talked about here, starting with the FBI, is going to cost us about $1.7 billion.

We know most of the time who comes into this country, but once they come here, they are lost in a maze of 270 million people. We need the Immigration and Naturalization Service to improve their tracking of people who are in this country and people who are on student visas. I believe we should do all we can to have exchange programs and have people study in our great universities. Out of the approximately 135 great universities in the world, 121 of them are in the United States. It is great we have people who want to come from other countries to study here. But we need to make sure that once they come here, they are not lost in the maze of people in the United States.

We need border enhancements, improved tracking of people, including people on student visas. This is going to cost about $1.5 billion. We know that airport security is going to cost more money, about $1 billion. Transit security is also important, $1.1 billion. We need to make sure there is adequate Federal security protection in Federal facilities such as nuclear plants and border facilities, national parks, and water projects. That will cost over $1 billion.

Enhancements for highways: I believe if we are going to have a real stimulus package in this country, we are going to have to do something with job creation. It is not going to be done all on the tax side. We have to create jobs.

For every billion dollars, for example, we spend on highways, we create 42,000 jobs. So much needs to be done with our highways. This would be an immediate pick-up, an immediate stimulus to our economy all over America, whether it is New York or Nevada or any of the other 48 States. There are projects that have been designed, and the only thing holding up the projects from going forward is money. We would create hundreds of thousands of jobs if we decided to spend $4 billion on these projects.

We could easily spend $2.5 billion for enhancement of highways. We could allocate $2.1 billion for clean and safe drinking water projects. Indian Health Service clinics and other initiatives need to be taken care of.

There needs to be a direct, strong movement to restore confidence in our economy. One way we can do that is to create jobs. The other way, and they go together, is to restore confidence in our homeland defense.

I have discussed with Senator Abraham, Governor Ridge, the head of the FBI, and the head of the CIA the need to have a place for training people who are part of our counter-terrorism task force. I am very provincial in this. I understand that. But the Nevada test site, where we set off 1,000 nuclear devices over the years, is a place as large as Rhode Island. It has mountains, valleys, deserts, dry lakes. It has a facility already there for testing chemical spills. It has huge dormitories and restaurants. It is a place that is waiting for some activity.

In addition to that, if we want to test hardened silos that Saddam Hussein and people in Afghanistan have dug and built, we can use a network of tunnels that have been built there for nuclear testing over the years that are miles long. So as part of restoring confidence in the economy, we should have this national terrorism center.

I only hope that we all understand that it is extremely important we not walk out of here with a stimulus package that is driven solely by tax cuts. I acknowledge that there are certain things we can do that are important on the tax side. There are other things we need to do. We need to look at those people who have been displaced in the September 11 aftermath.

Senator CARNAHAN offered an amendment on the airline security bill. It was a good amendment that failed on a party-line vote. That is too bad. We need to make sure before we leave here that the Carnahan amendment passes. We must do that.

We also must recognize that people who have been displaced not only have problems of unemployment, but they have no health insurance. We have to do something to extend COBRA or somehow to take care of COBRA.

While we talk about these extended unemployment benefits, we have to understand that unemployment compensation is a bridge to nowhere unless there is a job on the other end of it. We have to make sure we do something about that.

I spoke last evening to Senator NELSON of Florida. I have spoken to the two Senators from New York and other States who have an interest in tourism. That includes at least 30 States that have tourism as the No. 1, 2, or 3 most important economic forces in their States. We have to boost tourism.

There has been general agreement that we should look at a program to give a tax credit to people who travel—short-term, of course. We need to take a look and see if we need to restore the deductibility for business meals to stimulate the economy in that regard.

Senator DORGAN and I introduced legislation last week that would look at the ancillary businesses inside the airline business, such as rental car companies and travel agencies. These people also need a shot in the arm.

If we walk out of here this year and don't take into consideration the fact that we need to restore confidence in the economy by creating jobs and making sure people feel good about our homeland defense issues, we will have made a big mistake.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

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

RECESS

The PRESIDING OFFICER. Madam President, I ask unanimous consent that the Senate stand in recess until 2:15 today.

