Unfortunately, many farmers are not able to make use of this benefit because they're subject to the alternative minimum tax. Our tax relief bill will fix this problem for tens of thousands of farmers.

There are many other farmer-friendly measures that I and others advocated in the Senate bill. Unfortunately, some of our House counterparts didn't agree with us. I believe that will change next year and I will certainly be working hard to pass these in the next Congress.

In the meantime, we have some very good and necessary pro-farmer proposals before us that can be passed this year.

I only hope the Clinton-Gore administration doesn't veto the family farmer by vetoing this bill.

Thank you Mr. President.

SMALL BUSINESS REAUTHORIZATION CONFERENCE REPORT

Mr. GRASSLEY. Mr. President, I would like to take a moment to discuss some of the health care provisions in the tax bill. It's not a perfect bill, but it contains a lot of items that will improve health care in this country.

Let me touch on the issue of Medicare equity. We in Iowa have been frustrated by the inequitable payment formulas that hurt cost-efficient states like ours. These disparities exist in both traditional Medicare and in the Medicare+Choice program. Well, this bill takes a major step toward correcting this injustice. I'd like to walk through some of the reasons why this bill is good for health care in Iowa.

This bill corrects the Medicare Disproportionate Share program, known as ''DISH,'' as proposed in a bill I sponsored with Senator ROBERTS and others. This program helps hospitals that treat large numbers of uninsured patients. It's obvious that many rural Americans are uninsured, and that rural hospitals meet their duty to treat these people. But from its inception, this program has discriminated against rural hospitals. They have had to meet a much higher threshold than large urban hospitals have. Well, this bill finally equalizes the thresholds for all hospitals. There's still more work to do on this program, but this is a major step forward for equity in Medicare.

The bill also reforms the Medicare Dependent Hospital program, as proposed in legislation I co-sponsored with Senator CONRAD and many others. Many rural areas have aged populations, and this is especially true in Iowa. So this designation benefits small rural facilities that have more than 60% Medicare patients. But incredibly, hospitals only receive this benefit if they met that level way back in 1988! Unfortunately, the Medicare program is full of this kind of outdated, unreasonable rules. That's why we need Medicare reform. But in the meantime, I'm glad to report that this bill would correct this particular problem: if a rural hospital has been over that 60% level in recent years, it qualifies. That's great news for rural hospitals.

Other key provisions of the bill strengthen our Sole Community Hospitals, knock down obstacles to the success of the Critical Access Hospital program for rural areas, and enhance rural patients' access to emergency and ambulance services.

The bill also helps hospitals—including all Iowa hospitals, both urban and rural—by providing a full Medicare payment increase to offset inflation in 2001.

Low payment rates for Iowa and other efficient states have prevented the Medicare+Choice program from taking root in Iowa and offering seniors the full range of health care options available elsewhere. I am pleased that the bill provides a major boost to entice plans to enter such regions, raising the minimum monthly payments for plans in rural areas from $415 to $475 per month, and for urban areas from $415 to $525 per month. These increases were proposed in a bill I co-sponsored with Senator DOMENICI and others, and I am hopeful that they will soon provide Iowans with the same range of choices available to seniors in other areas.

The bill gives rural seniors access to the best medical care through telemedicine, as I have worked with Senator JEFFORDS and many others to do. In rural areas, medical specialists are not readily available. For many seniors, traveling long distances is simply not feasible. But technology now makes it possible for patients to go to their local hospital or clinic and be seen by a specialist hundreds of miles away. We in Iowa have tremendous capacity to take advantage of this. Yet for too long, the Medicare bureaucracy has put up every barrier it could think of to telemedicine. But this bill changes that, greatly expanding the availability of Medicare payment for services provided by telemedicine, Medicare patients will now have access to the world's best doctors and medical care regardless of where they live.

The bill protects funding for home health services by delaying a scheduled 15% cut in payments, as well as providing a full medical inflation update. It's not secret that I, like many of my colleagues, would have preferred to see that 15% cut canceled permanently rather than simply delayed for another year. I hope that we will accomplish that next year.

The bill also protects the access of our neediest beneficiaries to home health services when they use adult day care services. Patients can only receive home care under Medicare if they are ''homebound,'' and the bureaucracy has said that patients who leave their home for health care at an adult day care facility—such as many Alzheimer's patients—are no longer homebound. This has forced patients who are capable of living in their homes to move into institutions, just to get health care. I am very pleased that this bill includes the common-sense legislation I co-sponsored with Senator JEFFORDS to correct this Catch-22.

