(The above nomination was reported with the recommendation that it be confirmed, subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

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

By Mr. THOMPSON:

S. 1877. An original bill to amend the Federal Report Elimination and Sunset Act of 1995; from the Committee on Governmental Affairs; placed on the calendar.

By Mrs. HUTCHISON (for herself, Mr. Nickles, Mr. Brownback, Mr. Voinovich, Mr. Ashcroft, Mr. Craig, Mr. Enzi, Mr. Thomas, and Mr. Helms):

S. 1878. A bill to amend the Fair Labor Standards Act of 1938 to provide that an employee's ''regular rate'' for purposes of calculating compensation will not be affected by certain additional payments; to the Committee on Health, Education, Labor, and Pensions.

By Mr. MACK:

S. 1879. A bill to promote international monetary stability and to share seigniorage with officially dollarized countries; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. KENNEDY (for himself, Mr. Akaka, Mr. Inouye, Mrs. Lincoln, and Mr. Wellstone): S. 1880. A bill to amend the Public Health Service Act to improve the health of minority individuals; to the Committee on Health, Education, Labor, and Pensions.

By Mr. DODD:

S. 1881. A bill to amend chapter 84 of title 5, United States Code, to make certain temporary Federal service creditable for retirement purposes; to the Committee on Governmental Affairs.

By Mrs. HUTCHISON (for herself and Mr. Stevens):

S. 1882. A bill to expand child support enforcement through means other than programs financed at Federal expense; to the Committee on Finance.

By Mr. BINGAMAN:

S. 1883. A bill to amend tile 5, United States Code, to eliminate an inequity on the applicability of early retirement eligibility requirements to military reserve technicians; to the Committee on Governmental Affairs.

By Mr. KERRY:

S. 1884. A bill to designate the building of the United States Postal Service located at 5 Cedar Street in Hopkinton, Massachusetts, as the ''Thomas J. Brown Post Office Building''; to the Committee on Governmental Affairs.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. HELMS (for himself, Mr. Biden, Mr. Wellstone, and Mr. Lugar):

S. Res. 223. A resolution condemning the violence in Chechnya; to the Committee on Foreign Relations.

By Mr. CLELAND:

S. Res. 224. A resolution expressing the sense of the Senate to designate November 11, 1999, as a special day for recognizing the members of the Armed Forces and the civilian employees of the United States who participated in the recent conflict in Kosovo and the Balkans; to the Committee on the Judiciary.

By Mr. DURBIN (for himself, Mr. Frist, Mr. DeWine, Mr. Levin, Mr. Kennedy, Mr. Feingold, Mr. Dorgan, Mrs. Boxer, Mr. Mack, Mr. Dodd, and Mr. Thurmond):

S. Res. 225. A resolution to designate November 23, 2000, Thanksgiving Day, as a day to ''Give Thanks, Give Life'' and to discuss organ and tissue donation with other family members; to the Committee on the Judiciary.

By Mr. GRAHAM (for himself and Mr. Mack):

S. Con. Res. 71. A concurrent resolution expressing the sense of Congress that Miami, Florida, and not a competing foreign city, should serve as the permanent location for the Secretariat of the Free Trade Area of the Americas (FTAA) beginning in 2005; to the Committee on Finance.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mrs. HUTCHISON (for herself, Mr. Nickles, Mr. Brownback, Mr. Voinovich, Mr. Ashcroft, Mr. Craig, Mr. Enzi, Mr. Thomas, and Mr. Helms):

S. 1878. A bill to amend the Fair Labor Standards Act of 1938 to provide that an employee's ''regular rate'' for purposes of calculating compensation will not be affected by certain additional payments; to the Committee on Health, Education, Labor, and Pensions.

BONUS INCENTIVE ACT OF 1999

Mrs. HUTCHISON. Mr. President, I rise today to introduce the Bonus Incentive Act of 1999. I am joined in introducing this bill by my colleagues, Senators Nickles, Brownback, Voinovich, Ashcroft, Craig, Enzi, and Thomas. This important legislation will give America's hourly wage workers the same ability to receive performance-based bonuses that salaried employees currently have.

Mr. President, under the Fair Labor Standards Act, employers who give performance-based bonuses (usually at the end of the year) must go back and recalculate each employee's hourly base rate of pay and thus any overtime pay they received must be adjusted accordingly. Often, the employer must spend many hours of accountants' time for relatively minor adjustments in overtime pay.

This unnecessary and overly burdensome requirement discourages many employers (those who even know about this obscure provision) from providing a performance-based bonus system to their hourly wage employees, while salaried or ''exempt'' employees can enjoy such bonuses. Other employers attempt to comply with the law by reclassifying bonuses as not being performance-based. The net result of this law has been to hamper the productivity of the American worker and to trap unwary employers with unnecessary paperwork and even fines.

My legislation, the companion of which has been passed by the House Education and Workforce Committee, would allow performance-based bonuses to be paid to employees without the need to recalculate overtime pay, provided that employees are made fully aware of the requirements of receiving such bonuses and provided that such bonuses are not used as a substitute for hourly pay.

Mr. President, when the Fair Labor Standards Act (FLSA) was enacted in 1938, over 60 years ago, employers typically rewarded only their management personnel for the level of their achievement with performance-based bonuses. Such bonus programs for employees were very rare. But times have changed, and so has the American workplace. With the rise of the service-sector, post-industrial economy, increased competition from overseas, and the growing importance of workplace productivity and efficiency, ''gainsharing'' and other performance-based bonus programs for workers are commonplace.

Such programs are as varied as they are common. The model that comes first to mind is a bonus based on the number of items a factory worker produces in a month, quarter, or year. But gainsharing programs are equally effective in the service sector. Pam Farr, former senior vice president for Marriott Lodging and now president of the Cabot Advisory Group, recently testified before the House Education and the Workforce Committee that Marriott used gainsharing plans for housekeeping and customer service personnel that rewarded employees for the cleanliness of rooms, and customer service evaluations. Cordant Technologies, which makes solid rocket boosters for the space shuttle, rewards its workers for achieving goals involving workplace safety, customer satisfaction, and indirect cost reduction.

Whatever type of gainsharing arrangement an employer may have, there can be no doubt that these programs increase workers' pay, productivity, and contribute to higher customer satisfaction and better workplace relations. Studies have demonstrated that employees who participate in gainsharing arrangements on average receive about 5 to 10 percent more pay from such participation, and many bonus programs allow employees to increase their base pay by as much as 50 percent.

Employees who participate in these programs also report being more satisfied on the job and to have a more positive attitude toward their employer. A 1981 survey by the General Accounting Office found that over 80 percent of firms they interviewed reported improvements in labor-management relations from such programs. Grievances in such companies dropped 50 percent, and absenteeism by 20 percent when gainsharing was offered to workers.

Unfortunately, the majority of performance-based bonus programs are offered only to one segment of the American workforce: those employees who are salaried and therefore ‘‘exempt’’ from many of the strictures of the Fair Labor Standards Act. The other 70-plus million Americans who get paid by the hour are precluded from fully participating in these programs. Why is this? If performance bonuses work so well, why aren’t they offered to more hourly wage workers?

The answer is that the 61-year-old FLSA requires that when such bonuses are provided to hourly workers, the employer must then re-calculate each employee’s ‘‘regular rate’’ of pay, which in turn requires a recalculation of worker’s overtime pay. This process of recalculating employee overtime can consume substantial administrative time, often for very little in the way of additional overtime pay. One human resources director testified before Congress that it took four people 160 hours to calculate the bonuses for 235 employees.

This requirement can be particularly burdensome for many of the nation’s millions of small businesses that may not have computer hardware and software that can run these types of calculations. For employers who must try to do these calculations by hand, it can be such a headache that the employer will either drop the bonus program altogether or simply ignore the law, both of which are obviously undesirable outcomes.

The Bonus Incentive Act I am introducing today will alleviate this unnecessary and counterproductive requirement, and allow all employees to participate equally in gainsharing programs. In fact, by extending these programs to hourly wage employees who, on average, make less than their salaried counterparts, this bill could be a significant shot-in-the-arm to their take home pay. The Employee Policy Foundation reports that a median wage U.S. worker could earn between an additional $17,000 and $26,000 over a 20-year period by participating in a performance-based bonus plan.

Why would anyone oppose this bill, Mr. President? It is good for employers and employees alike. It means less paperwork and more pay, less bureaucracy and more productivity.

Some have raised the concern that employers may somehow attempt to disguise regular hourly pay as gainsharing bonuses. While it would take a very ambitious employer to make such a scheme profitable, particularly considering the impact such conduct would have on employee morale, there are protections in the bill against such a possibility.

First, the employer must provide all employees, in writing, a detailed description of what the requirements and benefits of the gainsharing plan will be. The actual formula by which the bonus is to be calculated must also be spelled-out. There can be no doubt about what the employee would be required to do and what he or she would stand gain.

Second, the employer is absolutely prohibited from using a performance-based bonus to in any way replace the hourly wage pay the employee would otherwise have received. In fact, the bill requires that the plan be ‘‘established and maintained in good faith for the purpose of distributing to employees additional remuneration over and above the wages and salaries that are not dependent upon the existence of such plan.’’ If an employer should violate this and, for example, but workers pay and substitute that for bonus pay, that employer would be subject to the same civil and even criminal sanctions as he would for any violation of the Fair Labor Standards Act, which is vigorously enforced by the U.S. Department of Labor’s Wage and Hour Division.

