their dependents across this country who have established an impressive grassroots effort. Their work, in conjunction with the efforts of the Retired Enlisted Association, the National Association of Uniformed Services, the National Military and Veterans Association, and the Retired Officers Association, have brought military health care to the forefront.

My amendment would allow the Senate Armed Services Committee to increase spending on military retiree health care while considering the fiscal year 2001 Department of Defense Authorization bill. It is important to note that my amendment must also be approved by the House and Senate conference committee on the budget resolution in order for the Senate Armed Services Committee to use the reserve fund.

A promise of lifetime health care has been broken. Testimony from military recruiters themselves, along with copies of recruitment literature dating back to World War II, show that health care was promised to active duty personnel and their families upon the personnel's retirement.

However, the creation on June 7, 1956, of space-available care for military retirees at military hospitals has led to a broken promise of health care coverage for these men and women and their families. Post-cold-war downsizing of military bases and their medical services have left many retirees out in the cold. A final insult is the fact that military retirees and their dependents are kicked off of the military's health care system, Tricare, upon turning age 65.

Chairman of the Joint Chiefs of Staff, Gen. Henry Shelton, testified before the Senate Armed Services Committee and said: ''Sir, I think the first thing we need to do is make sure that we acknowledge our commitment to the retirees for their years of service and for what we basically committed to at the time that they were recruited into the armed forces.''

Defense Secretary William Cohen testified before the Senate Armed Services Committee and said: ''We have made a pledge, whether it's legal or not, it's a moral obligation that we will take care of all those who served, retired veterans and their families, and we have not done so.''

My oldest son, Brooks, served as a peacekeeper with the United States Army in Bosnia, and he was recently deployed to Kosovo. I know how important ''quality of life'' issues are to military personnel and their families. Our country asks young men and women to willingly work in combat zones and receive minimal pay compared to the private sector. As compensation, military personnel have been promised that their health care needs and those of their families will be taken care of now and upon retirement. Despite the best efforts of many talented health care providers in the military, this promise has been broken, and it is impacting a young man or woman's decision to make a career of the military.

The question is whether Members of Congress want to make military retiree health care a priority instead of an afterthought. I am hopeful that, working on a bipartisan approach similar to that seen with my reserve fund amendment, we in Congress can choose military retiree health care as a priority this session.

The PRESIDING OFFICER. The Chair recognizes the Senator from Alabama.

Mr. SESSIONS. Mr. President, in order to make some logic out of this vote-arama process, on behalf of the leader, I ask unanimous consent that the first 10 amendments to be voted on tomorrow be the following and that as stated earlier all votes after the first vote be limited to 10 minutes, with 2 minutes for explanation prior to each vote. The amendments are: the Santorum amendment on military/vets benefits; the Conrad amendment on lockbox; the Abraham amendment on SOS lockbox; the Johnson amendment on veterans; the Ashcroft amendment on SOS Social Security investment; the Mikulski amendment on digital divide; the Bob Smith amendment on RX; the Graham of Florida amendment on education; the Voinovich amendment on strike tax reconciliation; and the Kennedy amendment on Pell grants.

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

MORNING BUSINESS

Mr. SESSIONS. Mr. President, on behalf of the leader, I now ask unanimous consent that there be a period for the transaction of morning business, with Senators permitted to speak for up to 10 minutes each.

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

HONORING THE GOOD WORKS OF THE SOCIETY FOR MATERNAL-FETAL MEDICINE

Mr. THURMOND. Mr. President, I rise to recognize the vital work performed by a group of tireless and dedicated professionals: The members of the Society for Maternal-Fetal Medicine (SMFM). I congratulate the Society for its outstanding achievements, and note this year they celebrated their 20th annual meeting.

It is often said that the United States is home to the finest pool of health care professionals in the world. I could not agree more. Each and every day, these professionals provide cutting edge care for millions across the country. Treatments that did not exist just ten years ago are now saving lives on a routine basis. I am hopeful that we never take this high level of care for granted.

The Society for Maternal-Fetal Medicine is one group that demonstrates the tremendous talent we have in our country. For many of us, ''maternal-fetal medicine'' may not be an everyday term. However, we all acknowledge that mothers experiencing complicated pregnancies require and deserve the best care possible. Maternal-fetal specialists provide care or consultation during complicated pregnancies. In addition, they provide education and research concerning the most recent approaches to the diagnosis and treatment of obstetrical problems. As a result, these specialists promote awareness of the diagnostic and therapeutic techniques for optimal management of these complicated pregnancies. In addition, it should be noted that maternal-fetal medicine specialists are complementary to obstetricians in providing consultations, co-management or direct care before and during pregnancy.

