''SUBCHAPTER V—SPECIAL PENSION FOR GOLD STAR PARENTS

''§ 1571. Gold Star parents

''(a) The Secretary shall pay monthly to each person who has received a Gold Star lapel pin under section 1126 of title 10 as a parent of a person who died in a manner described in subsection (a) of that section a special pension in an amount determined under subsection (b).

''(b) The amount of special pension payable under this section with respect to the death of any person shall be $125 per month. In any case in which there is more than one parent eligible for special pension under this section with respect to the death of a person, the Secretary shall divide the payment equally among those eligible parents.

''(c) The receipt of special pension shall not deprive any person of any other pension or other benefit, right, or privilege to which such person is or may hereafter be entitled under any existing or subsequent law. Special pension shall be paid in addition to all other payments under laws of the United States.

''(d) Special pension shall not be subject to any attachment, execution, levy, tax lien, or detention under any process whatever.

''(e) for purposes of this section, the term 'parent' has the meaning provided in section 1126(d)(2) of title 10.''.

(2) The table of sections at the beginning of such chapter is amended by adding at the end the following:

''SUBCHAPTER V—SPECIAL PENSION FOR GOLD STAR PARENTS

''1571. Gold Star parents.''.

(b) EFFECTIVE DATE.—Section 1571 of title 38, United States Code, as added by subsection (a), shall take effect on the first day of the first fiscal year beginning after the date of the enactment of this Act.

THE FAILURE OF MANAGED CARE

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, May 21, 2001

Mr. STARK. Mr. Speaker, many of us in Congress—and many of our constituents around the country—have serious concerns about the future of managed care and what it means for the quality of our nation's health care system.

I recommend the attached article for my colleagues' attention. It is written by Dr. Ronald J. Glasser, a practicing pediatrician at Children's Hospital in Minneapolis, Minnesota. The article appeared in the May 2001 edition of Washington Monthly.

As many of my colleagues know, I am a longtime champion of expanding Medicare to eventually provide health insurance coverage for everyone. The article below provides strong support for that proposal.

[From the Washington Monthly, May, 2001]

FLATLINING, THE COMING COLLAPSE OF MANAGED CARE AND THE ONLY WAY OUT

(By Ronald J. Glasser, M.D.)

Everyone knows the horror stories of managed care; the denied treatment, the preauthorizations, refusals to allow subspecialty care, etc. So there is little reason to mention the motorized wheel chairs denied for patients with spina bifida—''our evaluation team has determined that your patient can walk assisted with braces or walker the prescribed twenty meters in under the approved ninety seconds.'' Nor is there need to remind of the termination of skilled nursing care for adolescents with cystic fibrosis—''home nursing care will be discontinued at the end of the month due to the plan's determination that there has been stabilization of your patient's clinical course.''

Even as I write this, my home state of Minnesota's largest HMO is refusing to approve a discharge order to transfer a quadriplegic 18-month-old girl to the city's most respected and accomplished rehabilitation medical center because it isn't on the HMO provider list. Try to justify that to your conscience or explain it to traumatized, desperate parents. But these are only the everyday skirmishes. As a pediatric nephrologist and rheumatologist in Minneapolis, I've been on the front line of these battles for 15 years, and I've experienced first-hand the insanity of managed care.

Under managed care, physicians have fared no better than the patients. Despite what the managed-care industry would like you to believe, there is no real competition out there, no real choice. In any urban population of less than a million people, one dominant health plan usually covers more than 50 percent of the area's enrollees. In the larger cities, there are usually only four plans that cover more than 70 percent of the residents. These big plans run the show, shadow each others' prices, and do not easily tolerate criticism.

Steve Benson, a well-respected pediatrician for over 20 years worked in a clinic recently taken over by a health plan. After questioning the appropriateness of the plan's insistence on scheduling patients every 10 minutes, he was told that he was not a team player. But he continued to complain that ten minutes per patient was not enough time to perform an adequate exam, much less counsel young mothers. More pointedly, after he complained that such a draconian patient-care policy was detrimental to the family and demeaning to the doctor, the medical director took Benson aside and told him that he was disruptive. If he wanted to continue at the clinic, he would have to seek counseling with the plan's psychiatrist. When Dr. Benson refused, he was fired.

The plan was determined to make an example of the good doctor. The separation clause of his contract stated that if he left the clinic, he could not practice within two miles of the facility. The plan interpreted ''facility'' to mean anything owned by the health plan, including depots, warehouses, parking lots, machine shops, and administrative buildings. That meant virtually the whole metropolitan area and most of the rest of the state. Daunted by the prospect of endless lawsuits, Dr. Benson, at the age of 56, was forced to leave his practice as well as the state. There were no more complaints from the other physicians.

