PARTICIPATION OF TAIWAN IN THE WORLD HEALTH ORGANIZATION

Ms. COLLINS. I ask unanimous consent the Senate proceed to the consideration of Calendar No. 382, H.R. 1794.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 1794) concerning the participation of Taiwan in the World Health Organization.

There being no objection, the Senate proceeded to consider the bill.

Ms. COLLINS. I ask unanimous consent the bill be read the third time and passed, the motion to reconsider be laid upon the table, and any statements related to the bill be printed in the RECORD.

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

The bill (H.R. 1794) was read the third time and passed.

VETERANS' MILLENNIUM HEALTH CARE ACT—CONFERENCE REPORT

Ms. COLLINS. Mr. President, I submit a report of the committee of conference on the bill (H.R. 2116) to amend title 38, United States Code, to establish a program of extended care services for veterans and to make other improvements in health care programs of the Department of Veterans Affairs, and ask for its immediate consideration.

The PRESIDING OFFICER. The report will be stated.

The legislative clerk read as follows:

The committee on conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill, H.R. 2116, have agreed to recommend and do recommend to their respective Houses this report, signed by all of the conferees.

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

(The conference report is printed in the House proceedings of the RECORD of November 16, 1999.)

Mr. SPECTER. Mr. President, I urge my colleagues to join me in support of the Veterans Millennium Health Care and Benefits Act of 1999. On Veterans Day, many of the members honored America's veterans and acknowledged our debt to them for their service. This legislation gives the Senate an opportunity to do something tangible to honor our veterans.

The Veterans Millennium Health Care and Benefits Act of 1999 contains 74 substantive provisions; I refer the Members to the conference report text for a complete description. Let me highlight just a few provisions now.

Long-term care for veterans is one of the most pressing issues facing America—and the Department of Veterans Affairs (VA). A half century ago, the 16 million youthful veterans of World War II looked forward to building new civilian lives. Today, only about 6 million survive, and their average age is 75. Health care is their primary concern, the long-term care is a critical component of their health care needs. Simply put, what World War II veterans need from VA is long-term care. Soon, so too will the 4 million Korean war veterans, now in their mid-sixties, and the 8 million Vietnam veterans, now in their fifties, who follow them.

Under current law, VA is not required to provide long-term care to any veteran. Such care is purely discretionary to VA; it is supplied on a space available basis only. Under this "discretionary" authority—as inadequate as it has been—VA has made a substantial contribution to the long term care needs of veterans—by directly providing (at an annual cost of $1.1 billion) nursing home care to an average of approximately 13,000 veterans per day; by paying for nursing home care received by approximately 6,500 veterans per day in private nursing homes (at as annual cost of $316.8 million); by subsidizing (at an annual cost approximately $200 million per year) nursing home care provided to approximately 14,000 veterans per day in State veterans' homes; and by providing non-institutional alternatives to nursing home care to an average of 11,000 veterans at any given time at an annual cost of $154 million.

Notwithstanding these significant contributions by VA, there is increasing evidence that the discretionary nature of VA's long-term care mission has created an incentive for VA to divert resources to other missions and reduce its capacity to provide long-term care. This bill responds to that negative trend by requiring VA to maintain long term capacity at least the 1998 level. In addition, this legislation would, for the first time, require—not authorize—VA to provide nursing home care to veterans who need it to treat service-connected conditions, and to severely service-disabled veterans who need it to cope with other conditions.

Nursing home care is the most expensive form of long-term care and, from the veterans' standpoint, the form of care which is to be avoided if possible, or delayed until it is inevitable. This bill will assure that non-institutional alternatives to nursing home care—home-based primary care, home health aide visits, adult day health care, and similar services—will be available to veterans who need such services by requiring that VA include them in the package of medical services to which each veteran who enrolls for VA care is entitled. The provision of such services, as an alternative to much more expensive inpatient nursing home care, will save money and improve aging veterans' lives.

This legislation also directs VA to operate pilot programs to identify the best—and most cost-effective—ways to meet veterans' long term needs. Armed with the data generated by these pilot programs, Congress will reevaluate VA nursing home and non-institutional long term care after three years and determine how best to proceed at the four-year "sunset" point of this legislation. I might add that the conferees were all in agreement that, when we get to the point where we consider renewal of this legislation, we will be looking for ways to improve it, not to repeal it.

There is one additional key feature of this legislation that merits mention: this bill will plug a substantial hole in VA health care coverage by allowing VA to fund the emergency care needs of all enrolled veterans who do not have other health care coverage to fund such care. The President has stated that all Americans should have access to emergency care. This bill assures that veterans who rely on VA for care will.

I am particularly pleased that this bill will extend, expand, and improve VA's authority to provide counseling to the victims of sexual trauma while on active duty. It will also extend and improve services for homeless veterans; it will liberalize eligibility for survivors' benefits for widows of totally disabled ex-POWs; it will expand benefits available to veterans exposed to radiation while in service; and—importantly—it will ensure that the World War II Veterans' Memorial is constructed in a timely manner by facilitating fund raising for that monument.

This legislation does many positive things, particularly for our older veterans. The Committee on Veterans' Affairs, however, must also respond to the needs of veterans who are leaving the service today. Educational assistance is the most important benefit that our Nation provides to young veterans. Earlier this year, the Senate passed legislation which would have substantially improved benefits under the Montgomery GI bill. Unfortunately, budgetary pressures compelled the conferees to set these provisions aside for now. I know, however, that the House supports improvements in Montgomery GI bill benefits, and we will take that issue up again in the second session.