Mr. President, I urge my colleagues to join me in congratulating the members of the Society of Maternal-Fetal Medicine for their outstanding work. I also want to acknowledge the fine work of Dr. Peter Van Dorsten, President of the SMFM, who resides in my home state of South Carolina. There is no doubt that Americans across the country join me in thanking these unique individuals.

Mr. KENNEDY. Mr. President, seven months have elapsed since the House of Representatives passed the bi-partisan Norwood-Dingell bill to end insurance company and HMO abuses, and more than six months have passed since House and Senate conferees were appointed to prepare the final version of this important measure.

Today, I am releasing a new study by the Minority Staff of the Health, Education, Labor and Pensions Committee that documents how devastating this long delay has been for millions of Americans and their families, and how urgent it is for the House-Senate conference to complete its work as soon as possible.

Drawing on data gathered by the University of California School of Public Health and the Harvard School of Public Health, the report documents unacceptably high numbers of patients who are denied needed care, who suffer increased pain, or whose health has seriously declined because too many HMOs and insurance companies put profits ahead of patients.

According to the study, 59,000 patients each day—22 million patients a year—report added pain and suffering as the result of the actions of their health plans. Large numbers of patients have specialty referrals delayed or denied. Others are forced to change doctors. Still others are forced to take prescription drugs that are different from the drugs their doctor prescribed.

In addition to patients' reports of significant problems as the result of actions of their health plans, thousands of physicians report seeing patients every day whose health has seriously declined as the result of abuses

such as the failure to cover recommended prescription drugs, denial of needed diagnostic tests and procedures, and unwillingness to allow referrals for specialty care.

This study provides powerful new evidence of the need for Congress to move promptly to pass a strong Patient's Bill of Rights. Millions of families are suffering because of the failure of Congress to act. Families across America deserve protection, and it is time for Congress to fulfill its responsibility and see that they get it.

I ask unanimous consent the study be printed in the RECORD.

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

THE IMPACT ON PATIENTS OF DELAYS IN PASSING A PATIENTS' BILL OF RIGHTS: A SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE MINORITY STAFF STUDY

Delays in passing legislation to curb insurance company abuse result in injury to thousands of patients daily and millions of patients annually. Drawing on two prior studies on the incidence of abusive health plan practices, this report looks at the number of patients affected daily, weekly, monthly and yearly.

The estimates are based on patient self-reports of experiences with health plans and on physicians' reports of the frequency of various abuses and the seriousness of injuries sustained by the patients they see in their own practices.

Highlights

According to patient reports, every day, as the result of actions of their health plan: 59,000 patients experience added pain and suffering; 41,000 patients experience a worsening of their condition; 35,000 patients have needed care delayed; 35,000 patients have a specialty referral delayed or denied; 31,000 patients are forced to change doctors; and 18,000 patients are forced to change medications.

According to physician reports, every day: 14,000 physicians see patients whose health has seriously declined because an insurance plan refused to provide coverage for a prescription drug; 10,000 physicians see patients whose health has seriously declined because an insurance plan did not approve a diagnostic test or procedure; 7,000 physicians see patients whose health has seriously declined because an insurance plan did not approve referral to a medical specialist; 6,000 physicians see patients whose health has seriously declined because an insurance plan did not approve an overnight hospital stay; and 6,000 physicians see patients whose health has seriously declined because an insurance plan did not approve a referral for mental health or substance abuse treatment.

Table 1 shows the incidence of plan restrictions on care and patient injuries resulting from plan actions by day, week, month, and annually, as reported in the survey of patients. Table 2 shows the number of physicians seeing plan abuses that result in serious declines in patient health each day, month, week, and year.