But the truth is, Mr. President, that there is very little reason for employers today to abuse this provision, and every reason in the world to use it for the betterment of employees and to the long-term success of the company. If the tremendous economic revolution and growth we have witnessed in the last two decades has taught us anything, it is that wealth is not a zero-sum game. Our economy continues to outstrip that of the rest of the world not because we have more natural resources: other countries have more oil, gold, timber, and other resources than we. It is because the productive capacity, ingenuity, and entrepreneurship of the American people is allowed to flourish under our system.

Outdated laws such as this must be revised if we are to continue to enjoy the growing fruits of our labor. The Bonus Incentive Act will help accomplish this goal, and I urge my colleagues to support and pass it.

By Mr. KENNEDY (for himself, Mr. AKAKA, Mr. INOUYE, Mrs. LINCOLN, and Mr. WELLSTONE):

S. 1880. A bill to amend the Public Health Service Act to improve the health of minority individuals; to the Committee on Health, Education, Labor, and Pensions.

HEALTH CARE FAIRNESS ACT OF 1999

Mr. KENNEDY. Mr. President, over the past few decades, we have made extraordinary advances as a nation in science and medicine. Unfortunately, those advances are not benefitting all of our citizens equally. Minority communities suffer disproportionately from many severe health problems.

We know that poverty, lack of health insurance, and other barriers to care continue to undermine the health of minorities. Clearly we need to do more to give all Americans the fair chance for a healthy future that they deserve.

The Administration has taken important steps to address this challenge. Last year, the President announced the Initiative to Eliminate Racial and Ethnic Disparities in Health. This initiative, led by the Department of Health and Human Services, has identified several areas where new commitments, new ideas, and new resources are necessary. The goal is to eliminate disparities in the areas of cardiovascular disease, cancer screening and management, diabetes, infant mortality, HIV/AIDS, and immunizations by 2010. This ambitious goal cannot be met without a major effort to improve research on the health of minorities and develop the steps needed to reduce these disparities.

Today, Senators AKAKA, INOUYE, LINCOLN, WELLSTONE, and I are introducing the Health Care Fairness Act of 1999, to secure the commitment and resources needed in each of these areas to ensure that minorities have a fair chance for improved health.

Minority populations suffer disproportionately from cardiovascular disease. They have a greater risk of developing high blood pressure, and are less likely to receive treatment to manage the condition after it develops. As a result, African Americans are 40 percent more likely to die from coronary heart disease than whites.

A Georgetown University study published in the New England Journal of Medicine last February found that bias in the decisions made by doctors is a factor in the treatment that African Americans receive when they suffer from heart disease. These findings are based on an experiment where physicians volunteered to view a video of actors posing as patients with significant symptoms of heart disease. The physicians were asked to prescribe further interventions for each ‘‘patient,’’ all of whom had identical medical histories, insurance coverage, and occupations. While 91 percent of the white males, white females, and African American males in the study were referred for cardiac catheterization, a more effective but more expensive diagnostic procedure, only 79 percent of the African American females in the study were referred for this test.

A study published in the New England Journal of Medicine last month found similar disparities in the treatment of lung cancer. Patients whose tumors are discovered early are often able to be cured with surgery. This study found that African American patients with tumors small enough to be surgically removed were treated surgically in only 64 percent of cases, compared with 77 percent of white patients treated surgically. As a result, African Americans have only a 26 percent chance of surviving lung cancer, compared with a 34 percent survival rate for whites.

Other types of cancer also strike racial and ethnic minorities in disproportionate numbers. Vietnamese American women are five times more likely than white women to contract cervical cancer. Hispanic women are twice as likely to contract cervical cancer. Native Hawaiian men are 13 percent more likely to contact lung cancer. Alaskan

Native women are 72 percent more likely to contract colon cancer and rectal cancer, when compared with whites. In addition, African Americans and Hispanic Americans are more likely to be diagnosed with cancer once the disease has reached an advanced stage. For African Americans, the result is a 35 percent higher death rate.

The Institute of Medicine, issued a report last February concluding that federal efforts to research cancer in minority communities are insufficient. The report recommended an increase in resources and the development of a strategic plan to coordinate this research. The results of this study confirm that while NIH has been extremely successful in producing medical breakthroughs that improve health care, those breakthroughs do not always reach into racial and ethnic communities.

The same troubling differences are found with HIV/AIDS. The powerful new drugs that have dramatically decreased AIDS deaths and prevented or delayed progression from HIV to AIDS for so many citizens are not reaching minorities in proportion to their need. Racial and ethnic minorities make up approximately 25 percent of the total population, but these groups account for over half of all AIDS cases. The disparity is even greater for African American and Hispanic women, who account for nearly 80 percent of the AIDS cases reported among women.

In spite of recent bipartisan efforts to increase access to health care for all children, racial and ethnic disparities exist among young Americans as well. Minority children are less likely to receive prescription medications, and they have lower immunization rates than white children. Inadequate health care places a barrier in the path of healthy development for minority children, and that is an unfair disadvantage.

The Health Care Fairness Act of 1999 addresses these racial and ethnic health disparities in many ways. It contains sections on research, data collection, medical education, and outreach. Each of these aspects has an important role to play in the reduction and eventual elimination of these unacceptable health disparities.

Title I establishes a Center for Research on Minority Health at the National Institutes of Health. The Center will oversee the development of an NIH-wide strategic plan for minority health research. This step will enable those concerned with the advancement of research on minority health, both inside and outside NIH, to monitor the progress of NIH in this area. The Center will award Centers of Excellence grants to institutions across the country that serve under-represented populations. These funds will be used to conduct research into the nature, causes, and remedies for health disparities, to train minorities to become biomedical research professionals, to improve the infrastructure for conducting biomedical research on health disparities, and to provide long-term stability to these biomedical research programs.

Changing attitudes about race and ethnic backgrounds are an ongoing challenge for all sectors of our society. The Georgetown study does not conclude that most doctors are racist. No such assumptions are drawn from its results. What is shown is that health care providers, like all members of our society, enter their profession with perceptions and biases related to race. Many industries have confronted racial sensitivity issues in their training programs. This study shows that such training must also be a part of medical education, for both new students and experienced practitioners alike.

To help health care providers improve their ability to work with patients of different backgrounds, we must also develop educational techniques that are effective in improving this aspect of health care delivery. Title II of the Health Care Finance Act establishes demonstration projects to develop effective educational techniques such as courses that focus on reducing racial and ethnic disparities in health care.

The close connection between race and poverty in this country has had a significant negative impact on the access of minority communities to quality health care. Reducing racial and ethnic health disparities will require a better understanding of issues beyond effective treatments and other questions of basic science. Barriers to care, poor quality health services, and the lack of useful outcome measures are all part of this complex problem. Title III of our bill strengthens the federal commitment to these social science aspects of health disparities. It directs the Agency for Health Care Policy and Research to conduct and support research in these areas, to promote effective interventions in minority communities, and to develop outcome measures to assess and improve health care for minority populations.

Measuring our progress in reducing these racial and ethnic disparities will also require reliable and complete data on miniority health. In order to provide reliable information on the health status of minority communities, Title IV of our bill directs the National Academy of Sciences to conduct a study of the data collection and reporting systems at the Department of Health and Human Services that include race and ethnicity.

This study will evaluate the effectiveness of data collection at HHS and recommend improvements for ensuring that reliable and complete information on racial and ethnic health disparties is available.

The estimated cost of these provisions for fiscal year 2000 totals just under $350 million. The estimated cost in subsequent years is approximately $260 million. This is a small price when compared to the damage that racial and ethnic health disparities are causing in so many communities. We all know that in the long run better health is always less expensive than sickness and hospitalization.

We know that many other structural, personal, and historical factors contribute to racial and ethnic disparties in health care. Our legislation asks that we make the elimination of these disparties a higher priority. It asks that we do all we can to develop the knowledge necessary to do better. The result will be a fairer chance for the healthy future that all Americans deserve, and I look forward to early action by Congress on this needed legislation.

Mr. President, I ask unanimous consent that the full text of the bill and the accompanying letters and statement of support be printed in the RECORD.

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

S. 1880

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ‘‘Health Care Fairness Act of 1999’’.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The United States ranks below most industrialized nations in health status as

measured by longevity, sickness, and mortality.

(2) The United States ranks 24th among industrialized nations in infant mortality.

(3) This poor rank in health status is attributed in large measure to the lower health status of America's minority populations.

(4) Many minority groups suffer disproportionately from cancer. Disparities exist in both mortality and incidence rates. For men and women combined, African Americans have a cancer death rate about 35 percent higher than that for whites. Paralleling the death rate, the incidence rate for lung cancer in African American men is about 50 percent higher than white men. Native Hawaiian men also have elevated rates of lung cancer compared with white men. Alaskan Native men and women suffer from higher rates of cancers of the colon and rectum than do whites. Vietnamese women in the United States have a cervical cancer incidence rate more than 5 times greater than white women. Hispanic women also suffer elevated rates of cervical cancer.

(5) Infant death rates among African American, Native Americans and Alaskan Natives, and Hispanics were well above the national average. The greatest disparity exists for African Americans. The overall Native American rate does not reflect the diversity among Indian communities, some of which have infant mortality rates approaching twice the national rate.

(6) Sudden infant death syndrome (referred to in this section as ''SIDS'') accounts for approximately 10 percent of all infant deaths in the first year of life. Minority populations are at greater risk for SIDS. In addition to the greater risks among African Americans, the rates are 3 to 4 times as high for some Native American and Alaskan Native populations.

(7) Cardiovascular disease is the leading cause of death for all racial and ethnic groups. Major disparities exist among population groups, with a disproportionate burden of death and disability from cardiovascular disease in minority and low-income populations. Stroke is the only leading cause of death for which mortality is higher for Asian-American males than for white males.

(8) Racial and ethnic minorities have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to undergo treatment to control their high blood pressure.