I am also very pleased that the bill addresses the Medicare hospice benefit, providing for a higher payment increase for inflation. The bill also deals with the ''six-month rule'' for hospice eligibility, clarifying that it is only a guideline, not an inflexible requirement. These provisions respond to concerns aired at my Aging Committee hearing on hospice in September, and I look forward to continued work in the 107th Congress to strengthen hospice care.

The legislation extends the moratorium on therapy caps and provides Medicare beneficiaries in nursing homes with access to critical services. The Balanced Budget Act of 1997 included a $1,500 cap on occupational, physical and speech-language pathology therapy services received outside a hospital setting. Thirty-one days after the law was implemented, an estimated one in four beneficiaries had exhausted half of their yearly benefit. Furthermore, it was those beneficiaries in need of the most rehabilitative care that were penalized by being forced to pay the entire cost for these services outside of a hospital setting. I fought successfully during last year's Balanced Budget Refinement Act for a two-year moratorium on the therapy caps while the Health Care Financing Administration studies the issue; I am pleased to see this effort recognized and the moratorium extended for an additional year.

The bill protects the right of patients in Medicare+Choice plans to return to their Medicare Skilled Nursing Facility of origin if they have to leave that facility for a brief hospitalization. Without this right, there have been instances in which patients in religiously affiliated nursing facilities have not been permitted to return to those facilities after hospitalization. I am gratified that the bill includes the legislation I co-sponsored with Senator MACK on this issue.

The bill discontinues a policy to phase out Medicaid cost-based reimbursement to our nation's 3,000 Rural Health Clinics and 900 Community Health Centers. In its place, it provides a reimbursement solution to ensure that these essential primary care providers can continue to serve millions of uninsured and under-insured Americans. The bill establishes a prospective payment system in Medicaid for federally certified Rural Health Centers and Community Health Centers. This provision creates an equitable payment system for these providers and ensures that the health care safety net remains strong and secure.

As one example, the legislation also provides Medicare beneficiaries with greater access to the most thorough type of colon cancer screening—colonoscopy. As Chairman of the Senate Special Committee on Aging, I held

a hearing earlier this year to raise awareness about the far-reaching and devastating effects of colon cancer. This year 129,400 Americans will be diagnosed with this type of cancer and 56,000 Americans will die from it. However, if detected and treated early, colorectal cancer is curable in up to 90 percent of diagnosed cases. I fully support an expanded colon cancer screening benefit for Medicare beneficiaries and urge all older Americans to put the benefit to use.

For the first time, medical nutrition therapy may be reimbursed by Medicare for patients with diabetes or renal disease. As part of the Balanced Budget Act of 1997, Congress instructed the Institute of Medicine (IOM) to conduct a study of the benefits of nutrition therapy. IOM reported that nutrition therapy would improve the quality of care and would be an efficient use of Medicare resources. I cosponsored legislation to expand Medicare coverage to include nutrition therapy; offering coverage for beneficiaries with diabetes or renal disease is a step in the right direction.

In another first, this bill eliminates the arbitrary time limitation on Medicare coverage of immunosuppressive drugs following an organ transplant. Medicare covers expensive transplant operations but fails to follow through with coverage of the drugs necessary to preserve the transplanted organ; reimbursement is currently limited to the first three years following the procedure. While last year's BBRA extended coverage in some cases for an additional eight months, this legislation drops any time limitation for coverage of drugs critical to the health of transplant patients. This is common sense policy I am glad to support.

I plan to come to the floor on other occasions to discuss other provisions of this bill. While I'm not completely satisfied, I think there is a lot that will help Americans get the health care they need and deserve.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, I am going to speak, if I may, over the next few minutes, on a couple of different, unrelated subject matters. The first I would like to spend a few minutes talking about is the situation in Colombia, South America, and, as we have watched events unfold over the last several days, the great concern I have about a deteriorating situation in that nation.

Then, second, I will spend a couple of minutes talking about two of our colleagues who decided to retire from the Senate this year, Senator CONNIE MACK of Florida, my good friend, and Senator PAT MOYNIHAN of New York. I will take a few minutes on these separate, distinct subject matters. I appreciate the indulgence of the Chair.