CHERRY PICKERS

The lunacy of managed care began with the passage of the 1973 HMO Act. Within a decade, that craziness had grown into a full-blown catastrophe. It is fair to say that, back in 1973, no one had a clear vision of exactly what these organizations were, how they were to be run, what precisely they were supposed to do, or how they were to become profitable and remain fiscally sound.

The original idea was simple enough: Health-care costs were rising for employers and some method had to be devised to control them. What better way than to put together a whole new health-care delivery structure that would focus on keeping people healthy and that would place each patient into a health care ''network,'' based on sound medical and economic principles?

Not surprisingly, though, patients wanted to stay with their own doctors and were reluctant to sign up with a health plan that wouldn't let them go to hospitals not in the plan. The imposition of whole new structures and delivery systems would have their own unique costs and unexpected problems.

Still, the health-maintenance organizations had enormous built-in advantages that allowed them to quickly overcome patients' doubts while overwhelming both physician resistance and the skepticism of the business community. First of all, as the name implied, HMOs were never set up to care for the sick—a problem if you intend to be in the health-care business. In addition, HMOs only offered medical care through employers, which virtually guaranteed them a healthy population. The insurance industry calls this tactic ''cherry picking.''

Full-time employees are the perfect demographic for any health-care company. Eighteen-to-55-year-olds are universally the healthiest cohort in any society; but the real ''cherry picking'' lay in selling health insurance only to employers, because no one who has heart failure, severe asthma, or is crippled by arthritis can maintain full-time employment. You start with healthy people, and if workers become ill or injured on the job, there's always workers comp.

But the HMOs' real advantage lay in their start-up costs. No one in America will ever see another new car company built from scratch because of the billions of dollars it would take to build the factories, set up the infrastructure, and establish distribution systems. But HMOs were, from the very beginning, given a pass on initial expenditures. The original HMOs were not viewed as insurance companies. In California and many other states, they were licensed under the department of corporations rather than with the state's insurance commissioner.

At first they looked more like what were called ''independent contractors'' than insurance companies. In fact, that was precisely how the HMOs presented themselves—nothing more than a group of doctors offering to supply health-care services to a defined group of people, similar both professionally and legally to carpenters or roofers offering their services.

Amidst all this initial confusion, managed-care companies were exempted from the usual requirements of insurance, specifically the need for large cash reserves. In short, they could become insurance companies without having monies available to pay claims. One of the largest and most successful HMOs in Minnesota came into existence with nothing more than a $70,000 loan from a neighborhood bank to rent office space, hire two secretaries, and purchase a half-dozen phones.

This reckless financing led to what soon became a corporate Ponzi scheme. Without adequate reserves, HMOs had to keep premiums ahead of claims, and since premiums had to be kept artificially low to gain market share, that meant what it has always meant in the insurance business: lower utilization, or in the new health speak, denial of care.

Managed-care companies have always used certifications, pre-authorizations, formularies to restrict drug use, barriers to specialty care, limitations on high-tech diagnostic procedures, and the hiring of physicians willing to accept reduced fees to keep costs down and profits up. These restrictions were ignored when managed-care companies covered only a few hundred thousand people, but last year, over 140 million potential patients were enrolled in managed care. HMOs could no longer hide what they were doing.

DRIVE-BY DELIVERY DEBACLE

Managed care's first great PR disaster was the early discharge of new mothers within 24

hours of delivery. Obstetrics was always a financial black hole for these companies. About four million babies are born in the United States every year, and managed care covers the cost for almost two-thirds of the deliveries. The average cost in the Midwest of a standard delivery and two-day stay in the hospital, not including physician and anesthesiologist fees, is $4,500 for the mother and $1,000 for the baby. For a cesarean section, the cost jumps to $10,000 for the mother and $4,500 for the baby—and the hospital stay goes to four days. And these are the costs if everything goes right.

Do the math: Just assuming all the deliveries are standard ones, with two days in the hospital per delivery, the cost works out to nearly $22 billion a year. HMOs weren't financially equipped to handle those kind of costs year in and year out. They had become profitable by signing up only healthy people. Unfortunately, healthy people also have babies, and $22 billion a year was quite a hit on very narrow profit margins. So the managed-care managers got the bright idea that if they hustled mothers and babies out of the hospitals after one day, they'd recapture half to two-thirds of their costs.