There being no objection, the Senate, at 12:23 p.m., recessed until 2:16 p.m. and reassembled when called to order by the Presiding Officer (Ms. STABENOW).

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. WELLSTONE. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. WELLSTONE. Madam President, I yield to my colleague from New Mexico.

Mr. DOMENICI. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DOMENICI. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2002—Continued

Mr. REID. Madam President, I ask unanimous consent that the list I will send to the desk, once this consent has been granted, be the only first-degree amendments to H.R. 3061, the Labor-HHS appropriations bill, and that these amendments be subject to relevant second-degree amendments.

Mr. BROWNBACK. Madam President, I object.

The PRESIDING OFFICER. The objection is heard.

The Senator from New Mexico.

AMENDMENT NO. 2020

(Purpose: To provide for equal coverage of mental health benefits with respect to health insurance coverage unless comparable limitations are imposed on medical and surgical benefits)

Mr. DOMENICI. On behalf of myself, Senator WELLSTONE, and Senator KENNEDY, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from New Mexico (Mr. DOMENICI), for himself, Mr. WELLSTONE, and Mr. KENNEDY, proposes an amendment numbered 2020.

Mr. DOMENICI. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

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

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

The PRESIDING OFFICER. The Senator from New Mexico is recognized.

Mr. DOMENICI. Mr. President, I rise today to offer the Mental Health Equitable Treatment Act of 2001 as amendment to the fiscal year 2002 Labor-HHS bill. I am joined by my friend and partner in this endeavor, Senator WELLSTONE.

We are well aware of many of the arguments that will be made against our amendment. For instance, while the nation is rightly focused on recovering from the trauma and damage inflicted on September 11, it would be wrong to overlook this important issue because it is simply the right course of action to undertake. We are well past the time to act on extending and building on the federal mental health parity law that expired on September 30.

Others will argue that our amendment costs too much. However, CBO has scored our bill as costing less than one percent 0.9 percent and again passing this bill is long overdue and the right thing do for the millions of Americans suffering from a mental illness. The number of Americans suffering from a mental illness or the number of family members affected by a mental illness has not magically decreased over the past couple of months.

We are ready for a vigorous debate on a host of issues, but I would like to begin by saying: Our bill has 64 bipartisan cosponsors; the HELP Committee reported out the bill on August 1 by a vote of 21–0; 144 organizations support the bill; and CBO has scored the bill as raising insurance premiums by 0.9 percent.

The human brain is the organ of the mind and like the other organs of our body, it is subject to illness. And just as we must treat illnesses to our other organs, we must also treat illnesses of the brain.

Building upon that, I would ask the following question: what if thirty years ago our nation had decided to exclude heart disease from health insurance coverage? Think about some of the wonderful things we would not be doing today like angioplasty, bypasses, and valve replacements and the millions of people helped because insurance covers these procedures.

I would submit these medical advances have occurred because insurance dollars have followed the patient through the health care system. The presence of insurance dollars has provided an enticing incentive to treat those individuals suffering from heart disease.

But sadly, those suffering from a mental illness do not enjoy those same benefits of treatment and medical advances because all too often insurance discriminates against illnesses of the brain. More often than not, opponents of mental health parity argue the costs are too great. However, I would submit the cost of parity is negligible, especially, when contrasted with the cost impact upon society. The devastating consequences inflicted upon not only those suffering from a mental illness, but their families, their friends, and their loved ones.

Furthermore, the following are several additional costs that result from mental illness: 16 percent of all individuals incarcerated in State and local jails suffer from a mental illness; suicide is currently a national public health crisis, with approximately 30,000 Americans committing suicide every year; of the 850,000 homeless individuals in the United States, about one-third or 300,000 of those individuals suffer form a serious mental illness; and finally what about the people that are crying out for help and society only hears their cries after they have committed a violent act against themselves or others.