(9) Diabetes, the seventh leading cause of death in the United States, is a serious public health problem affecting racial and ethnic communities. The prevalence of diabetes in African Americans is approximately 70 percent higher than whites and the prevalence in Hispanics is nearly double that of whites. The prevalence rate of diabetes among Native Americans and Alaskan Natives is more than twice that for the total population and at least 1 tribe, the Pimas of Arizona, have the highest known prevalence of diabetes of any population in the world.

(10) The human immunodeficiency virus (referred to in this section as ''HIV''), which causes acquired immune deficiency syndrome (referred to in this section as ''AIDS''), results in disproportionate suffering in minority populations. Minority persons represent 25 percent of the total United States population, but 54 percent of all cases of AIDS.

(11) More than 75 percent of AIDS cases reported among women and children occur in minority women and children.

(12) Nearly 2 of 5 (38 percent) Hispanic adults, 1 of 4 (24 percent) African American adults, and 1 of 4 (24 percent) Asian-American adults are uninsured, compared with 1 of 7 (14 percent) white adults.

(13) Elderly minorities experience disparities in access to care and health status, in part because medicare covers only half the health care expenses of older Americans.

(14) Two of 5 Hispanic and 2 of 5 African Americans age 65 and older rate their health status as fair or poor, compared with less than 1 of 4 (23 percent) white Americans 65 and over.

(15) Nearly 2 of 5 (39 percent) African American adults and almost half (46 percent) of Hispanic adults report that they do not have a regular doctor, compared with 1 of 4 (26 percent) of white adults.

(16) Minority Americans 65 and older are less likely to have a regular doctor or to see a specialist.

(17) Ninety percent of minority physicians produced by Historically Black Medical Colleges live and serve in minority communities.

(18) Almost half (45 percent) of Hispanic adults, 2 of 5 (41 percent) Asian-American adults, and more than 1 of 3 (35 percent) African American adults report difficulty paying for medical care, compared with 1 of 4 (26 percent) white adults.

(19) Despite suffering disproportionate rates of illness, death, and disability, minorities have not been proportionately represented in many clinical research trials, except in studies of behavioral risk factors associated with negative stereotypes.

(20) Culturally sensitive approaches to research are needed to encourage minority participation in research studies.

(21) There is a national need for minority scientists in the field of biomedical, clinical, and health services research.

(22) In 1990, only 3.3 percent of all United States medical school faculties were underrepresented minority persons.

(23) Only 1 percent of full professors were underrepresented minority persons in 1990.

(24) The proportion of underrepresented minorities in high academic ranks, such as professors and associated professors, decreased from 1980 to 1990.

(25) African Americans with identical complaints of chest pain are less likely than white Americans to be referred by physicians for sophisticated cardiac tests.

(26) Cultural competency training in medical schools and residency training programs has the potential to reduce disparities in health care and health outcomes.

(27) More detailed data on health disparities is needed to—

(A) evaluate the impact that race and ethnicity have on health status, access to care, and quality of care; and

(B) enforce existing protections for equal access to care.

TITLE I—IMPROVING MINORITY HEALTH THROUGH THE NATIONAL INSTITUTES OF HEALTH

SEC. 101. RESEARCH ON MINORITY HEALTH.

Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended by adding at the end the following:

''PART J—RESEARCH ON MINORITY HEALTH

''SEC. 499A. ESTABLISHMENT OF CENTER.

''(a) In General.—There is established within the National Institutes of Health an organization to be known as the Center for Research on Minority Health and Health Disparities (referred to in this part as the 'Center'). The Center shall be headed by a director, who shall be appointed by the Secretary and shall report to the Director of the National Institutes of Health.

''(b) Task Force.—The Director of the Center shall chair a trans-NIH task force that is composed of Institute Directors, NIH senior staff, and representatives of other public health agencies, that will establish a comprehensive plan and budget estimates under section 499C for minority health that should be conducted or supported by the national research institutes, and shall recommend an agenda for conducting and supporting such research.

''(c) Duties.—

''(1) Interagency coordination of minority health research.—With respect to minority health, the Director of the Center shall facilitate the establishment of, and provide administrative support to, the task force referred to in subsection (b) to plan, coordinate, and evaluate all research conducted at or funded by NIH.

''(2) Minority health research information system.—The Director of the Center shall establish a minority health research information system in order to track minority-related research, training, and construction. The system shall capture, for each minority-related research, training, or construction project year-end data.

''(3) Consultations.—The Director of the Center shall carry out this part (including developing and revising the plan required in section 499C) in consultation with the Advisory Council established under section 499B, the heads of the agencies of the National Institutes of Health, and the advisory councils of such agencies.

''(4) Coordination.—The Director of the Center shall act as the primary Federal official with responsibility for monitoring all minority health research conducted or supported by the National Institutes of Health, and—

''(A) shall serve to represent the National Institutes of Health minority health research program at all relevant Executive branch task forces, committees and planning activities; and

''(B) shall maintain communications with all relevant Public Health Service agencies and with various other departments of the Federal Government, to ensure the timely transmission of information concerning advances in minority health research between these various agencies for dissemination to affected communities and health care providers.

''(d) Innovative Grants.—

''(1) In general.—The Director of the Center, in consultation with the Advisory Council, shall identify areas of insufficient minority health research at the Institutes and Centers, and shall provide funds to the Institutes and Centers for the awarding of peer-reviewed grants for innovative projects that address high priority areas of minority health research that are not adequately addressed by other Institutes or Centers.

''(2) Exceptional circumstances.—

''(A) In general.—If the Director of the Center determines that the Institutes or Centers are unwilling or unable to award a grant under paragraph (1) for the conduct of a research project identified under such paragraph, the Director, in consultation with the Advisory Council, shall award 1 or more peer reviewed grants to support such research project.

''(B) Limitation.—The total amount of grants awarded under subparagraph (A) for a fiscal year shall not exceed an amount equal to 10 percent of the total final budget for the minority health disparities comprehensive plan for the National Institutes of Health for the fiscal year, or $130,000,000, whichever is greater.

''(3) Administration of research proposals.—

''(A) Requests.—The Director of the Center may issue requests for research proposals in areas identified under paragraph (2)(A).

''(B) Delegation.—The Director of the Center may delegate responsibility for the review and management of research proposals under this subsection to another Institute or Center, or to the Center for Scientific Review.

‘‘(C) FINAL APPROVAL.—The Director of the Center may issue a final approval of research awards under paragraph (1) so long as such approval is provided within 30 days of the date on which the award is approved by an Institute or Center.

‘‘(e) DEFINITIONS.—In this part:

‘‘(1) MINORITY HEALTH CONDITIONS.—The term ‘minority health conditions’, with respect to individuals who are members of racial, ethnic, and indigenous (including Native Americans, Alaskan Natives, and Native Hawaiians) minority groups, means all diseases, disorders, and conditions (including with respect to mental health)—

‘‘(A) unique to, more serious, or more prevalent in such individuals;

‘‘(B) for which the factors of medical risk or types of medical intervention are different for such individuals; or

‘‘(C) which have been found to result in health disparities but for which insufficient research has been conducted.

‘‘(2) MINORITY HEALTH RESEARCH.—The term ‘minority health research’ means basic and clinical research on minority health conditions, including research on preventing such conditions.

‘‘SEC. 499B. ADVISORY COUNCIL.

‘‘(a) IN GENERAL.—The Secretary shall establish an advisory council (referred to in this part as the ‘Advisory Council’), pursuant to the Federal Advisory Committee Act, for the purpose of providing advice to the Director of the Center on carrying out this part.

‘‘(b) COMPOSITION.—The Advisory Council shall be composed of not less than 18, and not more than 24 individuals, who are not officers or employees of the Federal Government, to be appointed by the Secretary. A majority of the members of the Advisory Council shall be individuals with demonstrated expertise regarding minority health issues. The Advisory Council shall include representatives of communities impacted by racial and ethnic health disparities. The Director of the Center shall serve as the chairperson of the Advisory Council.

‘‘SEC. 499C. COMPREHENSIVE PLAN AND BUDGET.

‘‘(a) IN GENERAL.—Subject to this section and other applicable law, the Director of the Center (in consultation with the Advisory Council) and the members of the Task Force established under section 499A, in carrying out section 499A, shall—

‘‘(1) establish a comprehensive plan and budget for the conduct and support of all minority health research activities of the agencies of the National Institutes of Health (which plan shall be first established under this subsection not later than 12 months after the date of the enactment of this part), which budget shall be submitted to the Secretary, the Director of the Office of Management and Budget and Congress and included in the annual budget justification for the National Institutes of Health;

‘‘(2) ensure that the plan and budget establishes priorities, consistent with sound medical and scientific judgment, among the minority health research activities that such agencies are authorized to carry out;

‘‘(3) ensure that the plan and budget establishes objectives regarding such activities, describes the means for achieving the objectives, and designates the date by which the objectives are expected to be achieved;

‘‘(4) ensure that all amounts appropriated for such activities are expended in accordance with the plan and budget;

‘‘(5) review the plan and budget not less than annually, and coordinate revisions to the plan as appropriate; and

‘‘(6) ensure that the plan and budget serve as a broad, binding statement of policies regarding minority health research activities of the agencies, but does not remove the responsibility of the heads of the agencies for the approval of specific programs or projects, grant management, or for other details of the daily administration of such activities, in accordance with the plan and budget.

‘‘(b) CERTAIN COMPONENTS.—With respect to minority health research activities of the agencies of the National Institutes of Health, the plan and budget shall—

‘‘(1) provide for basic research;

‘‘(2) provide for clinical research;

‘‘(3) provide for research that is conducted by the agencies;

‘‘(4) provide for research that is supported by the agencies;

‘‘(5) provide for proposals developed pursuant to solicitations by the agencies and for proposals developed independently of such solicitations; and

‘‘(6) provide for prevention research, behavioral research and social sciences research.