Beginning in the early 1990s, HMOs began demanding that their obstetricians discharge women who had uncomplicated vaginal deliveries within 24 hours of giving birth. The plans presented company data proving early discharge to be safe. Medical directors began to track which doctors followed this new guideline. Those who refused or balked were reprimanded or fired. But the data was nonsense. This year, a study on early discharge was published in the prestigious American Journal of Medicine entitled ''The Safety of Newborn Early Discharge.'' In the article, physicians from two university pediatric centers not only challenged the managed-care pronouncements of safety, but denounced them as fabrications: ''Newborns discharged early [less then 30 hours after birth] are at increased risk of re-hospitalization during the first month of life.''

Not only was the data erroneous, but so, it turns out, was the math. Delivery costs are front loaded, so most of the expenses are incurred during the first day in the hospital. Unless HMO administrators somehow managed to persuade women to give birth in taxis on the way to the hospital simply kicking them out of the hospital a day early didn't end up saving the HMOs much money.

Nonetheless, by the mid-1990s, the health plans were in charge, pushing their own agendas and their own data. First, they encouraged and then demanded early discharges. But a funny thing happened on the way to the bank. These early discharges, unlike all the other cost shaving, affected a very large, unexpected and quite formidable group of consumers: husbands. These weren't just any old husbands, they were a very unique subset of husbands: state legislators.

The average American state legislator is male, 38 to 53 years of age, usually four to seven years older than his wife, fiercely committed to family values—and usually, to his wife. All over the country, these men, unaware of the new 24-hour policy, went to the hospital following the birth of their child, and were met at the entrance to the maternity ward or, in some cases, at the doorway of the hospitals, by an exhausted spouse. In all probability, she was in a wheelchair, holding their new child, and accompanied by an aid or an OB nurse who explained to the bewildered husband that his wife and child were fine and that both had been cleared for discharge.

More than likely, the nurse handed the husband a prescription or an anti-nausea medication, and advised him that a representative from their health plan's home-care division would probably be calling in a day or two to set up an in-house visit or make an appointment with a pediatrician. If anything went wrong, they were to call 911.

The husbands clearly didn't like the early discharge policy, but had no idea where or how to complain. So they called their wives' obstetricians. The doctor would explain that she'd seen the wife in the morning and that, while she would have preferred to keep her in the hospital another day or so, their health plan's policy was to discharge within 24 hours after delivery.

The husband then called the health plan, and after a dozen or so phone calls, reached a benefits coordinator sitting at a computer screen somewhere in another state. The husband, like every husband who called, was rather unceremoniously told that early discharge for uncomplicated deliveries was the accepted standard of medical practice in their community and that the wife's attending physician had clearly authorized the discharge. If the husband still felt concerned, he should write a letter or call their HMO's toll-free complaint number.

It was a big mistake. Legislators and congressmen are not the kind of husbands who write letters or call 800-numbers. Instead, they went back to the state legislatures, and within weeks passed laws stipulating longer hospital stays for uncomplicated vaginal deliveries. Some states refused to allow discharge in less than two days; others gave new mothers a minimum of 72 hours. What was so astonishing about these laws, of which there were some 26 different versions, was not that they were passed so quickly and so unanimously, but that no health plan put up even a semblance of resistance, and none tried to have a single law repealed.

More tellingly, not a single HMO offered up the safety data that they used so successfully to coerce physicians into sending new mothers home within a day of delivery. Faced for the first time with an advocacy group that could do them real harm, the health plans simply caved in and admitted by their silence that they had been wrong. One HMO apologist, the president of the California Association of Health Plans, did try to defend the early discharge policy, explaining that ''no one is looking at the big picture, at what will happen to monthly premiums.''

The HMO industry took a terrible beating on early discharge, but it continues to try to ration care by restricting both diagnosis and treatments, further limiting mental health coverage, sending stroke victims to nursing homes instead of rehabilitation hospitals, and simply refusing to pay for new, cutting edge prosthesis, while putting more and more bureaucratic hurdles in the way of physicians prescribing new drugs. It is, after all, what managed care does, what it has always done, and what it needs to continue to do to stay in business.

THE ANSWER

Over the last decade, I have seen managed care harass and demean physicians and punish patients. Now, it is punishing the business community, once its staunchest supporter, with premium increases of 15 to 20 percent a year. Last month, the president of the University of Minnesota asked the state for a supplemental funding appropriation of $280 million, a third of which simply covered the year's increase in employee health insurance costs. Honeywell and Boeing have the same problem, only they can't go to the state for relief. They must eat the premium increases rather than decrease health-care coverage and risk losing employees in a tight labor market.