EVENTS IN COLOMBIA

Mr. DODD. Mr. President, I am deeply concerned about events in Colombia. It is a wonderful nation, one of the oldest continuous democracies in Latin America. It is a nation with a wonderful, rich heritage, delightful people, a nation that has made significant contributions to the stability and well-being in Latin America historically. Over the last few decades, we have seen Colombia become a nation whose sovereignty, whose very nationhood, is placed in jeopardy because of the turmoil that is shredding this marvelous nation and wonderful people.

Earlier this year, Congress considered the administration's $1.3 billion emergency request to support the program called Plan Colombia. I voted for that program, as did a majority of our colleagues in the Senate of the United States and the House of Representatives. I said at the time of the debate, that while I believed a substantial assistance package was absolutely necessary to help address the multiple challenges confronting the Colombian people and the Andean region as a whole, I would not have allocated the monies among the various programs in the exact same way as the administration had proposed, nor would I have fashioned the assistance package exactly the same way that the Congressional package which was signed into law.

That is often times the case here. This is not unique. But there were those who expressed deep concerns about how the package was put together. I happened to have been one of them. But I also thought it was so vitally important the United States should take a stand and try to do what we could to make a difference in Colombia, not just because of the relationship we have with the democratic nation to our south but for the very enlightened self-interest of trying to deal with the crippling problem of drug addiction and drug abuse in this country. Let me explain why, as many of my colleagues and others are already familiar.

I believe we as Americans need to respond to Colombia's difficulties because, among other things, Colombia is currently the world's leading supplier of cocaine and a major source of heroin. That means the difficulties Colombia faces are not simply a Colombian problem; they are our problem as well, since these illicit substances end up in the United States, in our cities and small towns all across this country.

Today there are an estimated 14 million drug consumers in the United States; 3.6 million of the 14 million are either cocaine or heroin addicts. Colombian heroin and cocaine are the substances of choice in nearly 80 percent of the total U.S. consumption of these drugs.

The impact on U.S. communities has been devastating. Every year, 52,000 Americans lose their lives in drug-related deaths throughout this Nation. The numbers are going up, and 80 percent of the product is coming from Colombia. This is why we cannot sit idly by and do nothing.

The economic costs, we are told, of these deaths and drug-related illnesses and problems exceed $110 billion a year. That is a sizable financial impact.

The $1.3 billion that we appropriated to help Colombia respond to this situation is what was decided would be helpful. That is why I supported it, despite, as I mentioned earlier, the difficulties I had with it.

A little history is important to give the American people some idea of what the nation of Colombia has been through over the last decade and a half or two decades.

Colombia's current crisis did not just happen overnight. Yet its civil society has been ripped apart for decades by the violence and corruption which rages in that nation. Colombia has long been characterized as having one of the most violent societies in the Western Hemisphere. It means historically Colombian civil leaders, judges, and politicians have put their lives in jeopardy simply by aspiring to positions of leadership and responsibility.

Over this past weekend, for example, there were press reports that 36 candidates running for Colombia's municipal elections had been murdered by the time of the election. That is just in the last 2 weeks. An additional 50 of these candidates for municipal office were kidnaped in the nation of Colombia. On a daily basis, judges, prosecutors, human rights activists, journalists, and even church officials live in fear for their lives.

That has been the state of Colombian life for far too long. Between 1988 and 1995, more than 67,000 Colombians were victims of political violence in the small nation to our south. Political violence continued in the last half of the 1990s. Between 10,000 and 15,000 people have lost their lives since 1995, losing between 2,000 and 3,000 people annually to this violence.

Life in Colombia has been made even more difficult as a result of additional violence and intimidation by drug traffickers, and these are one of the major causes of it. The right wing paramilitaries and left-wing revolutionary groups are also responsible. High-profile assassinations of prominent Colombian officials trying to put an end to the drug cartels began more than 20 years ago with the 1984 murder of the Minister of Justice, Rodrigo Lara Bonilla.

In 1985, a year later, terrorists stormed the Palace of Justice in Colombia and murdered 11 supreme court justices, gunned down 11 supreme court justices who supported the extradition of drug traffickers.

A year later in 1986, another supreme court justice was murdered by drug traffickers, as well as a well-known police captain and prominent Colombian journalist who had spoken out against these cartels. These narco-terrorists