‘‘(c) APPROVAL.—The plan and budget established under this section are subject to the approval of the Director of the Center and the Director of the National Institutes of Health.

‘‘(d) BUDGET ITEMS FOR MINORITY HEALTH.—In the Budget of the United States that is submitted to Congress by the President, the President shall, with respect to each Institute or agency of the National Institutes of Health, include a separate line item account for the amount that each such Institute or agency requests for minority health activities.

‘‘SEC. 499D. CENTER FUNDING.

‘‘For the purpose of carrying out administrative functions related to minority health research activities under the plan under sections 499A, 499B, and 499C, there are authorized to be appropriated $100,000,000 for fiscal year 2000, and such sums as may be necessary for each of fiscal years 2001 through 2004.

‘‘SEC. 499E. CENTERS OF EXCELLENCE FOR RESEARCH ON HEALTH DISPARITIES AND TRAINING.

‘‘(a) IN GENERAL.—The Secretary, acting through the Director of the National Institutes of Health, shall make grants to, and enter into contracts with, designated biomedical research institutions described in subsection (c), and other public and nonprofit health or educational entities, for the purpose of assisting the institutions in supporting programs of excellence in biomedical research education for under-represented minority individuals.

‘‘(b) REQUIRED USE OF FUNDS.—

‘‘(1) IN GENERAL.—The Secretary may not make a grant under subsection (a) unless the designated biomedical research institution involved agrees, subject to subsection (c)(1)(B), to expend the grant—

‘‘(A) to conduct minority health research and research into the nature of health disparities that affect racial, ethnic, and indigenous minorities, the causes of such disparities, and remedies for such disparities;

‘‘(B) to train minorities as professionals in the area of biomedical research;

‘‘(C) to expand, remodel, renovate, or alter existing research facilities or construct new research facilities for the purpose of conducting biomedical research related to health disparities; or

‘‘(D) to establish or increase an endowment fund in accordance with paragraph (2).

‘‘(2) ENDOWMENT FUNDS.—

‘‘(A) IN GENERAL.—Except as provided in subparagraph (B), an institution that meets the requirements of subparagraph (B) may utilize not to exceed 35 percent of the amounts received under a grant under subsection (a) to establish or increase an endowment fund at the institution. Amounts used under this subparagraph shall be dedicated exclusively to the support of biomedical research and the associated costs of such research.

‘‘(B) REQUIREMENTS.—To be eligible to use funds as provided for under subparagraph (A), an institution shall not have a endowment fund that is worth in excess of an amount equal to 50 percent of the national average of all endowment funds at all institutions that are of the same biomedical research discipline.

‘‘(c) CENTERS OF EXCELLENCE.—

‘‘(1) GENERAL CONDITIONS.—The conditions specified in this paragraph are that a designated biomedical research institution—

‘‘(A) has a significant number of under-represented minority individuals enrolled in the institution, including individuals accepted for enrollment in the institution;

‘‘(B) has been effective in assisting under-represented minority students of the institution to complete the program of education and receive the degree involved;

‘‘(C) has been effective in recruiting under-represented minority individuals to enroll in and graduate from the institution, including providing scholarships and other financial assistance to such individuals and encouraging under-represented minority students from all levels of the educational pipeline to pursue biomedical research careers; and

‘‘(D) has made significant recruitment efforts to increase the number of under-represented minority individuals serving in faculty or administrative positions at the institution.

‘‘(2) CONSORTIUM.—Any designated biomedical research institution involved may, with other biomedical institutions (designated or otherwise) form a consortium to carry out the purposes described in subsection (b) at the institutions of the consortium.

‘‘(3) APPLICATION OF CRITERIA TO OTHER PROGRAMS.—In the case of any criteria established by the Secretary for purposes of determining whether institutions meet the conditions described in paragraph (1), this section may not, with respect to racial, ethnic, and indigenous minorities, be construed to authorize, require, or prohibit the use of such criteria in any program other than the program established in this section.

‘‘(d) DURATION OF GRANT.—The period during which payments are made under a grant under subsection (a) may not exceed 5 years. Such payments shall be subject to annual approval by the Secretary and to the availability of appropriations for the fiscal year involved to make the payments.

‘‘(e) DEFINITIONS.—In this section:

‘‘(1) MINORITY.—The term ‘minority’ means an individual from a racial or ethnic group that is under-represented in health research.

‘‘(2) PROGRAM OF EXCELLENCE.—The term ‘program of excellence’ means any program carried out by a designated biomedical research institution with a grant made under subsection (a), if the program is for purposes for which the institution involved is authorized in subsection (b) or (c) to expend the grant.

‘‘(f) FUNDING.—

‘‘(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of making grants under subsection (a), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2000 through 2004.

‘‘(2) NO LIMITATION.—Nothing in this subsection shall be construed as limiting the centers of excellence referred to in this section to the designated amount, or to preclude such entities from competing for other grants under this section.

‘‘(3) MAINTENANCE OF EFFORT.—

‘‘(A) In general.—With respect to activities for which a grant made under this part are authorized to be expended, the Secretary may not make such a grant to a center of excellence for any fiscal year unless the center agrees to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the center for the fiscal year preceding the fiscal year for which the institution receives such a grant.

‘‘(B) Use of federal funds.—With respect to any Federal amounts received by a center of excellence and available for carrying out activities for which a grant under this part is authorized to be expended, the Secretary may not make such a grant to the center for any fiscal year unless the center agrees that the center will, before expending the grant, expend the Federal amounts obtained from sources other than the grant.

‘‘SEC. 499F. LOAN REPAYMENT PROGRAM FOR BIOMEDICAL RESEARCH.

‘‘(a) In General.—The Secretary, acting through the Director of the National Institutes of Health, shall establish a program of entering into contracts with qualified health professionals under which such health professionals agree to engage in minority health research or research into the nature of health disparities that affect racial, ethnic, and indigenous populations, in consideration of the Federal Government agreeing to repay, for each year of such service, not more than $35,000 of the principal and interest of the educational loans of such health professionals.

‘‘(b) Service Provisions.—The provisions of sections 338B, 338C, and 338E shall, except as inconsistent with subsection (a), apply to the program established in such subsection (a) to the same extent and in the same manner as such provisions apply to the National Health Service Corps Loan Repayment Program established in subpart III of part D of title III.

‘‘(c) Availability of Appropriations.—Amounts available for carrying out this section shall remain available until the expiration of the second fiscal year beginning after the fiscal year for which the amounts were made available.

‘‘(d) Health Disparities.—In carrying out this section, the Secretary shall take steps sufficient to ensure the active participation of appropriately qualified minority heath professionals, including extensive outreach and recruitment efforts. In complying with this subsection, the Secretary shall waive the requirement that the recipients of loan repayment assistance agree to engage in minority health research or research into the nature of health disparities that affect racial, ethnic and indigenous populations.

‘‘(e) Authorization of Appropriations.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2000 through 2004.

‘‘SEC. 499G. ADDITIONAL AUTHORITIES.

‘‘(a) In General.—In overseeing and supporting minority health research, the Director of the Center—

‘‘(1) shall assist the Director of the National Center for Research Resources in carrying out section 481(c)(3) and in committing resources for construction at Institutions of Emerging Excellence;

‘‘(2) shall assist in the administration of section 492B with respect to the inclusion of members of minority groups as subjects in clinical research; and

‘‘(3) subject to section 405(b)(2) and without regard to section 3324 of title 31, United States Code, and section 3709 of the Revised Statutes (41 U.S.C. 5), may enter into such contracts and cooperative agreements with any public agency, or with any person, firm, association, corporation, or educational institution, as may be necessary to expedite and coordinate minority health research.

‘‘(b) Report to Congress and the Secretary.—The Director of the Center shall each fiscal year prepare and submit to the appropriate committees of Congress and the Secretary a report—

‘‘(1) describing and evaluating the progress made in such fiscal year in minority health research conducted or supported by the Institutes;

‘‘(2) summarizing and analyzing expenditures made in such fiscal year for activities with respect to minority health research conducted or supported by the National Institutes of Health; and

‘‘(3) containing such recommendations as the Director considers appropriate.

‘‘(c) Projects for Cooperation Among Public and Private Health Entities.—In carrying out subsection (a), the Director of the Center shall establish projects to promote cooperation among Federal agencies, State, local, and regional public health agencies, and private entities, in minority health research.

‘‘SEC. 499H. GENERAL PROVISIONS REGARDING THE CENTER.

‘‘(a) Administrative Support for Center.—The Secretary, acting through the Director of the National Institutes of Health, shall provide administrative support and support services to the Director of the Center and shall ensure that such support takes maximum advantage of existing administrative structures at the agencies of the National Institutes of Health.

‘‘(b) Required Expertise.—The Director of the Center, in consultation with the Advisory Council and the Center for Scientific Review, shall ensure that scientists with appropriate expertise in research on minority health are incorporated into the review, oversight, and management processes of all research projects in the National Institutes of Health minority health research program and other activities under such program.

‘‘(c) Technical Assistance.—The Director of the Center, in consultation with the directors of the national research institutes and centers, shall ensure that appropriate technical assistance is available to applicants for all research projects and other activities supported by the National Institutes of Health minority health research program.