TABLE 1.—PATIENT SURVEY

Health plan abuse	Number of patients affected per year	Number of patients affected per month	Number of patients affected per week	Number of patients affected per day
Delay in Needed Care	12,880,000	1,073,000	247,000	35,000
Delay or Deny Specialty Referral	12,880,000	1,073,000	247,000	35,000
Forced to Change Doctors	11,270,000	939,000	216,000	31,000
Forced to Change Medications	6,440,000	537,000	124,000	18,000
Results of Health Plan Abuse:				
Added Pain and Suffering	21,638,000	1,803,000	415,000	59,000
Worsening of Condition	14,876,000	1,240,000	285,000	41,000

Source: Committee Analysis Based on Helen H. Schauffler's "California Managed Health Care Improvement Task Force Survey of Public Perceptions and Experiences with Health Insurance Coverage." U.C. Berkeley School of Public Health and Field Research Corporation, September, 1997, reported in Improving Managed Health Care in California, Findings and Recommendations, Volume Two, January 1998, tables 4 and 19, projected to the national level.

TABLE 2.—PHYSICIAN SURVEY

Health plan abuse	Number of doctors each year seeing patients with serious decline in health plan abuse	Number of doctors each month seeing patients with serious decline in health from plan abuse	Number of doctors each week seeing patients with serious decline in health from plan abuse	Number of doctors each day seeing patients with serious decline in health from plan abuse
Denied coverage of recommended prescription drug	137,000	111,000	71,000	14,000
Denied coverage of needed diagnostic test	149,000	100,000	51,000	10,000
Denied referral for needed specialty care	122,000	76,000	37,000	7,000
Denied overnight hospital stay	110,000	65,000	29,000	6,000
Denied referral for mental health or substance abuse treatment	116,000	63,000	30,000	6,000

Source: Committee Analysis Based on Kaiser Family Foundation and Harvard School of Public Health, "Survey of Physicians and Nurses," July, 1999.

METHODOLOGY

The data presented in this report was drawn from two sources. Patients' self-reports on difficulties with their health plans and illness and injury caused by actions of their health plans was drawn from a random sample survey of individuals in California with private health insurance conducted by the Center for Health and Public Policy Studies, School of Public Health, University of California at Berkeley. Helen Schauffler, Ph.D., was the principal investigator. The survey was conducted during September, 1997 for the Managed Care Improvement Task Force of the State of California, and reported in Improving Managed Health Care in California, Findings and Recommendations, Volume Two, January, 1998, Tables 4 and 19.

The survey asked whether the respondent experienced specific difficulties with a health plan. Those who experienced difficulties were asked about the impact of the difficulty on their health. The figures presented in this report assume that the incidence of such events is the same among the total U.S. population of privately insured individuals as it is among the privately insured population in California. Daily, weekly, and monthly figures were derived by dividing annual rates by 365, 52, and 12, respectively. All figures in the tables are rounded to the nearest 1,000 patients.

Data on physicians' reports of health plan practices and serious declines in health experienced by patients as the result of health plan actions were drawn from the 1999 Survey of Physicians and Nurses by the Kaiser Family Foundation and the Harvard School of Public Health. The survey was conducted between February 11 and June 5, 1999. Physicians were asked how frequently a set of plan practices occurred (weekly, monthly, every six months, yearly, never, or not applicable to my practice). Physicians who reported that the practice occurred were asked for the impact on the health of their patients.

The figures reported in the survey were converted into daily, weekly, monthly, and annual totals by adding the proportions seeing the specified event during the specified time period. For example, to derive a weekly total, the numbers of doctors reporting seeing such patients weekly was added to one-fourth of the doctors reporting seeing such patients monthly plus one-fifty-second of the doctors reporting seeing such patients annually. The proportion was then multiplied by the size of the sampling universe of 470,364 physicians. All figures reported in the table are rounded to the nearest 1,000 patients.

Note that the tables are not comparable, since one reports on numbers of patients affected, while the other reports on numbers of doctors seeing affected patients. Many doctors saw numerous affected patients. Moreover, judgments of doctors who attribute health declines to specific plan practices may not coincide with patients' own conclusions. Also, the doctor survey reports on patient injuries due to specific plan practices which are not identical with the problems identified in the patient survey.

SMITH AND WESSON AGREEMENT

Mr. LEVIN. Mr. President, for the first time in the United States, a gun manufacturer has agreed to make major changes to the design, distribution and marketing of its products. In a historic settlement reached by Smith & Wesson, the Administration, and cities and states around the country, Smith & Wesson will make sweeping changes to its business practices.

Under the terms of the agreement, several cities and counties will drop lawsuits filed against Smith & Wesson in exchange for reforms designed to make guns safer and limit access to them by unauthorized users. Specifically, Smith & Wesson agreed to increased safety standards, such as the