognized for 60 minutes as the designee of the majority leader.

Mr. PITTS. Mr. Speaker, tonight several of us are gathered here in the hall of the House in a legislative body that represents the freedom that we know and love in America to discuss what our Founding Fathers believed about the First Amendment, about the issue of religious liberty, about the freedom of religion, about the interaction of religion in public life. We are talking tonight about the First Amendment, not the Second Amendment, not the Tenth Amendment, the 16th, not the 26th, the First Amendment, without which our Constitution would not have been ratified.

Mr. Speaker, there has been a lot said by people of all political stripes and ideologies about the role of religion in public life and the extent to which the two should intersect, if at all.

Lately, with the increased discussion of issues like opportunity scholarships for children to attend religious educational institutions, about Government contracting with faith-based institutions, and even about the debate on the Ten Commandments being posted on public property, we have heard the phrase ''separation of church and state'' time and time again.