‘‘(d) Evaluation and Report.—

‘‘(1) Evaluation.—Not later than 5 years after the date of the enactment of this part, the Secretary shall conduct an evaluation to—

‘‘(A) determine the effect of this section on the planning and coordination of the minority health research programs at the institutes, centers and divisions of the National Institutes of Health;

‘‘(B) evaluate the extent to which this part has eliminated the duplication of administrative resources among such Institutes, centers and divisions; and

‘‘(C) provide recommendations concerning future alterations with respect to this part.

‘‘(2) Report.—Not later than 1 year after the date on which the evaluation is commenced under paragraph (1), the Secretary shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Commerce of the House of Representatives, a report concerning the results of such evaluation.’’.

TITLE II—MEDICAL EDUCATION

SEC. 201. GRANTS FOR HEALTH CARE EDUCATION CURRICULA DEVELOPMENT.

Part F of title VII of the Public Health Service Act (42 U.S.C. 295j et seq.) is amended by inserting after section 791 the following:

‘‘SEC. 791A. GRANTS FOR HEALTH PROFESSIONS EDUCATION CURRICULA DEVELOPMENT.

‘‘(a) Grants for Graduate Education Curricula Development.—

‘‘(1) In general.—The Secretary, acting through the Administrator for the Health Resources and Services Administration and in collaboration with the Administrator for Health Care Policy and Research and the Deputy Assistant Secretary for Minority Health, may make awards of grants, contracts, or cooperative agreements to public and nonprofit private entities for the purpose of carrying out research projects and demonstration projects to develop curricula to reduce disparity in health care outcomes, including curricula and faculty development for cultural competency in graduate and undergraduate health professions education.

‘‘(2) Eligibility.—To be eligible to receive a grant, contract or cooperative agreements under paragraph (1), an entity shall—

‘‘(A) be a school of medicine, school of osteopathic medicine, school of dentistry, school of public health, school of nursing, school of pharmacy, school of allied health, or other recognized health profession school; and

‘‘(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

‘‘(3) Use of funds.—An entity shall use amounts received under a grant under paragraph (1) to carry out research projects and demonstration projects to develop curricula to reduce disparity in health care outcomes, including curricula for cultural competency in graduate medical education. Such curricula shall focus on the need to remove bias from health care at a personal level as well as at a systematic level.

‘‘(4) Number of grants and grant term.—The Secretary shall award not to exceed 20 grants, contracts or cooperative agreements (or combination thereof) under paragraph (1) in each of the first and second fiscal years for which funds are available under subsection (f). The term of each such grant, contract or cooperative agreement shall be 3 years.

‘‘(b) Grants for Continuing Health Professional Education Curricula Development.—

‘‘(1) In general.—The Secretary, acting through the Health Resources and Services Administration and the Agency for Health Care Policy and Research and in collaboration with the Office of Minority Health, shall award grants, contracts or cooperative agreements to eligible entities for the establishment of demonstration projects to develop curricula to reduce disparity in health care and health outcomes, including curricula for cultural competency, in continuing medical education.

‘‘(2) Eligibility.—To be eligible to receive a grant, contract, or cooperative agreement under paragraph (1) an entity shall—

‘‘(A) be a school of medicine, school of osteopathic medicine, school of dentistry, school of public health, school of nursing, school of pharmacy, school of allied health, or other recognized health profession school; and

‘‘(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

‘‘(3) Use of funds.—An entity shall use amounts received under a grant, contract, or cooperative agreement under paragraph (1) to develop and evaluate the effect and impact of curricula for continuing medical education courses or programs to provide education concerning issues relating to disparity in health care and health outcomes, including cultural competency of health professionals. Such curricula shall focus on the need to remove bias from health care at a personal level as well as at a systemic level.

''(4) NUMBER OF GRANTS AND GRANT TERM.—The Secretary shall award not to exceed 20 grants, contracts, or cooperative under paragraph (1) in each of the first and second fiscal years for which funds are available under subsection (f). The term of each such grant shall be 3 years.

''(c) DISTRIBUTION OF PROJECTS.—The Secretary shall ensure that, to the extent practicable, projects under subsections (a) and (b) are carried out in each of the principal geographic regions of the United States and address issues associated with different minority groups and health professions.

''(d) MONITORING.—An entity that receives a grant, contract or cooperative agreement under subsection (a) or (b) shall ensure that procedures are in place to monitor activities undertaken using grant, contract or cooperative agreement funds. Such entity shall annually prepare and submit to the Secretary a report concerning the effectiveness of curricula developed under the grant contract or cooperative agreement.

''(e) REPORT TO CONGRESS.—Not later than January 1, 2002, the Secretary shall prepare and submit to the appropriate committees of Congress, a report concerning the effectiveness of programs funded under this section and a plan to encourage the implementation and utilization of curricula to reduce disparity in health care and health outcomes. A final report shall be submitted by the Secretary not later than January 1, 2004.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $3,500,000 for fiscal year 2000, $7,000,000 for fiscal year 2001, $7,000,000 for fiscal year 2002, and $3,500,000 for fiscal year 2003.''.

SEC. 202. NATIONAL CONFERENCE ON CONTINUING HEALTH PROFESSIONAL EDUCATION AND DISPARITY IN HEALTH OUTCOMES.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall convene a national conference on continuing health professions education as a method for reducing disparity in health care and health outcomes, including continuing medical education on cultural competency. The conference shall include sessions to address measurements of outcomes to assess the effectiveness of curricula in reducing disparity.

(b) PARTICIPANTS.—The Secretary of Health and Human Services shall invite minority health advocacy groups, health education entities described in section 741(b)(1) of the Public Health Service Act (as added by section 201), and other interested parties to attend the conference under subsection (a).

(c) ISSUES.—The national conference convened under subsection (a) shall address issues relating to the role of continuing medical education in the effort to reduce disparity in health care and health outcomes, including the role of continuing medical education in improving the cultural competency of health professionals and health professions faculty. The conference shall focus on methods to achieve reductions in the disparities in health care and health outcomes through continuing medical education courses or programs and on strategies for measuring the effectiveness of curricula to reduce disparities.

(d) PUBLICATION OF FINDINGS.—Not later than 6 months after the convening of the national conference under subsection (a), the Secretary of Health and Human Services shall publish in the Federal Register a summary of the proceedings and the findings of the conference.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 203. ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish an advisory committee to provide advice to the Secretary on matters related to the development, implementation, and evaluation of graduate and continuing education curricula for health care professionals to decrease the disparity in health care and health outcomes, including curricula on cultural competency as a method of eliminating health disparity.

(b) MEMBERSHIP.—Not later than 3 months after the date on which amounts are appropriated to carry out this section, the Secretary of Health and Human Services shall appoint the members of the advisory committee. Such members shall be appointed from among individuals who—

(1) unless otherwise specified, are not officers or employees of the Federal Government;

(2) are experienced in issues relating to health disparity; and

(3) meet such other requirements as the Secretary determines appropriate;

and shall include a representative of the Office of Minority Health under section 1707 of the Public Health Service Act (42 U.S.C. 300u-6) and such other representatives of offices and agencies of the Public Health Service as the Secretary determines to be appropriate. The Secretary shall ensure that members of minority communities are well represented on the advisory committee. Such representatives shall include 1 or more individuals who serve on the advisory committee under section 1707(c) of such Act.

(c) COLLABORATION.—The advisory committee shall carry out its duties under this section in collaboration with the Office of Minority Health of the Department of Health and Human Services, and other offices, centers, and institutes of the Department of Health and Human Services, and other Federal agencies.

(d) TERMINATION.—The advisory committee shall terminate on the date that is 4 years after the date on which the first member of the committee is appointed.

(e) EXISTING COMMITTEE.—The Secretary may designate an existing advisory committee operating under the authority of the Office of Minority Health of the Department of Health and Human Services to serve as the advisory committee under this section.

SEC. 204. CULTURAL COMPETENCY CLEARINGHOUSE.

(a) ESTABLISHMENT.—The Director of the Office of Minority Health of the Department of Health and Human Services shall establish within the Resource Center of the Office of Minority Health, or through the awarding of a contract provide for the establishment of, an information clearinghouse for curricula to reduce racial and ethnic disparity in health care and health outcomes. The clearinghouse shall facilitate and enhance, through the effective dissemination of information, knowledge and understanding of practices that lead to decreases in the disparity of health across minority and ethnic groups, including curricula for continuing medical education to develop cultural competency in health care professionals.

(b) AVAILABILITY OF INFORMATION.—Information contained in the clearinghouse shall be made available to minority health advocacy groups, health education entities described in section 791A(b)(2)(A) of the Public Health Service Act (as added by section 201), health maintenance organizations, and other interested parties.

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

TITLE III—MINORITY HEALTH RESEARCH BY THE AGENCY FOR HEALTH CARE POLICY AND RESEARCH.

SEC. 301. MINORITY HEALTH RESEARCH BY THE AGENCY FOR HEALTH CARE POLICY AND RESEARCH.

(a) IN GENERAL.—Part A of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended by adding at the end the following:

''SEC. 906. RESEARCH ON MINORITY HEALTH DISPARITIES.

''(a) IN GENERAL.—The Administrator of the Agency for Health Care Policy and Research shall—

''(1) conduct and support research to identify how to improve the quality and outcomes of health care services for minority populations and the causes of health disparities for minority populations, including barriers to health care access;

''(2) conduct and support research and support demonstration projects to identify, test, and evaluate strategies for eliminating the disparities described in paragraph (1) and promoting effective interventions;

''(3) develop measures for the assessment and improvement of the quality and appropriateness of health care services provided to minority populations; and

''(4) in carrying out 902(c), provide support to increase the number of minority health care researchers and the health services research capacity of institutions that train minority health care researchers.