This legislation reflects the hard work and dedication of many members of the Senate and the other body. I particularly acknowledge the contribution of the Ranking Minority Member of the Committee on Veterans' Affairs, Senator ROCKEFELLER, and our Committee's longest-serving member and a member of the conference committee, Senator THURMOND. The conference committee could not have reached a successful conclusion without them, or without the energy and commitment of the chairman of the House Committee, BOB STUMP and his ranking member, LANE EVANS. I thank them. And I urge the Senate to approve this conference report.

Mr. DOMENICI. Mr. President, it is with great pleasure that I rise today to talk about the Senate passage of the Veterans' Millennium Health Care Act.

I am extremely pleased the act contains a provision that will extend the useful life of the Santa Fe National Cemetery in New Mexico. I also want to thank Senator SPECTER for his assistance in making passage of this Bill possible.

The men and women who have served in the United States Armed Forces have made immeasurable sacrifices for the principles of freedom and liberty that make this Nation unique throughout civilization. The service of veterans has been vital to the history of the Nation, and the sacrifices made by veterans and their families should not be forgotten.

These veterans at the very least deserve every opportunity to be buried at a National Cemetery of their choosing. Unfortunately, projections show the Santa Fe National Cemetery will run out of space to provide casketed burials for our veterans at the conclusion of 2000. However, with Senate passage of this bill we are ensuring the continued viability of the Santa Fe National Cemetery.

I believe all New Mexicans can be proud of the Santa Fe National Cemetery that has grown from 39/100 of an acre to its current 77 acres. The cemetery first opened in 1868 and within several years was designated a National Cemetery in April of 1875.

Men and women who have fought in all of nation's wars hold an honored spot within the hallowed ground of the cemetery. Today the Santa Fe National Cemetery contains almost 27,000 graves that are mostly marked by upright headstones.

The Senate's action today guarantees the Santa Fe National Cemetery will not be forced to close next year. A provision in the bill passed today allows the Secretary of Veterans Affairs to provide for the use of flat grave markers that will extend the useful life of the cemetery until 2008.

While I wish the practice of utilizing headstones could continue indefinitely if a veteran chose, my wishes are outweighed by my desire to extend the useful life of the cemetery. I would note that my desire is shared by the New Mexico Chapter of the American Legion, the Albuquerque Chapter of the Retired Officers' Association, and the New Mexico Chapter of the VFW who have all endorsed the use of flat grave markers.

Finally, this is not without precedent because exceptions to the law have been granted on six prior occasions with the most recent action occurring in 1994 when Congress authorized the Secretary of Veterans Affairs to provide for flat grave markers at the Willamette National Cemetery in Oregon.

Mr. President, I again want to thank Senator SPECTER for his assistance and state how pleased I am with the final passage of this important bill.

Mr. ROCKEFELLER. Mr. President, as the ranking member of the Committee on Veterans' Affairs, I am enormously pleased that the Congress has passed this comprehensive bill which would make extensive changes to a wide range of veterans' benefits and services. This legislation is the culmination of extensive oversight and investigation, as well as the normal process of developing legislation—hearings and markups in both the House and Senate. Further, the bill represents compromise on both sides of the aisle and in both Houses of Congress. It represents many, many hours of staff and Members' work, and for that, I thank everyone involved.

The bill covers a wide spectrum of issues—from long-term care to new educational benefits for servicemembers. I will address some of the more substantive provisions.

Mr. President, H.R. 2116, as amended, represents a comprehensive effort to address the long-term care needs of our veterans.

We know that there is an expanding need for long-term care in our country, and in the VA, the demand is even more pressing. About 35 percent of the veteran population is 65 years or older, and that number will grow dramatically in the next few years. With this legislation, we are taking an important step forward for our veterans, and I am hopeful that it signals a new concern for providing long-term care for all elderly Americans.

For the first time, the VA will be required to provide extended care services to enrolled veterans. Section 101 directs the VA to provide nursing home care to any veteran who is in need of such care for a service-connected condition, or who is 70 percent or more service-connected disabled. In addition, the VA is directed to provide non-institutional care, such as home care and adult day health care, to all enrolled veterans. This latter provision was included in the Veterans' Long-term Care Enhancement Act of 1999 which I introduced this summer. Within three years of the bill's enactment, VA would evaluate and report to the House and Senate Committees on Veterans' Affairs on its experience in providing services under both of these provisions.

Under the bill, the VA is also required to operate and maintain extended care programs so as to ensure that the level of extended care services is not less than the level of such services provided during fiscal year 1998.

Finally, in order to offset the cost of this new program expansion, the conference agreement requires new long-term care copayments for services exceeding 21 days in any year. Veterans who have compensably rated service-connected conditions and veterans with incomes below the pension rate are exempted from these copayments. Under this provision, VA would be required to develop a methodology for establishing the amount of copayments, taking into account the income of the veterans, the need to protect the veteran's spouse from financial difficulties, and the desire to allow the veteran to retain a personal allowance. Further, it was the conferees' desire that copayments would not apply to patients who are currently receiving long-term care services.

Section 102—also based on the Veterans' Long-term Care Enhancement Act of 1999 which I authored—mandates that the Secretary of Veterans Affairs carry out a series of pilot programs, over a period of three years, which would be designed to gauge the best way for VA to meet veterans' long-term care needs: either directly, through cooperative arrangements with community providers, or by purchasing services from non-VA providers.

While VA has developed significant expertise in long-term care over the past 20-plus years, it has not done so with any mandate to share its learning with others, nor has it pushed its program development beyond that which met the current needs at the time. Some experts even believe that VA's expertise is gradually eroding. For VA's expertise to be of greatest use to others, it needs both to better capture what it has done and to develop new learning that would be most applicable to other health care entities.