All those original pronouncements of the managed-care industry in the late 1980s and early 1990s guaranteeing high-quality health care at low and affordable prices have been abandoned as these companies scramble to stay afloat as costs escalate and stock prices slip to new lows. This year, Aetna Health Care, in a letter to stockholders, stated that it planned over the next four quarters to drop 2.5 million members, raise premiums, and cut back on full-time staff. Not a very encouraging business plan, especially for a company insuring more than 19 million people.

Years ago, a few people warned that this market-driven experience was bound to fail. The essence of sustainable insurance, whatever the product, is the size and diversity of the risk pool. The Royal Charter establishing Lloyd's of London, the world's first insurance company, made the point of their enterprise quite clear: ''So that the many can protect the few.'' The idea hasn't changed in over 300 years. A sustainable insurance plan demands a large risk pool so that it can offer low rates and cover future claims. Managed-care companies handled the problems of risk by ignoring the elderly, the poor, the indigent and the needy, but it was hardly a strategy for long-term fiscal health.

Early skeptics of this new industry had watched the growth of Medicare, the government's insurance plan for the elderly, since its passage in 1965 and had no illusions that managed care could operate both efficiently and at a profit. Although an astonishing success, Medicare had also grown more and more expensive over the years. The increasing costs had nothing to do with greed on the part of physicians or hospitals, poor administrative controls, or excessive utilization of services, but plain old-fashioned need.

The creators of Medicare were shocked at the unmet needs that Medicare had unleashed, the hundreds of thousand of seniors who had gone untreated because they could not afford to visit a doctor, much less be admitted to a hospital. The country had clearly underestimated the demographics of an aging population of people who simply refused to die, as well as the astonishing growth of medical technology now able to keep the elderly healthy.

Vice President Cheney's multiple cardiac angiographies, balloon angioplasties, and coronary stints, along with his cholesterol-lowering drugs, beta-blockers and ACE inhibitors, not to mention his blood-thinning medications and anti-platelet drugs, are a testament to what can be done today that couldn't be done in the '60s and early '70s. Sooner or later, taking care of people gets costly.

Managed care had a bit of a head start on controlling costs by only offering coverage to a healthy, employed population. But as that population aged, the demand for service increased and all bets were off. Indeed, despite the bizarre claim-denial schemes the industry has implemented, it continues to lose money. Many, if not all companies, have dropped their sickest members, raised premiums and cut services just to keep in business.

How many more years of increased premiums, ever more complicated administrative hoops and decreasing services will it take to prove that private-sector health care doesn't work? Every survey, from the first nationwide study performed in 1935, has shown that most Americans want their government to support health care to those in need. That's a fact. It is also a fact that we already have a system in place that would provide an obvious solution: expanding Medicare.

While managed care has faltered. Medicare has prospered. Throughout the whole history of Medicare, there has never been evidence that Medicare has ever denied treatment

that a physician considered necessary. At a time when managed care routinely rations care, Medicare has simply paid for what is prescribed.

While it isn't perfect—many seniors still need Medigap insurance to cover some of the things Medicare doesn't, such as prescription drugs—it still offers a good model of efficient health care administration that could be replicated for the rest of America if expanded. Medicare is administered by fewer than 4,000 full time employees to cover some 39 million people. Aetna Health Care, meanwhile, employs 40,000 administrators to handle roughly 19 million enrollees.

Here in Minnesota, every health care dollar is funneled through eight HMOs and approximately 250 other health insurance companies. A recent audit by the state attorney general estimated that as much as 47 percent of that premium dollar is pocketed by these companies before distributing what is left to the doctors, patients, nursing homes, pharmacies, and hospitals.

By contrast, Medicare doesn't have to screw around with manipulating patient claims. It doesn't need a provider network coordinator to explain why a claim hasn't been paid or a treatment refused. And more to the point, Medicare doesn't have to underwrite its own insurance, market its ''product,'' skim off profits, or spend a fortune on advertising and lobbying to keep the playing field tilted in their direction.

There have been times when Medicare has been unresponsive, but it has never been as ruthless or intransigent as an insurance company executive or medical director hack working for an HMO. If there is going to be a so-called tyranny of Medicare, it will be our tyranny, rather than the dictates of some anonymous corporate executive deciding the meaning of ''medical necessity.'' There is no need under Medicare to refer an objection to ''the Complaint Procedure Section as designated in the booklet explaining the rules of benefits of your Group Health Plan Membership Contract.'' Just call your congressman.