Just look, at the tragic incidents in Houston with the mother killing her five children, the Baptist church in Dallas/Forth Worth, and the United States Capitol to see the common link: a severe mental illness. Unfortunately, there is no place that a community can take these individuals for help. The police can do very little and likewise for hospitals.

Some of you may have seen last year's 4 part series of articles in the New York times reviewing the cases of 100 rampage killers.

Most notably the review found that 48 killers had some kind of formal diagnosis for a mental illness, often schizophrenia: 25 of the killers had received a diagnose of mental illness before committing their crimes; 14 of 24 individuals prescribed psychiatric drugs had stopped taking their medication prior to committing their crimes.

In particular I would point to a couple of passages from the series:

> They give lots of warning and even tell people explicitly what they plan to do.
>
> . . . a closer look shows that these cases may have more to do with society's lack of knowledge of mental health issues . . . In case after case, family members, teachers and mental health professionals missed or dismissed signs of deterioration.

Now let us look at the number of individuals suffering from some of the dreaded mental illnesses.

Major depressive disorder: 9.9 million American adults age 18 and older suffer from this disorder in a given year;

Bipolar disorder: 2.3 million American adults age 18 and older suffer rrom this disorder in a given year;

Schizophrenia: 2.2 million American adults age 18 and order suffer from this disorder in a given year; and

Obsessive—compulsive disorder: 3.3 million American adults age 18–54 suffer from this disorder in a given year.

However, medical science is in an era where we can accurately diagnose mental illnesses and treat those afflicted so they can be productive.

I would ask then, why with facts like these would we not cover these individuals and treat their illnesses like any other disease? We should not.

Working together, we took a historic first step with the passage of the Mental Health Parity Act of 1996, but that law is also not working as intended. While there may be adherence to the letter of the law, there are violations of the spirit of the law.

For instance, ways are being found around the law by placing limits on the number of covered hospital days and outpatient visits. Consequently, Senator WELLSTONE and I have again joint forces and introduced the Mental Health Equitable Treatment Act of 2001.

The bill seeks a very simple goal: provide the same mental health benefits already enjoyed by Federal employees.

The bill is modeled after the mental health benefits provided through the Federal Employees Health Benefits Program and expands the Mental Health Parity Act of 1996 by prohibiting a groups health plan from imposing treatment limitations or financial requirements on the coverage of mental health benefits unless comparable limitations are imposed on medical and surgical benefits.

At 2:25 this afternoon, an amendment arrived at the desk. I read off the names of the cosponsors, but I did not name the bill. So let me do that. This bill is called a mental health parity amendment. Another way of talking about it is that it is the mental health parity bill put into an amendment form. So we will not have to wait any longer to have a national debate as to whether insurance companies in the future—not this year but one full year from now is the way we have drafted the bill—will or will not be able to insure people against their illnesses and/or diseases and provide less coverage for the mentally ill as defined in this bill than they do for other well-recognized diseases such as cancer, diabetes, whatever they may be.

That means the thousands upon thousands of American families who have young people in their teens with schizophrenia—well diagnosed, they are told by the medical people what they have, they are subject to treatment, to medication and, yes, a very long life of difficulty if, in fact, they do not have medication and treatment facilities in these great United States, the last group of Americans who have no health insurance because they are defined out of the coverage by the conventional approach to what is a disease and an illness and what is not. They are left out.

So if one goes to New York or Chicago or, yes, Albuquerque, and finds street people and watches them and looks at them and says, oh, my, what are they doing, they will find that fully between 33 percent and 40 percent are

sick. That is why they are there. They are sick and they probably have no insurance coverage, even though they are as sick as someone's next door neighbor who had a heart attack and is being taken care of in the best heart facility at the local hospital, and the insurance company pays the bill.