A key purpose of the pilot program would be to test and evaluate various approaches to meeting the long-term care needs of eligible veterans, both to develop approaches that could be expanded across VA, as well as to demonstrate to others outside of VA the effectiveness and impact of various approaches to long-term care. To this end, the pilot program would include specific data collection on matters such as cost effectiveness, quality of health care services provided, enrollee and health care provider satisfaction, and the ability of participants to carry out basic activities of daily living.

Another provision based on my veterans' long-term care legislation would authorize the VA to establish a pilot program for assisted living services. Assisted living is the last remaining gap in VA's long-term care continuum, and the Federal Advisory Committee on the Future of VA Long-Term Care recommended that VA be granted the authority to provide assisted living services. I urge VA to undertake this pilot program, as it will provide a basis on which to recommend expanding the authority.

Mr. President, earlier this year I joined with Senator DASCHLE as an original cosponsor to S. 1146, the Veterans' Access to Emergency Care Act of 1999. In June, I offered the provisions included in this bill as an amendment to a veterans omnibus measure being discussed at a Senate Committee on Veterans' Affairs markup. The amendment was agreed to by a majority of the Committee members.

Just this week I was reminded of the need for better coverage for non-VA emergency care. The wife of a seriously ill veteran in my state of West Virginia called my office. Her husband is a non-

service-connected, low income veteran with no health insurance. Recently, severe chest pains sent him to a VA medical center. Because he is a cardiac patient and because he was in so much distress, his family wanted to call the rescue squad to transport him to the VA medical center. The veteran refused. Why? Because he had used the ambulance service before in an emergency situation, leaving the family with a sizeable bill that they are unable to pay. So, this sick veteran almost crawled to the family car, insisting that his family drive him. Once there, the VA medical staff told the veteran and his family that by not calling for an ambulance, the veteran was placed at risk.

Section 111 would authorize the VA to make non-VA emergency care reimbursement payments on behalf of enrolled veterans in all priority groups, provided the veteran has received VA care within a two-year period prior to the emergency and has no other health insurance options.

While this emergency care provision is significantly more restrictive than I had wanted, it is a valuable first attempt at ensuring that veterans who do not have other health insurance options—like the seriously ill West Virginia veteran who refused when his family tried to call for an ambulance—will be reimbursed for their non-VA emergency care services. In negotiating this provision, I was resolute in pushing for all enrolled veterans to have this coverage. I will be watching closely to ensure that this more limited emergency care provision is working for our veterans.

Section 112 is based on legislation introduced by Senator ROBB. It would establish a specific eligibility for VA health care for veterans who were awarded the Purple Heart. This provision is designed to provide priority for enrollment to these veterans who have no other special eligibility for care.

According to the Military Order of the Purple Heart, there are about one-half million veterans with this award. Roughly half of these honored veterans already would qualify for high priority care based on a service-connected disability or because of income.

The recipients of the Purple Heart award are American heroes, and I thank Senator ROBB for his leadership on this measure, which will ensure that the remaining 500,000 Purple Heart veterans will have unfettered access to VA health care services.

Military retirees have had a difficult time accessing various health care programs. Reductions in military treatment facilities, in particular, have restricted military retirees' health care options. Section 113 attempts to improve their situation.

Under the bill, the Secretaries of Defense and Veterans Affairs will be directed to enter into an agreement to allow for VA reimbursement for health care services provided to military retirees. Veterans who have retired from military service and who are not otherwise eligible for VA care will not be responsible for copayments.

In order to protect current enrollees, the Secretary must document that VA—in a given area—has the capacity in such an area to provide timely care to enrollees and has determined that VA would recover its cost of providing such care.

I am very pleased that House and Senate conferees were able to reach agreement on this provision to improve care for military retirees.

Section 117 is of particular interest to me as it addresses VA's specialized mental health services for veterans.

Last year, I directed my staff on the Committee on Veterans' Affairs to undertake a study of the services the Department of Veterans Affairs offers to veterans with special needs. Earlier this summer, I received the report my Committee staff wrote based on their 8-month oversight investigation, which sought to determine if VA is complying with a Congressional mandate to maintain capacity in five of the specialized programs: Prosthetics and Sensory Aids Services, Blind Rehabilitation, Spinal Cord Injury (SCI), Post-Traumatic Stress Disorders (PTSD), and Substance Use Disorders. I was dismayed to learn that because of staff and funding reductions, with the resulting workload increases and excessive waiting times, the latter two programs are failing to sustain services at the needed levels.

With specific regard to PTSD, VA has been moving to reduce inpatient treatment of PTSD, while expanding its use of outpatient programs. VA's decision has been fueled in part by studies of the cost effectiveness of various treatment approaches. The potential to stretch limited VA dollars to be able to treat more veterans is appealing. However, VA needs to be cautious before subscribing to the idea that outpatient care is as good as inpatient care for all veterans with PTSD. For some of the more seriously affected veterans—those who have not succeeded in shorter inpatient or outpatient programs, are homeless or unemployed, or have dual diagnoses—longer inpatient or bed-based care may be a necessity.

Substance use disorders also present complex treatment problems and have taken the brunt of reductions in specialized programs. Some substance use disorder programs have terminated inpatient treatment completely, except for veterans requiring short detoxifications in extreme situations. While some medical centers have closed inpatient substance use disorder beds, they have worked to provide alternative, sheltered living arrangements. Unfortunately, not all facilities have made these efforts. Many have moved directly to the closure of inpatient units without first developing these other alternatives.