''(b) RESEARCH AND DEMONSTRATION PROJECTS.—

''(1) IN GENERAL.—In carrying out subsection (a), the Administrator shall conduct and support research to—

''(A) identify the clinical, cultural, socioeconomic, and organizational factors that contribute to health disparities for minority populations (including examination of patterns of clinical decisionmaking and of the availability of support services);

''(B) identify and evaluate clinical and organizational strategies to improve the quality, outcomes, and access to care for minority populations;

''(C) support demonstrations to test such strategies; and

''(D) widely disseminate strategies for which there is scientific evidence of effectiveness.

''(2) USE OF CERTAIN STRATEGIES.—In carrying out this section the Administrator shall implement research strategies and mechanisms that will enhance the involvement of minority health services researchers, institutions that train minority researchers, and members of minority populations for whom the Agency is attempting to improve the quality and outcomes of care, including—

''(A) centers of excellence that can demonstrate, either individually or through consortia, a combination of multi-disciplinary expertise in outcomes or quality improvement research and a demonstrated capacity to engage minority populations in the planning, conduct and translation of research, with linkages to relevant sites of care;

''(B) provider-based research networks, including health plans, facilities, or delivery system sites of care (especially primary care), that make extensive use of minority health care providers or serve minority patient populations and have the capacity to evaluate and promote quality improvement; and

''(C) other innovative mechanisms or strategies that will facilitate the translation of past research investments into clinical practices that can reasonably be expected to benefit these populations.

''(c) QUALITY MEASUREMENT DEVELOPMENT.—

''(1) IN GENERAL.—To ensure that minority populations benefit from the progress made in the ability of individuals to measure the quality of health care delivery, the Administrator of the Agency for Health Care Policy and Research shall support the development of quality of health care measures that assess the experience of minority populations with health care systems, such as measures that assess the access of minority populations to health care, the cultural competence of the care provided, the quality of the care provided, the outcomes of care, or other aspects of health care practice that the Administrator determines to be important.

''(2) REPORT.—Not later than 24 months after the date of enactment of this section, the Secretary, acting through the Administrator, shall prepare and submit to the appropriate committees of Congress a report describing the state-of-the-art of quality measurement for minority populations which will identify critical unmet needs, the current activities of the Department to address those needs, and a description of related activities in the private sector.''.

(b) FUNDING.—Section 926 of the Public Health Service Act (42 U.S.C. 299c-5) is amended by adding at the end the following:

''(f) MINORITY HEALTH DISPARITIES RESEARCH.—For the purpose of carrying out the activities under section 906, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2000 through 2004.''.

TITLE IV—DATA COLLECTION RELATING TO RACE OR ETHNICITY

SEC. 401. STUDY AND REPORT BY NATIONAL ACADEMY OF SCIENCES.

(a) STUDY.—The Secretary of Health and Human Services shall enter into a contract with the National Academy of Sciences for the conduct of a comprehensive study of the Department of Health and Human Services' data collection systems and practices, and any data collection or reporting systems required under any of the programs or activities of the Department, relating to the collection of data on race or ethnicity, including other Federal data collection systems (such as the Social Security Administration) with which the Department interacts to collect relevant data on race and ethnicity.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the National Academy of Sciences shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Commerce of the House of Representatives, a report that—

(1) identifies the data needed to support efforts to evaluate the effects of race and ethnicity on access to and quality of health care and other services and on disparity in health and other social outcomes, the data needed to define appropriate quality of care measures to assess the equivalence of health care outcomes in health care payer systems, and the data needed to enforce existing protections for equal access to health care;

(2) examines the effectiveness of the systems and practices of the Department of Health and Human Services described in subsection (a), including demonstration projects of the Department, and the effectiveness of selected systems and practices of other Federal and State agencies and the private sector, in collecting and analyzing such data;

(3) contains recommendations for ensuring that the Department of Health and Human Services, in administering its entire array of programs and activities, collects, or causes to be collected, accurate and complete information relating to race and ethnicity as may be necessary to monitor access to and quality of health care and to ensure the capability to monitor and enforce civil rights laws; and

(4) includes projections about the costs associated with the implementation of the recommendations described in paragraph (3), and the possible effects of the costs on program operations.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for fiscal year 2000 to carry out this section.

TITLE V—PUBLIC AWARENESS

SEC. 501. PUBLIC AWARENESS.

(a) PUBLIC AWARENESS CAMPAIGN.—The Secretary of Health and Human Services, acting through the Surgeon General and the Director of the Office for Civil Rights, shall conduct a national media campaign for the purpose of informing the public about racial and ethnic disparities in health care and health outcomes.

(b) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out subsection (a), there are authorized to be appropriated such sums as may be necessary for fiscal year 2000.

STATEMENT OF LOUIS W. SULLIVAN, M.D., PRESIDENT, MOREHOUSE SCHOOL OF MEDICINE ON THE HEALTH CARE FAIRNESS ACT OF 1999, NOVEMBER 5, 1999

Thank you for the opportunity to speak in strong support of the Health Care Fairness Act of 1999, which would elevate the NIH's Office of Research on Minority Health to a National Center for Research on Minority Health and Health Disparities. Senator Kennedy and his colleagues are to be commended for their initiative.

For too many years, this country has witnessed one disturbing report after another detailing the growing disparities in health status between our minority and majority populations. Unfortunately, while these reports continue, not enough has been done to change this shocking and unacceptable dynamic.

Infant mortality is nearly twice the rate for minorities as it is for non-minorities.

African-Americans, Hispanics, and Native Americans disproportionately suffer a variety of health care disparities including cancer, diabetes, heart disease and stroke.

The HIV virus and AIDS cases result in disproportionate suffering in minority populations. While minorities in the United States represent about 28% of the population, minorities account for 54% of all AIDS cases.

The above mentioned are only a few of the health care challenges faced by minorities and disadvantaged populations.

If we as a nation are to solve these complex problems, we must take an aggressive approach on all fronts. At the core of improving the health status for all Americans is a strong biomedical research effort to understand the factors which contribute to health problems.

During the time I was HHS Secretary, I was very pleased to work with the Congress, particularly Congressman Louis Stokes (D–OH) to establish the existing Office for Research on Minority Health at NIH. Notwithstanding the success of this office in highlighting and addressing health disparities, and in supporting research focused on improving minority health, the magnitude of the problem of health status disparities warrants an even more aggressive effort.

At the beginning of this year, we were very pleased to begin working with Congressman Jesse Jackson, Jr. (D–IL), Charlie Norwood (R–GA), J.C. Watts (R–OK), and Congresswoman Donna Christensen (D–VI) to introduce H.R. 2391, the National Center for Domestic Health Disparities Act of 1999. The bipartisan Jackson bill, and the legislation that is being introduced today, would elevate the existing NIH Office of Research on Minority Health to a National Center for Research on Minority Health and Health Disparities, and provide the National Center with four new major mechanisms, which the existing office does not have. They are:

(1) The Director of the Center will participate with other Institute and Center Directors to determine research policy and initiatives at NIH.

(2) The Center will serve as the catalyst for forward-thinking, strategic planning for the entire NIH, in order to bring all of NIH's considerable resources to bear, to close the health status gap.

(3) The bill empowers the Center Director to make peer-reviewed grants in areas of promising research which are not being addressed by the existing centers and institutes at NIH.

(4) There will be a new program of support for research excellence at those academic health centers which have demonstrated a historic commitment to studying and addressing diseases which disproportionately affect minority Americans. As a result of this legislation, minority investigations and institutions like Morehouse School of Medicine, of which I am President, Meharry Medical College, and others will have access to the types of resources necessary to build and enhance research infrastructure, and seek to compete on a level playing field with other prominent institutions.

I am grateful that both of the comprehensive bills which are being introduced today in the Senate and the House embody these four principles, and I am particularly pleased that both bills enjoy strong bipartisan support.

Today, I am urging members of Congress in both chambers, and from both sides of the aisle to support and cosponsor these important bills. We need to act as quickly as possible to reverse the persistent health status gap, which affects some 28% of our citizens.

ASSOCIATION OF MINORITY
HEALTH PROFESSIONS SCHOOLS,
Washington, DC, November 3, 1999.

Hon. EDWARD M. KENNEDY,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR KENNEDY: Thank you for introducing the Health Care Fairness Act of 1999. This important legislation would, among other things, elevate the existing Office of Research on Minority Health at the National Institutes of Health (NIH) to a National Center for Research on Minority Health.

The National Center would be better able to respond to the health status disparity crisis facing minority Americans and medically underserved populations through the establishment of the following provisions:

The Director of the new Center would actively participate with Institute and Center Directors in planning major NIH initiatives.

This includes discussing how NIH's considerable resources can be used to effectively address health status disparities.

The Center Director would be able to make peer-reviewed grants in areas of promising research not currently being addressed by the NIH institutes and centers.

The Center would establish a Centers of Excellence program to support those academic health centers which have a historic commitment to studying diseases which disproportionately affect minority and disadvantaged populations.

On behalf of the Association of Minority Health Professions Schools, I extend our enthusiastic support for this important legislation. Please advise me as to how we can work with you and other members of the Senate to pass this important legislation.

Thank you again for your leadership in this area.

Sincerely,

RONNY B. LANCASTER,
President.

NATIONAL MEDICAL ASSOCIATION,
Washington, DC, November 4, 1999.

Hon. EDWARD KENNEDY,
Ranking Minority, Senate Committee on Health, Education, Labor and Pensions, Hart Senate Office Building, Washington, DC.

DEAR SENATOR KENNEDY: The National Medical Association (NMA) is pleased to support the ‘‘Health Care Fairness Act of 1999.’’ While the nation has experienced tremendous advances in biomedical research, the benefits of these advances have not fully transferred to the African American and other minority communities, which are unduly plagued with disproportionate rates of death and disease. As the changing demographics of the United States yield growing racial and ethnic minority populations, it is absolutely essential that the nation become more proactive in addressing the critical health and biomedical research needs of communities of color.