The nation's oncologists convinced Congress to have Medicare approve payments for outpatient intravenous chemotherapy rather than solely hospital-based treatments. Even more recently, physicians were able to get Medicare to reverse regulations that proved too foolish and time consuming to be practical in the real world. Last month, the nation's teaching hospitals had Congress place back monies that had been removed from Medicare under the 1997 Balanced Budget Act in order to fund ongoing teaching and patient-care projects. When was the last time a CEO of a managed-care company gave back anything?

ROTTING CORPSES

But a $1.2 trillion-a-year industry does not go away easily. Recently, Dr. George Lundberg, the former editor of the Journal of the American Medical Association, discussing managed care, put the whole issue in more prosaic terms. ''Managed care is basically over,'' he said. ''But like an unembalmed corpse decomposing, dismantling managed care is going to be very messy and very smelly.''

But managed care is determined to survive, and it is proposing a number of programs to shift the cost and risks of health care onto the consumer while lifting the burden of increasing premiums off the shoulders of the employers. One method is the ''Defined Contribution,'' where employers simply wash their hands of any increasing costs and give each employee a certain amount of money for health care. If the $2,000 or so lump sum doesn't cover the cost of a plan that allows employees to see their favorite doctors, or if they want say, dental coverage, they must pay for it themselves.

A second concoction is the ''Medical Savings Account,'' modeled on individual retirement accounts to provide health care by allowing tax-free contributions to cover medical and surgical expenses. Again, there is general agreement among economists that these new programs will so fragment risk pools that those managed-care plans offering these programs but signing up the sickest members will slide into insolvency even faster than the current managed-care companies.

But to hide these structural defects and obfuscate the issue, and to stifle debate of any other rational public-sector alternatives, the advocates of managed care always bring up Canada's health care system as an example of a failed Medicare-type program. What they don't say is that each year, Canadians pay a little less than $1,600 U.S. per person for health care coverage. We pay more than $4,000 per American, and the price tag is going up annually. Canada would be able to do everything they have to do and, more importantly, what they would like to do, with what we pay. In fact, we should be able to do everything we want to do right now with our $4,000.

But the inefficiencies of a system with 2,500 different private health plans virtually guarantees the continued failure of our health-care system to provide high-quality, affordable health care for everyone. For flood insurance to work, it has to cover everyone, those who live on the hills and up in the mountains as well as those who live along the lakes and river banks. If all 280 million Americans are in the same risk pool; if the inefficiencies as well as the predatory behaviors of managed care can be eliminated, we can have the best health-care system in the world, and we can have it now.

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Tuesday, May 22, 2001 may be found in the Daily Digest of today's RECORD.

MEETINGS SCHEDULED

MAY 23

9:30 a.m.

Commerce, Science, and Transportation
To hold hearings to examine issues relating to the boxing industry.
SR–253

Health, Education, Labor, and Pensions
Public Health Subcommittee
To hold hearings to examine issues surrounding human subject protection.
SD–430

Appropriations
Labor, Health and Human Services, and Education Subcommittee
To hold hearings on proposed budget estimates for fiscal year 2002 for the National Institutes of Health, Department of Health and Human Services.
SH–216

Environment and Public Works
Business meeting to consider pending calendar business.
SD–628

Energy and Natural Resources
Business meeting to consider pending calendar business; a hearing on the Administration's national energy policy report will immediately follow.
SD–106

Governmental Affairs
Business meeting to consider the nomination of John D. Graham, of Massachusetts, to be Administrator of the Office of Information and Regulatory Affairs, Office of Management and Budget; the nomination of Stephen A. Perry, of Ohio, to be Administrator of General Services; the nomination of Angela Styles, of Virginia, to be Administrator for Federal Procurement Policy; and the nomination of Erik Patrick Christian, and Maurice A. Ross, both of the District of Columbia, each to be an Associate Judge of the Superior Court of the District of Columbia.
SD–342

Appropriations
Defense Subcommittee
To hold hearings on proposed budget estimates for fiscal year 2002 for the Department of Defense and related programs.
SD–192

10 a.m.