As an outgrowth of this oversight effort, I developed legislation to require that VA provide better care for veterans in need. I thank Chairman SPECTER for accepting this legislation and including it in S. 1076, the Veterans Benefits Act of 1999.

Under section 117, the Secretary of Veterans Affairs is required to carry out programs to enhance the provision of specialized mental health services to veterans. The conference agreement specifically targets services for those afflicted with PTSD and substance use disorders. The legislation also requires that $15 million in funding will be made available, in a centralized manner, to fund proposals from the VISNs and the individual facilities to provide specialized mental health services. The legislation specifically ensures that this $15 million in grant funding will be over and above what VA currently spends on these programs.

The focus of Section 117 is on expanding outpatient and residential treatment facilities, developing better case management, and generally improving the availability of services. Though not specifically mentioned in the legislation, I encourage VA to carry out programs for the following: (1) additional outpatient and residential treatment facilities for PTSD in areas that are underserved by existing programs; (2) short-term or long-term care services that combine residential treatment of PTSD; (3) dedicated case management services on an outpatient basis for veterans suffering from PTSD; (4) enhanced staffing of existing PTSD programs; (5) additional community-based residential treatment facilities for substance use disorder programs; (6) expanded opioid treatment services; and (7) enhanced substance use disorder services at facilities where such services have been eliminated.

In my view, VA's mental health treatment programs, in general, have been cut back to the point that veterans in some areas of the country are suffering needlessly. That is why I am so pleased that H.R. 2116 includes provisions to prompt VA to begin to rebuild some of what has been lost.

Section 201—based on the House bill—would allow the Secretary of Veterans Affairs the authority to set copayments, both for pharmaceuticals and for outpatient treatment. Currently, all veterans who are below 50 percent service-connected disabled, and veterans whose income is below the pension level, are required to pay $2 for each 30-day supply of medication. And all "category C" veterans are required to pay copayments based on the estimated average cost of an outpatient visit—currently $45.80.

The outpatient copayment rate needs to be adjusted. This charge is incurred each and every time a category C veteran receives outpatient care, regardless of the services provided. There is no doubt that $45 for a routine outpatient visit is unreasonable at best, and at its worst, may, in fact, discourage veterans from getting the primary care they need. I am confident that VA will study this issue closely and will

set the outpatient copayment to be more in line with managed care plans which charge either $5 or $10.

While I am supportive of adjusting the outpatient copayment, I have serious concerns about increasing the pharmaceutical drug copayment. The House Committee on Veterans' Affairs was adamant that the Senate recede to this increase to help offset the Senate-sponsored program expansions in long-term care and emergency care. And although the $2 per prescription charge that veterans are paying now may seem like an insignificant amount to some, I can assure my colleagues that to the veteran and his family living on a very limited income, it is quite significant. I hear from a number of veterans whose income hovers just above the pension level, who must pay the assigned copayment for their pharmaceuticals. Many of them are older veterans who are on a number of different medications for multiple medical conditions.

It is critically important that we do not place this segment of our veteran population in the same situation as many of our aging population receiving care in the private sector—having to choose between buying their medication or putting food on the table.

In an effort to prevent this from happening, I strongly urge the VA to set maximum monthly and annual copayment amounts which are sensitive to the financial situation of veterans for those who have multiple outpatient prescriptions. I will be closely watching the implementation of this provision to ensure that it does not impose an undue burden on our veterans.

While the Senate was not able to stave off the House in increasing prescription copayments, we were able to flatly reject a House provision to require copayments for hearing aids and eyeglasses. Such a provision would penalize veterans who are taking advantage of a needed benefit.

Section 206 extends the VA's program for the evaluation of the health of spouses and children of Gulf War veterans for four years. I pushed for the original legislation providing for these health evaluations after hearing about Gulf War veterans and their families who reported miscarriages, birth defects, and other reproductive problems.

Last year, the Congress modified this program to allow VA to use fee-basis care. It seems that these modifications are working well, as many new dependants have applied and are now waiting to be seen.

I am delighted that this program has been extended because the need for assessments continues. By this time last year, 2,800 dependents had applied for the program, and this year that total is up to 4,000. However, although 4,000 dependents have applied for the evaluations, VA has only completed 1,140 examinations. I urge VA to process these examinations as rapidly as possible. These dependents of servicemembers should not be delayed in their quest for answers.

Section 208 contains provisions to improve VA's enhanced use lease authority. I am delighted with these provisions, because I believe enhanced use leases are a critical component of VA's management strategy for its property. Many terrific projects that better serve veterans and assist the VA have been developed under this authority. By way of this legislation, we are encouraging VA to develop more enhanced use lease projects to leverage its assets, rather than begin to dispose of irreplaceable property.

Since VA received enhanced use authority, it has been used in a variety of ways. One approach has been to lease land to companies that build nursing homes where VA can place veterans at discounted rates, resulting in savings of millions of dollars. Another use has been to provide transitional housing for homeless veterans. Other projects have created reliable child care and adult day care facilities for VA employees' families, so that they can care for veterans without having to worry about the health and safety of their loved ones. In other locations, VA regional offices are moving onto VA medical center campuses, resulting in more convenient access for veterans and better cooperation between the Veterans Benefits Administration and the Veterans Health Administration.

Section 208 of H.R. 2116 would remove many of the current barriers preventing VA from having an even more successful enhanced use lease program. It would allow VA to enter into leases with terms of up to 75 years, rather than the current 20 and 35 years, while eliminating the distinction in lease terms that exists between leases involving new construction or substantial renovation, and those involving current structures.