Critical provisions of the ‘‘Health Care Fairness Act of 1999’’ include:

The establishment of the Center for Research on Minority Health and Health Disparities at the National Institutes of Health (NIH);

The provision of funds for peer-reviewed minority health-focused research grants, at the Institutes and Centers of the NIH;

The requirement to establish a comprehensive plan and budget for the conduct and support of all minority research activities of the NIH agencies; and

The establishment of a grant program to support the development of culturally competent curricula in health care education.

The NMA supports the ‘‘Health Care Fairness Act of 1999’’ and believes that this legislation will create important opportunities for the nation to make concrete advances in it’s effort to close the health disparity gap.

Sincerely,

WALTER W. SHERVINGTON,
President.

ASSOCIATION OF
BLACK CARDIOLOGISTS, INC.,
Atlanta, GA, November 4, 1999.

Hon. EDWARD M. KENNEDY,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR HONORABLE SENATOR KENNEDY: The Association of Black Cardiologists, Inc. (ABC) would like to offer its full support of The Health Care Fairness Act of 1999. Its premise and objectives serve to meet the creativity and foresight needed to eliminate the disparity in health care and the mortality rate among African Americans versus White Americans. We wholeheartedly endorse the efforts of this bill to improve minority health, minority health research, data collection relating to race or ethnicity, and the promotion of medical education.

A robust economy and years of government pressure have helped move minority groups closer to the mainstream, but when it comes to health, studies show a stubborn, daunting and in some respects continuous disparity between Black and White Americans. For decades, Blacks have suffered higher death rates from nearly all-major causes including asthma, diabetes, cancer, major infectious diseases and cardiovascular diseases. The ABC recognizes that cardiovascular diseases, the leading cause of deaths in the United States, affect every family. CVD is the major cause of death for the African American population. Contrary to popular belief, the number one killer in the African American community is not violence, cancer, or AIDS. Blacks are more likely to die from cardiovascular disease than from any other disease. We can reduce the cost of health care, improve patient adherence to prescribed drug regimens, and improve the cultural competence of medical professionals with the passing of this bill.

The ABC mission states: ‘‘We believe that good health is the cornerstone of progress for our people. We are firm in our resolve to make exemplary health care accessible and affordable to all in need, dedicated to lowering the high rate of cardiovascular diseases in minority populations and committed to advocacy and diversity. We are guided by high ethics in all our transactions and strive for excellence in our training and skills.’’

Our mission throughout our organization is to assure that ‘African American Children know their Grandparents’. Typically, African American men, with a life expectancy of less than 65 years, die without the joy of nurturing and guiding their grandchildren as only grandparents can.

What we know from our past efforts to address this issue is that it takes a focus effort to increase awareness, to educate, and to eliminate the disparities in health care. We are pleased that this bill will take this direction. Little progress will be made without a strong partnership among medical, public health and community organizations, and government. Please let us know what else we can do to aid in this effort. We applaud your commitment and stand ready to work actively with you to accomplish these objectives.

Sincerely,

B. WAINE KONG,
Chief Executive Officer.

BOSTON UNIVERSITY
SCHOOL OF MANAGEMENT,
Boston, MA, October 14, 1999.

Senator EDWARD M. KENNEDY,
Russell Senate Building,
U.S. Senate, Washington, DC.

DEAR SENATOR KENNEDY: I am writing to register my strong and enthusiastic support for the Comprehensive Minority Health Bill, that is currently under consideration by the United States Senate. Considerable research has documented the great disparities in minority health status and health outcomes nationally. Racial and ethnic minorities are known to suffer disproportionately high mortality and morbidity rates, impaired access to health care, and lower quality health care services. This bill includes a host of provisions that would contribute importantly to the correction of this imbalance. The Bill’s proposals; to establish a NIH ‘‘Center for Health Disparities Research;’’ to provide grants to support programs of excellence in biomedical research education for underrepresented minorities; to direct AHCPR to study the causes of health disparities; to expand DHHS collection/reporting of race/ethnicity data; to improve the quality/outcomes of health care services to minority populations; and to develop graduate/continuing medical education curricula devoted to the reduction of disparity in health care and health outcomes, all represent strong actions intended to address the continuing health imbalance for racial/ethnic minorities.

I write as an academic researcher and educator, and as the national director of the Robert Wood Johnson Foundation’s Scholarships in Health Policy Research Program, an initiative that supports fellowships for talented young social scientists who are interested in conducting research on critical health and health policy issues facing the United States, including racial/ethnic disparities in health status and health outcomes. I write also as a citizen who is concerned with the needless loss of human potential and quality of life resulting from the continuing health disparities in our society. I call upon you and your colleagues in the U.S. Senate to support this Bill in all of its elements.

Respectfully submitted,

ALAN B. COHEN,
Professor of Health Policy and Management; Director, Health Care Management; Director, RWJF Scholars in Health Policy Research Program.

UCLA,
Los Angeles, CA, October 13, 1999.

Senator EDWARD M. KENNEDY,
Russell Senate Building,
U.S. Senate, Washington, DC.

DEAR SENATOR KENNEDY: I write to register my strong and enthusiastic support for the Comprehensive Minority Health Bill currently under consideration by the United States Senate. Considerable research has documented the great disparities in minority health status and health outcomes nationally. Race and ethnic minorities are known to suffer disproportionate mortality and morbidity rates and lower quality health care services. This bill includes a host of provisions that will contribute to the correction of this imbalance. The Bill’s proposals: to establish a NIH ‘‘Center for Health Disparities Research’’; to provide grants to support programs of excellence in biomedical research education for underrepresented minorities; to direct AHCPR to study the causes of health disparities; to expand HHS collection/reporting of race/ethnicity data and to improve the quality/outcomes of health care services to minority populations and to develop graduate/continuing medical education curricula devoted to the reduction of disparity in health care and health outcomes represent strong actions intended to address the continuing health imbalance for racial/ethnic minorities.

I write as an academic researcher and citizen who is concerned with the needless loss of human potential and quality of life resulting from the continuing health disparities in our society. I call upon you and your colleagues in the U.S. Senate to support this Bill in all of its elements.

Respectfully submitted,

WALTER R. ALLEN,
Professor of Sociology.

Attention: Ms. Stephanie Robinson

OCTOBER 13, 1999.

Senator KENNEDY,
Dirksen Senate Building,
Washington, DC.

DEAR SENATOR KENNEDY: I have read with interest your proposed changes and budget recommendations for the Office of Minority Health ‘‘Improving Minority Health Through NIH. As a scholar who does work and collaborations in the field of minority health, and the Chair of a Sociology and Anthropology Department with 62 young scholars in our Graduate Programs, many of whom care about these issues, we are collectively pleased to see this bill brought forward.

Support for intervention and prevention research (of significance) in our community is too long over overdue. I have held grants from the National Cancer Institute and the National Science Foundation and I know first hand about the obstacles of under funding and a focus that is primarily on advocacy and community based ‘‘feel good’’ projects rather than solid research. Research that could possibly bring about some parity in health and health care for people of color in our society. We in our Medical Sociology Program and colleagues who work in the many disciplines connected to health and qualify of life issues applaud you and bring our support by way of many letters like this one. Thank you.

Joy,

FLORENCE B. BONNER,
Chair.

By Mr. DODD:

S. 1881. A bill to amend chapter 84 of title 5, United States Code, to make certain temporary Federal service creditable for retirement purposes; to the Committee on Governmental Affairs.

THE FERS BUYBACK ACT OF 1999

Mr. DODD. Mr. President, today I am introducing the FERS Buyback Act of 1999, legislation that offers retirement security to many federal employees. Companion legislation has already been introduced in the House. Specifically, this legislation would help employees throughout the country hired as temporary workers in the 1980s that continued to work for the federal government into the 1990s.

Hundreds of current and former term employees in federal service find themselves ineligible to receive retirement benefits because of their inability to receive credit for post-1988 service as temporary federal workers.

This legislation would close a loophole in the federal pension system that has adversely impacted many federal workers through no fault of their own. It would change current law to allow individuals who have become eligible for the Federal Employee Retirement System (FERS) the option to receive credit for their past service as temporary employees and pay into the retirement fund for the prior years they worked as temporary employees. Because the legislation would merely allow qualified workers to buy into the retirement system, the government would not incur costs that it would not have incurred had the law treated them as permanent employees.

During the 1980s, the Federal Deposit Insurance Corporation (FDIC) hired thousands of employees under temporary status in response to the savings and loan crisis. Despite their temporary designation, many served in excess of five years with the federal government because of the FDIC's annual renewal of their one-year contracts. Unfortunately, these loyal employees did not enjoy the retirement benefits accorded their colleagues serving the same length of service under permanent status. To their credit, the FDIC did try to rectify the problem several years ago by granting many of their former temporary employees term appointments. Such appointments are for more than one year and allowed employees to be eligible for FERS.

The original FERS Act allowed for employees to make payments or buy back certain years of service prior to 1989 for which deductions were not taken. Therefore, the bill unintentionally denied many federal employees credit for time served after January 1, 1989.

I invite you to join me in correcting this inequity and ask that you cosponsor this fair and straightforward legislation.

By Mrs. HUTCHISON (for herself and Mr. STEVENS):

S. 1882. A bill to expand child support enforcement through means other than programs financed at Federal expense; to the Committee on Finance.

CHILD SUPPORT ENFORCEMENT OPTIONS ACT OF 1999

Mrs. HUTCHISON. Mr. President, I rise today to introduce, along with my colleague, Senator STEVENS, the Child Support Enforcement Options Act of 1999. This bill will give parents the tools and options they need to made sure their children have the resources they need to get a good start in life.