Environment and Public Works
Fisheries, Wildlife, and Water Subcommittee
To hold hearings to examine the Environmental Protection Agency's support of water and wastewater infrastructure.
SD–628

Appropriations
Foreign Operations Subcommittee
To hold hearings on proposed budget estimates for fiscal year 2002 for international financial institutions.
SD–138

Judiciary
To hold hearings on the nomination of Deborah L. Cook, of Ohio, and the nomination of Jeffrey S. Sutton, of Ohio, each to be a United States Circuit Judge for the Sixth Circuit, the nomination of John G. Roberts, Jr., of Maryland, to be United States Circuit Judge for the District of Columbia Circuit, and the nomination of Ralph F. Boyd, Jr., of Massachusetts, and the nomination of Robert D. McCallum, Jr., of Georgia, each to be an Assistant Attorney General, all of the Department of Justice.
SD–226

Banking, Housing, and Urban Affairs
Business meeting to consider the nomination of Alphonso R. Jackson, of Texas, to be Deputy Secretary, the nomination of Richard A. Hauser, of Maryland, to be General Counsel, and the nomination of John Charles Weicher, of the District of Columbia, and Romolo A. Bernardi, of New York, each to be an Assistant Secretary, all of the Department of Housing and Urban Development.
SD–538

Joint Economic Committee
To hold joint hearings on the economic outlook of the nation.
311, Cannon Building

2 p.m.

Commerce, Science, and Transportation
Science, Technology, and Space Subcommittee
To hold hearings to examine issues relating to carbon sequestration.
SR–253

2:30 p.m.

Foreign Relations
To hold hearings to examine future policy between the United States and North Korea.
SD–419

MAY 24

9:30 a.m.

Health, Education, Labor, and Pensions
To hold hearings to examine issues surrounding Congress' role in patient safety.
SD–430

Governmental Affairs
Investigations Subcommittee
To hold hearings to examine alleged problems in the tissue industry, such as claims of excessive charges and profit making within the industry, problems in obtaining appropriate informed consent from donor families, issues related to quality control in processing tissue, and whether current regulatory efforts are adequate to ensure the safety of human tissue transplants.
SD–342

Energy and Natural Resources
To hold hearings on the research and development, workforce training, and Price-Anderson Act provisions of pending energy legislation, including S.242, to authorize funding for University Nuclear Science and Engineering Programs at the Department of Energy for fiscal years 2002 through 2006; S. 388, to protect the energy and security of the United States and decrease America's dependency on foreign oil sources to 50% by the year 2011 by enhancing the use of renewable energy resources conserving energy resources, improving energy efficiencies, and increasing domestic energy supplies; improve environmental quality by reducing emissions of air pollutants and greenhouse gases; mitigate the effect of increases in energy prices on the American consumer, including the poor and the elderly; S. 472, to ensure that nuclear energy continues to contribute to the supply of electricity in the United States; and S. 597, to provide for a comprehensive and balanced national energy policy.
SD–106

Commerce, Science, and Transportation
Business meeting to consider S. 368, to develop voluntary consensus standards to ensure accuracy and validation of the voting process, to direct the Director of the National Institute of Standards and Technology to study voter participation and emerging voting technology, to provide grants to States to improve voting methods; S. 633, to provide for the review and management of airport congestion; the nomination of Michael K. Powell, of Virginia, Kathleen Q. Abernathy, of Maryland, Michael Joseph Copps, of Virginia, Kevin J. Martin, of North Carolina, and Timothy J. Muris, of Virginia, each to be a Member of the Federal Trade Commission; the nomination of Donna R. McLean, of the District of Columbia, to be Assistant Secretary for Budget and Programs/Chief Financial Officer, and Sean B. O'Hollaren, of Oregon, to be Assistant Secretary for Governmental Affairs, both of the Department of Transportation; and the nomination of Kathleen Marie Cooper, of Texas, to be Under Secretary for Economic Affairs, Maria Cino, of Virginia, to be Assistant Secretary and Director General of the United States and Foreign Commercial Service, and Bruce P. Mehlman, to be Assistant Secretary for Technology Policy, all of the Department of Commerce.
SR–253

10 a.m.

Appropriations
Legislative Branch Subcommittee
To hold hearings on proposed budget estimates for fiscal year 2002 for the Secretary of the Senate and the Architect of the Capitol.
SD–124

Appropriations
Transportation Subcommittee
To hold hearings to examine transportation safety issues and Coast Guard modernization proposals.
SD–192

Judiciary
Business meeting to consider pending calendar business.
SD–226

Banking, Housing, and Urban Affairs
Securities and Investment Subcommittee
To hold hearings on the implementation and future of decimalized markets.
SD–538

10:30 a.m.

Foreign Relations
Business meeting to consider pending calendar business.
SD–419