I am very interested in seeing VA engage in more of these projects, so I am pleased to see that H.R. 2116 would require the Secretary to provide training and outreach regarding enhanced use leasing to personnel at VA medical centers. The bill also requires the Secretary to contract for independent assessments of opportunities for enhanced use leases. These assessments would include surveys of suitable facilities, determinations of the feasibility of projects at those facilities, and analyses of the resources required to enter into a lease. I hope that more training—which until now has been sporadic and provided primarily on a by-request basis—and a more systematic and centralized approach would assist the VA in maximizing its enhanced use lease opportunities.

While VA currently has a policy which allows for fee-basis care for chiropractic care, section 303 of H.R. 2116 requires the VA Under Secretary for Health, in consultation with chiropractors, to establish a wider VA policy on chiropractic care. While conferees have agreed that VA should establish a policy regarding chiropractic care, they have remained silent on mandating that VA furnish veterans with chiropractic treatment. Indeed, it is Congress' intent that this provision not be read as an endorsement for chiropractic care.

Complementary and alternative medicine, including chiropractic care, are important aspects of health care. I urge VA to use this opportunity to develop a policy on all forms of complementary and alternative medicine. In particular, the report ''VHA Complementary and Alternative Medicine Practices and Future Opportunities'' recommended that VHA consider providing acupuncture, following guidelines set forth by the National Institutes of Health, since NIH has already approved acupuncture as an effective treatment for back pain.

I am extremely disappointed that the House would not move the Senate Montgomery GI Bill (MGIB) enhancement legislation. The Senate passed MGIB enhancements on three occasions this year, but the House did not respond.

S. 1402, the education bill reported out of the Senate Committee on Veterans' Affairs, contained a provision, among others, to increase the monthly benefit provided to current servicemembers from $528 to $600. This more than 12 percent increase would have followed on the heels of a 20 percent increase last year. Additionally, the Senate bill would have allowed servicemembers to elect to contribute up to an additional $600, in exchange for receiving four times their contribution. Although these increases fall short of the full tuition recommended by the so-called Transition Commission, they would have provided a substantial assistance to veterans. The costs of tuition and fees for public and private educational institutions rose approximately 90 percent from 1980–1995, while the MGIB benefit rates only increased 42 percent from 1985 to 1995.

The statistics regarding education and employment for veterans are also revealing. Despite almost full enrollment in the program by servicemembers, the number of eligible veterans who take advantage of their MGIB benefits is startlingly low, around 50 percent. Less than 20 percent of those who use the MGIB attend private institutions. And the Transition Commission reports that the unemployment rate for veterans ages 20–24 and 35–39 is higher than their non-veteran counterparts. All these are reasons why I believe that there is more that we can and must do. Unfortunately, we will need to wait until at least next year to tackle these issues.

H.R. 2116 does provide for two provisions—relating to test preparation and Officer Candidate Training—which while small, can make a significant difference to the individual veterans affected.

The Department of Veterans Affairs currently has authority to provide MGIB benefits for post-graduate exam preparatory courses that are required

for a particular profession, such as CPA exam or bar review courses. However, it does not have authority to provide for pre-admission preparatory coursework.

Nevertheless, studies by national consulting companies have shown improvement of over 100 points on the SAT exam and an average improvement of seven points in LSAT scores for students who take exam preparatory courses. An article in the April 13, 1998, New Republic stated, "[t]horough, expertly taught preparation can raise a student's ability to cope with, and hence succeed on, a particular exam. In many cases, then, test prep can make the difference between getting into a top-flight law school and settling for the second tier." At some of the nation's top schools, scores on entrance exams can count for half of the total application.

The problem is that many of these exam preparatory courses are quite costly. One national provider charges as much as $750 for a two-month, part-time, SAT preparatory course. One educational advocacy group, Fairtest, argues that "[t]he SAT has always favored students who can afford coaching over those who cannot . . ." To be able to compete, it is critical that veterans have access to such courses.

That is why I am pleased that section 701 corrects that disparity by allowing veterans to use their MGIB benefits for preparatory courses for entrance examinations required for college and graduate school admission ("test prep"). By giving veterans the opportunity to better their admissions test scores, this amendment would expand the choices available to veterans in their course of higher education. It will also improve access to the top educational institutions for veterans.

Section 702 allows servicemembers who failed to complete their initial period of service—because of entry to Officer Candidate School or Officer Training School ("OCS")—to retain their eligibility for MGIB benefits. This would allow their OCS service to count toward that initial obligated period of service (generally three years total).

In most instances, these servicemembers had already made a $1,200 contribution to the MGIB, which cannot be refunded, by law. Rather than refund this money, the House and Senate agree that we should allow these men and women to retain their MGIB eligibility and further their education.

Like the test prep provision, it should be our policy to always encourage servicemembers and veterans to strive for greater achievement. This provision corrects an oversight in the MGIB statutes that penalizes servicemembers for seeking promotions.

As we are all sadly aware, the veteran population is aging rapidly. In 1997, 537,000 veterans died. Projections of the veteran death rate show an increase through the year 2008, when the death rate of the WWII and Korea-era veterans will peak at 620,000 veterans. Unless expanded, 21 national cemeteries are scheduled to close to inground burial or close completely by FY 2005. National cemeteries take an average of seven years to open. That is why I felt it was critical to address now VA's plan to provide burial sites for our nation's veterans.

VA conducted studies in 1987 and 1994 that identified the top 10 veteran population areas that are not served by a national cemetery. Pursuant to those studies, VA has begun, and in some cases completed, construction of six cemeteries in: Cleveland (OH), Chicago (IL), Seattle (WA), Dallas (TX), Saratoga (NY), and San Joaquin Valley (CA).