This bill will provide local public agencies and private attorneys access to certain child support enforcement procedures and information not currently available to them. To obtain this access, however, a local public agency or private attorney would first have to obtain a certificate of registration from the Secretary of the Federal Department of Health and Human Services and agree to certain federal requirements and procedures in using the enforcement tools.

Mr. President, in recent years Congress created a number of new information gathering and child support enforcement tools to enable some child support enforcement agencies to better enforce support awards. Unfortunately, these new tools are not available to hundreds of governmental and a growing number of private collection entities which many parents must use or choose to use. These so-called ‘‘non IV–D’’ entities have limited or no access to some new and effective federal collection tools. This legislation will extend these tools to so-called ‘‘non IV–D’’ entities that are properly approved and monitored by the Department of Health and Human Services.

Specifically, the bill will allow non-IV–D government agencies and private collection firms to be able to submit cases for the interception of Federal and State tax refunds for the collection of unpaid child support, in accordance with Federal and State statutory guidelines; to seek passport sanctions against delinquent parents; to report unpaid child support to credit bureaus; and to obtain current location and asset information on parents who owe child support. In addition, the bill provides that unemployment compensation benefits would be subject to income withholding for child support obligations in all child support cases, not just those enforced by a IV–D agency, as current law allows.

Mr. President, my bill will cost the Federal Government minimal or no additional funds. Nor will it impose any significant obligation on state or local child support agencies, since all government agencies would be allowed under the bill to charge necessary fees to non-IV–D agencies with which they share this information.

What this bill will do is take a significant step toward collecting on the estimated $57 billion in overdue child support owed in this country. Many states and local child support agencies are simply overwhelmed and unable to effectively and timely enforce the tens of millions of child support awards in this country. Far from undermining their role in this process, the Child Support Enforcement Options Act will help them accomplish the mutual goal of making sure that child support is collected and delivered to where it is needed the most—to the children to whom it is owed.

Particularly for families on welfare or other public assistance, child support is often critical to make ends meet. It helps put food on the table, clothes in the closet, and gas in the car. When a non-custodial parent reneges on his or her obligation to provide that support, it is incumbent upon the government to help enforce that award, through whatever means are available to the struggling custodial parent. In my opinion, any other consideration is secondary, and I am hopeful and confident that my colleagues in the Senate will agree and will work to pass this important legislation.

By Mr. BINGAMAN:

S. 1883. A bill to amend title 5, United States Code, to eliminate an inequity on the applicability of early retirement eligibility requirements to military reserve technicians; to the Committee on Governmental Affairs.

THE DUAL STATUS NATIONAL GUARD TECHNICIANS RETIREMENT EQUITY ACT

Mr. BINGAMAN. Mr. President, I rise today to introduce a bill that seeks to remove an inequity in retirement pay benefits for critical personnel in our National Guard and Reserve units who are Dual Status Technicians. They are called ‘‘Dual Status’’, Mr. President, because they serve both as military and civilian personnel. There are about 40,000 Dual Status Technicians covered by retirement requirements and restrictions contained in Title 32 of the United States Code. These men and women are the backbone of the National Guard and Reserve structure. They are the mechanics, pilots, engineers, equipment operators, supply and support technicians who keep things running so that the Guard is able to respond to natural disasters and national emergencies, as well as serve on active duty in accordance with the ‘‘total force concept’’ that integrates active and reserve forces in the military.

These hardworking men and women are often the first called to duty in an emergency.

As essential as Dual Status Technicians are, they suffer from the worst of two employment worlds. These technicians are by statute both military and civilian employees. Guard technicians must maintain their military job and grade in order to keep their technician status and remain a federal employee. In the event of separation from military service, however, they are denied the retirement benefits of those who serve in the same grade in the active military. Frequently, Dual Status Technicians who are separated from the military must wait years to qualify for their Federal Service retirement benefits.

The bill I am introducing in the Senate today is a companion bill already introduced on the House side by Representative ABERCROMBIE. It seeks to eliminate retirement inequities—a problem we just addressed head on in the Armed Services Committee when we included a provision in this year's Defense Authorization Bill the eliminate retirement inequities between active duty personnel who retired before or after 1986. We voted this year to effectively eliminate the ‘‘Redux’’ retirement benefit program because of the lower benefits it offered to personnel who retired after 1986. The action I am proposing in this legislation is somewhat similar.

This bill will permit Dual Status Technicians to retire at any age with 25 years of service or at 50 with 20 years of service. Those benefits are similar to benefits provided to Federal police and fire employees. They're similar to federal employees who retire from the Congress.

I am pleased to see, Mr. President, that this year's Defense Authorization bill took a step to provide equitable benefits to Dual Status Technicians, but in doing so, it crated an inequity within the Technician community itself. A provision in the bill provides for early retirement after 25 years at any age, or at age 50 with 20 years of service—but only for those employed as Dual Status Technicians after 1996. Those same benefits are withheld from those employed before 1996. In other words, Mr. President, we created a situation similar to the one the Senate dealt with regarding the ‘‘Redux’’ retirement program in the Defense Authorization bill. The bill I offer today would remove that inequity in the same way the Senate voted to remove the inequity for active duty personnel who retired under the ‘‘Redux’’ program.

Mr. President, the cost of equity is not high. An initial estimate by the Congressional Budget Office estimates that this bill could cost about $54 million over a five year period. That number will vary, of course, depending on the number of Technicians who would choose to take advantage of the change in the law when this bill is enacted. Of course, we're not only paying for equity here, Mr. President. We're paying appropriate, equitable compensation to the men and women who have devoted their careers to service for the nation both at home and abroad—our National Guard and Reserve who serve us all so well.

I urge my colleagues to support this bill and urge my fellow Members to support this effort through cosponsorship.

ADDITIONAL COSPONSORS

S. 311

At the request of Mr. MCCAIN, the names of the Senator from Arkansas (Mr. HUTCHINSON) and the Senator from Montana (Mr. BURNS) were added as cosponsors of S. 311, a bill to authorize the Disabled Veterans' LIFE Memorial Foundation to establish a memorial in the District of Columbia or its environs, and for other purposes.

S. 312

At the request of Mr. MCCAIN, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 312, a bill to require certain entities that operate homeless shelters to identify and provide certain counseling to homeless veterans, and for other purposes.

S. 345

At the request of Mr. ALLARD, the name of the Senator from New York (Mr. MOYNIHAN) was added as a cosponsor of S. 345, a bill to amend the Animal Welfare Act to remove the limitation that permits interstate movement of live birds, for the purpose of fighting, to States in which animal fighting is lawful.

S. 765

At the request of Ms. COLLINS, the name of the Senator from Iowa (Mr. HARKIN) was added as a cosponsor of S. 765, a bill to ensure the efficient allocation of telephone numbers.

S. 786

At the request of Ms. MIKULSKI, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 786, a bill to amend title II of the Social Security Act to provide that a monthly insurance benefit thereunder shall be paid for the month in which the recipient dies, subject to a reduction of 50 percent if the recipient dies during the first 15 days of such month, and for other purposes.

S. 819

At the request of Mr. GRAHAM, the name of the Senator from Georgia (Mr. CLELAND) was added as a cosponsor of S. 819, a bill to provide funding for the National Park System from outer Continental Shelf revenues.

S. 955

At the request of Mr. WARNER, the name of the Senator from Mississippi (Mr. LOTT) was added as a cosponsor of S. 955, a bill to allow the National Park Service to acquire certain land for addition to the Wilderness Battlefield in Virginia, as previously authorized by law, by purchase or exchange as well as by donation.

S. 1016

At the request of Mr. DEWINE, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 1016, a bill to provide collective bargaining for rights for public safety officers employed by States or their political subdivisions.

S. 1020

At the request of Mr. GRASSLEY, the names of the Senator from Missouri (Mr. ASHCROFT) and the Senator from Idaho (Mr. CRAPO) were added as cosponsors of S. 1020, a bill to amend chapter 1 of title 9, United States Code, to provide for greater fairness in the arbitration process relating to motor vehicle franchise contracts.

S. 1075

At the request of Mrs. BOXER, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 1075, a bill to promote research to identify and evaluate the health effects of silicone breast implants, and to insure that women and their doctors receive accurate information about such implants.

S. 1242

At the request of Mr. AKAKA, the names of the Senator from Vermont (Mr. LEAHY) and the Senator from Vermont (Mr. JEFFORDS) were added as cosponsors of S. 1242, a bill to amend the Immigration and Nationality Act to make permanent the visa waiver program for certain visitors to the United States.

S. 1263

At the request of Mr. JEFFORDS, the name of the Senator from North Carolina (Mr. EDWARDS) was added as a cosponsor of S. 1263, a bill to amend the Balanced Budget Act of 1997 to limit the reductions in medicare payments under the prospective payment system for hospital outpatient department services.

S. 1327

At the request of Mr. CHAFEE, the names of the Senator from Washington (Mr. GORTON) and the Senator from Washington (Mrs. MURRAY) were added as cosponsors of S. 1327, a bill to amend part E of title IV of the Social Security Act to provide States with more funding and greater flexibility in carrying out programs designed to help children make the transition from foster care to self-sufficiency, and for other purposes.

S. 1332

At the request of Mr. BAYH, the names of the Senator from Virginia (Mr. ROBB) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of S. 1332, a bill to authorize the President to award a gold medal on behalf of Congress to Father Theodore M. Hesburg, in recognition of his outstanding and enduring contributions to civil rights, higher education, the Catholic Church, the Nation, and the global community.