However, there has been no activity in the remaining six locations contained on the 1987 and 1994 lists: Detroit (MI), Sacramento (CA), Miami (FL), Atlanta (GA), Pittsburgh (PA), and Oklahoma City (OK). That is why I am pleased that H.R. 2116 authorizes VA to build cemeteries in the top areas in need. I am hopeful that the Appropriations Committee will fund construction of these cemeteries, particularly in light of their direction of advanced planning funds in this year's VA-HUD Appropriations bill.

Sections 601–603 authorize the American Battle Monuments Commission to borrow funds from the Treasury Department to construct the WWII memorial on the Mall if it is unable to raise sufficient funds through private donations. It also extends the authority to break ground for four years. This will ensure that the veterans who are to be honored by this memorial will be able to see it constructed.

I have agreed to a study, based on a House provision, of the current state of cemeteries to assess repair needs, ways to improve appearance, and the number of cemeteries needed to serve veterans who die after 2005. Finally, section 621 requires that the VA study the adequacy and effectiveness of burial benefits that a veteran's dependents receive, as well as options to better serve veterans and their families. In light of inflation in the cost of burials, as well as the increase in options such as cremation and burial at sea, it is appropriate that VA reevaluate this program.

This bill contains a number of benefits provisions that will aid veterans. For example, section 503 will add bronchiolo-alviolar carcinoma to the list of presumptive conditions associated with exposure to ionizing radiation. Bronchiolo-alviolar carcinoma is a type of lung cancer. The Senate has passed provisions adding lung cancer to the list of presumptive conditions on several occasions, but the House has not moved similar legislation.

Section 711 will extend the reservist home loan guaranty authority to December 31, 2007. The current authority is set to expire in 2003. However, a reservist must serve six years before being eligible for the home loan guaranty. Therefore, in order for it to be used as a recruiting incentive, the authority must be extended beyond 2006.

I am extremely gratified that section 501 authorizes payment of dependency and indemnity compensation ("DIC") to the surviving spouse of a former POW veteran who dies of a non-service-connected condition if the former POW was rated totally disabled due to a POW-related presumptive condition for a period of one or more years immediately prior to death. In the case of former POWs, this reduces the 10-year period prior to death that a veteran must be rated 100 percent service-connected for the spouse to receive DIC if the veteran dies of a non-service-connected condition. This provision recognizes that former POW's suffered extreme hardships and that their spouses cared for them throughout the years that VA did not recognize their health conditions as being service-related. I am proud that we named this provision of the bill the "John William Rolen Act." John passed away this year. He was a tireless advocate for America's former POWs, and I will miss him.

Section 502 of H.R. 2116 corrects an oversight in last year's transportation bill (TEA 21) that reinstated DIC to remarried widows of veterans whose remarriages have now been terminated. The benefit had previously been cut off as a budget reconciliation item. While reinstating DIC payments, however, the transportation bill failed to restore the limited ancillary benefits that accompany the receipt of DIC: CHAMPVA, home loan guaranty, and educational benefits. This bill restores those ancillary benefits.

Finally, I am so glad that we will maintain our commitment to homeless veterans by reauthorizing the Homeless Veteran Reintegration Program (HVRP). Section 901 authorizes increased funding levels for job training for veterans for four consecutive years, beginning with $10 million additional in the first year, $15 million additional in the second year, and $20 million additional in each of the third and fourth years. We have also required, in section 903, that VA formulate a comprehensive plan that includes the Departments of Labor and Housing and Urban Development, to conduct a cross-cutting report evaluating the effectiveness of homeless programs beyond six months of placement or service delivery.

Title XI of H.R. 2116 provides VA with authority to offer voluntary separation incentives through December 31, 2000, to a specified number of FTEE. As is well known, inadequate VA budgets in the last several years have forced VA to make sweeping changes, (many of which were warranted, including the downsizing of employees. VHA has already eliminated thousands of employees via "reductions in force" ("RIFs"). VHA FTEE staff now stands at 182,000, down from 218,000 in 1994. VBA FTEE has also declined, from 13,500 in 1994 to

11,200 today. All this is occurring at a time when VA is treating more patients and deciding more claims.

Usually, a condition of voluntary separation incentives—or buyouts as they are known—is that the FTEE slot is eliminated in a one-for-one reduction, i.e. downsizing. But I believe that VA has already reached the precipice of staff reductions—the point beyond which we should not go if quality of VA health care is to be maintained. However, VA says that it still requires buyouts in order to ''rightsize.'' That is, VA must let go of employees who do not have the needed skills, in order to free up FTEE positions so that VA can hire the most appropriately qualified people. The buyout language in this bill prohibits VA from eliminating the FTEE positions of employees who have received buyouts.

If we do not provide VA with buyout authority, VA will proceed down the path of reductions regardless. For example, VHA will RIF thousands of employees next year. However, RIFs are an inexact management tool. RIFs would not necessarily result in the skills mix VA needs, due to the civil service employment rights that allow senior employees to take the job of junior employees. I believe that buyouts offer a better option, but one that must still be used wisely and monitored carefully—which is why H.R. 2116 allows only limited buyouts under very strict conditions.

I am very disappointed that we were unable to move the Senate provision overturning the ''$1,500 rule.'' Since 1933, the law has required VA to suspend the compensation or pension benefits of incompetent veterans who have no dependents and are hospitalized at government expense. This suspension is triggered when the veteran's estate exceeds $1,500, and VA benefits are cut off until the veteran's estate is spent down to $500. At that time, the VA commences reinstating the veteran's compensation, until such time the veteran is hospitalized again and the estate exceeds $1,500, when the benefits are cut off again. No similar suspension is made for competent veterans or for incompetent veterans who are not hospitalized.

The rationale for cutting off benefits was that these veterans might have been institutionalized for years, and that it was not good policy to allow their estates to build up when they have no dependents to inherit them. There was also a fear of fraud on the part of the veteran's guardian or fiduciary.

The dollar amounts have not changed since 1933, when $1,500 equaled almost three years' worth of VA benefits at a 100 percent rating level. In today's dollars, this is less than one month's benefit at a 100 percent rating level.

Although veterans are generally being hospitalized for shorter periods of time, based on the low dollar limit, the rule may be applied very quickly, sometimes immediately, when it does apply. Further, it takes VA an average of 66 days to restore the benefits to incompetent veterans once their estates have been spent down. Since incompetent veterans are no longer routinely institutionalized for years at a time, it is very difficult for a non-Medicaid eligible veteran (which would be any veteran receiving any significant amount of VA compensation) to be released from the hospital and placed in either a private assisted living or group home with only $500 in his bank account. I fear some of these veterans may end up on the streets because of this policy, despite the best efforts of VHA to place them at discharge.

I believe that this outdated and indefensible policy discriminates against incompetent veterans—those who are least likely to be able to fight for themselves. The fact is, we are means testing VA compensation for this one class of veterans. Why is a competent veteran with no dependents entitled to receive his compensation, but an incompetent veteran not entitled? There is no justification for this discrimination. It may also have some harmful effects for a small population of veterans, facilitating their downward spiral into homelessness. That may be too much of a price to pay for the government to save some money from reverting to the state if that veteran died while hospitalized. While we were not successful in addressing this issue in this bill, I plan to readdress this policy until it is corrected.

Mr. President, in closing, I want to acknowledge the work of our Committee's Chairman, Senator SPECTER, in developing this comprehensive legislation. Through his efforts, and that of his staff—especially the former Committee Staff Director, Charles Battaglia, and the new Committee Staff Director, William Tuerk—the Senate Committee on Veterans' Affairs has fully met its responsibilities and can be proud of the legislation we consider today.

I appreciate the willingness of the House Committee on Veterans' Affairs, especially Chairman BOB STUMP and Ranking Member LANE EVANS, to work together to reach compromise on so many vital issues.

And I would be remiss if I did not acknowledge the efforts of my own staff, Minority Staff Director, Jim Gottlieb, Professional Staff Member, Kim Lipsky, and Counsel, Mary Schoelen. I am enormously grateful for their diligence, and for their commitment to the work we do in this Committee on behalf of our Nation's veterans.

Ms. SNOWE. Mr. President, I rise in support of H.R. 2116, the Veterans Millennium Health Care and Benefits Act of 1999.

I would like to begin by thanking my colleague, Senator SPECTER, chairman of the Senate Veterans' Affairs Committee, for his leadership on issues of importance to veterans. H.R. 2116 contains a number of provisions that will benefit veterans in Maine and elsewhere because of his strong leadership. I applaud Senator SPECTER for his efforts.

I would especially like to thank the chairman for his efforts to address a concern I had about a specific provision in the House-passed version of the bill, which would have jeopardized millions of dollars in grant funding for the Maine State Veterans Homes system.

H.R. 2116 contains a provision which fundamentally reorders the manner in which VA construction grants will be awarded in the future, placing the focus on renovation of existing facilities so that maintenance projects will take precedence in grant awards over proposals to construct new facilities. The House-passed version of the bill would have made Maine veterans homes and state homes in a number of states ineligible for funding, even through they had already prepared and filed grant applications under existing law and regulations.

In an effort to address this concern, I worked closely with Senator SPECTER to craft a transition provision balancing the need to treat current state home applicants fairly and not change the rules in the middle of the game, while at the same time implementing the new rules as soon as possible.

I am very pleased that the conference for H.R. 2116 agreed to the measure I helped author that grandfathers proposals already filed by veterans homes, thereby exempting them from new criteria in the bill that would have precluded funding in this and coming fiscal years.

I believe this compromise remains true to the intent of the new criteria included in the House-passed version of the bill, while at the same time protecting the interests of states that had already submitted applications for funding.

In addition to work with Senator SPECTER personally, I wrote a letter to the chairman in September alerting him to my concerns, followed by a letter to my colleague from Maine, Senator COLLINS. In addition, last month, I spearheaded a letter with 14 other Senators urging modification of the House construction grant provision to grandfather proposals made by Maine and other states under existing law, so that it would not change the methodology in the middle of the current fiscal year—after applications have been filed; after architectural, engineering, and legal fees have been incurred, and after local matching funds have been appropriated or borrowed by states for these projects.

If the House-passed provision had been enacted without this change, many states veterans homes would have lost their positions for Fiscal Year 2000 grants because these applications would have been judged according to a new set of criteria.

In Maine, this would have jeopardized funding for the entire Maine Veterans Homes system, which earlier this year applied for about $9.3 million in grant

funding, and is seeking to construct new veterans' residential care facilities in Augusta, Bangor, Caribou, and Scarborough. In their applications, the Maine Veterans Home System notes that more than half of Maine's veterans population is reaching the age where long-term nursing care or domicillary care is typically required. Since 1991, the number of Maine veterans aged 75–79 has doubled, from 6,000 to 12,500. Over the same time period, the numbers of veterans aged 80–84 has doubled from 2,400 to 6,000; and veterans over the age of 85 has increased by 50 percent from 1,200 to 1,800.

I would also like to thank Senator SPECTER for supporting another provision in H.R. 2116 based on legislation I introduced in the Senate, S. 1579, the Veterans Sexual Trauma Treatment Act. S. 1579 extends a VA program that offers counseling and medical treatment to veterans who were sexually abused while serving in the military, and requires a VA mental health professional to determine when counseling is necessary. Currently, the VA Secretary makes this determination. The bill also calls for the dissemination of information concerning the availability of counseling services to veterans through public service announcements.

According to the Department of Defense, at least 55 percent of active duty women and 14 percent of active duty men have been subjected to sexual harassment. As a member of the Senate Armed Services Committee, I credit the DoD with working to reduce the prevalence of sexual harassment in the military. However, as long as there is harassment in the military, it is vital that victims have access to treatment, and H.R. 2116 provides the tools to do this.

Finally, I would like to commend the Senate and House Veterans' Affairs Committees and the conferees for H.R. 2116 for their efforts to expand a whole range of benefits for veterans in this conference report. For example, the bill expands long-term care for veterans, and will increase home and community-based care and assisted-living options for veterans. It expands mental health services, and requires the VA to enhance specialized services for PTSD and drug abuse disorders. It provides coverage for uninsured veterans who need care but who do not have access to a VA facility. It expands VA authority to provide services to homeless veterans. It improves Montgomery GI bill benefits by providing benefits for students in preparatory courses and to those whose enlistment is interrupted to attend officers training school. And these are just a few of the important provisions in this bill.

Mr. President, this is a strong bill, and I urge my colleagues to join me in a strong show of support.

I yield the floor.

SECTION 207

Mr. SMITH of New Hampshire. Mr. President, I too, would like to recognize Senator SPECTER, for his tremendous work and skillful leadership and sensitivity in bringing the Veterans Millennium Health Care bill (H.R. 2116) to the floor. As a veteran myself, I can assure you that this bill means a great deal in providing for the health and welfare of our veterans both in my state of New Hampshire as well as those veterans throughout the country. I congratulate Senator SPECTER's leadership on issues that are of particular importance to our veteran community.

If I may also ask the senator to clarify the transition clause of Section 207(c) of the bill. Does the Senator mean that provided that state home grant applicants covered by the transition clause follow all applicable laws and regulations in effect on November 10, 1999, that the Secretary of Veterans Affairs shall award grants to all applications remaining unfunded for fiscal year 1999 priority one projects first, then proceed to awarding grants to priority one projects as outlined and in the order in which they appeared in the Department of Veteran Affairs Fiscal Year 2000 priority list as covered by Section 207(c) of the bill, prior to awarding grants to any other applicants?

Mr. SPECTER. Yes, the Senator is correct. The purpose of this section is to reform the priorities under which state home grant applications are considered so that much needed renovation and maintenance projects will receive more appropriate consideration for funding than under the current system.

I am pleased that we were able to craft a transition provision that balanced the desire to ensure that all states had an opportunity to participate under the old rules, with the desire to implement the new rules as quickly as possible.

Mr. SMITH of New Hampshire. Thank you Mr. Chairman and again I appreciate your consideration and sensitivity to the veteran community. Your leadership on this issue will enable the Veterans Home in Tilton, New Hampshire to better meet the medical needs of veterans in New Hampshire. I yield the floor.

Ms. SNOWE. I commend my colleague, Senator SPECTER, chairman of the Senate Veteran's Affairs Committee, for the remarkably responsive and skillful manner in which he managed the progress of H.R. 2116. This bill means a lot to veterans throughout the nation, and especially in my home state of Maine. I applaud Senator SPECTER's leadership on issues of importance to veterans.

I have only one point of clarification. Does the transition clause of Section 207(c) of the bill mean, that for all state home grant applications covered by the transition clause and otherwise in compliance with applicable law and regulations in effect on November 10, 1999, the Secretary of Veterans Affairs shall award grants first to all unfunded applications remaining for fiscal year 1999 priority one projects? And that following those projects, the Secretary shall next fund those FY 2000 applications and which both meet the criteria set forth in the bill and which were accorded priority one status for FY 2000? And that the Secretary would fund these projects in the order in which they would appear on the fiscal year 2000 priority one list, prior to awarding grants to any other applications?

Mr. SPECTER. Yes, the Senator is correct. The purpose of this section is to reform the priorities under which state home grant applications are considered so that much needed renovation and maintenance projects will receive more appropriate consideration for funding than under the current system. I am pleased that we were able to craft a transition provision that balanced the desire to ensure that all states had an opportunity to participate under the old rules, with the desire to implement the new rules as quickly as possible.

Ms. SNOWE. I thank the chairman once again, and I yield the floor.

Ms. COLLINS. I ask unanimous consent the conference report be agreed to, the motion to reconsider be laid upon the table, and any statements related to the conference report be printed in the RECORD.

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

SUDAN PEACE ACT

Ms. COLLINS. Mr. President, I ask unanimous consent the Senate proceed to the consideration of Calendar No. 410, S. 1453.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 1453) to facilitate famine relief efforts and a comprehensive solution to the war in Sudan,

There being no objection, the Senate proceeded to consider the bill, which had been reported from the Committee on Foreign Relations, with an amendment to strike all after the enacting clause and inserting in lieu thereof the following:

S. 1453

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Sudan Peace Act''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) With clear indications that the Government of Sudan intends to intensify its prosecution of the war against areas outside of its control, which has already cost nearly 2,000,000 lives and has displaced more than 4,000,000, a sustained and coordinated international effort to pressure combatants to end hostilities and to address the roots of the conflict offers the best opportunity for a comprehensive solution to the continuing war in Sudan.

(2) A viable, comprehensive, and internationally sponsored peace process, protected from manipulation, presents the best chance for a permanent resolution of the war, protection of human rights, and a self-sustaining Sudan.