We have had a history in America of not covering the mentally ill under conventional, typical insurance coverage. Quite to the contrary, we have sat by and watched insurance companies—obviously they are doing the best they can and this is part of their business. They are remaining solvent and being able to insure people at the most reasonable prices. The insurance companies come along and say: Since we are not obligated to do so, we will not cover the mentally ill; or if we do, they will be covered with a much smaller total coverage number, and everything about the coverage will be less than what we cover for people with the ordinary diseases that we so often talk about, including the great strides being made in heart disease treatment, heart disease research, heart disease care, or any of the other diseases we are so free to talk about. Somebody is being taken care of. The insurance company is paying the bill. New buildings rise up to cover them because they are insured.

That is a great resource, coming directly from the back of the insured to the marketplace, the marketplace of paying for the best doctors, of paying for facilities. If somebody can pay for them, you are apt to build them.

What about the mentally ill? The mentally ill have no facilities to speak of—just a few—because nobody will pay for them. There are no specialty clinics to speak of. There is very little private sector involvement in building health facilities where the mentally ill can be taken to make sure they take their medicine and are cared for. In the ordinary language of the marketplace, there is no money in it. There is no money in it because the people are not insured.

Five plus years ago, my friend Senator WELLSTONE and I passed the first parity bill. It was partial parity. It caused the discrimination against the mentally ill under insurance policies to go away partially. It just expired. This bill, that is now in amendment form, passed out of the committee 21 to 0. A couple of Republican Senators want to offer amendments, and I am pleased they can offer them now, this afternoon. We tried our best to get the bill called up as a freestanding bill, hoping we would be given a day, 2, or 3 days. We could never get it done because there were some Senators—and it is their privilege and prerogative—who thought that we don't need to mandate coverage, even a year and a half from now, as we do here, and we do not need to cover the mentally ill that doctors define as having a brain disease and should have coverage. Some think their cause of not covering it is better served if we never get this bill up.

I understand what a great imposition this is on the appropriations process and on the two wonderful Senators managing this bill, but I don't see any other way to do it. There are millions of Americans who have worked through their organizations. There are 140 organizations in America supporting this legislation. Some have a special interest. Some will receive better payment for taking care of the mentally ill. Some, such as the National Alliance of the Mentally Ill, understand the plight of people with schizophrenia, the plight of people with bipolar diseases, the manic-depressive. They understand what parents are going through in America.

These diseases do not always strike the elderly or the young. As a matter of fact, one of the most dread of these diseases has a propensity for showing itself when our young people are teenagers, between the ages of 17 and 18, up to 25 or 30. At this age the disease causes a great disability and poses a major problem for care of a son or daughter. Across this land thousands of people have already gone broke, cashing out every asset they own, trying to take care of their child, while America looks on the insurance system and says: We cannot tell anybody what kind of insurance they should cover. We cannot tell any insurance company what they ought to cover. We take for granted that they will cover heart conditions, heart research, they will cover any of the other diseases we more or less call ''physical'' diseases. On the periphery sits the mentally ill with little or no coverage.

My good friend, Senator WELLSTONE, and I have been joined by 65 Senators. I sent this to the desk at 2:25. This is a very historic time. This amendment will pass, if not today, tomorrow. And today we will finally have made the Senate vote. I am convinced they will vote yes, let's get this started; get rid of this discrimination that has festered long enough in terms of the health coverage system of the United States. Before the day is out, I believe the number of Senators will go up, not down.

For those frightened for small business, the committee, headed by Senator KENNEDY, the committee we entrusted with our bill, which has the jurisdiction, has the authority to decide to send us a bill or not, decided, in order to have great unity and the first time through to get Democrats and Republicans on board, they would make an exception for small business. Everyone should know, all businesses with 50 employees or fewer are exempt; we are not mandating this coverage at this point. Small businesses that might be worried about this, or Senators who might be worried in their behalf, can read this bill. They will find that exemption.

There is much more to say. Taking this up at the end of the year does not do this bill justice. It is a major undertaking by the legislative branch of the U.S. Government, led by the Senate. Nonetheless, we are going to proceed. To those who procedurally are determined not to let us have a straight vote, you will find a few changes in this bill from the language that came out of the committee. We wanted to make sure this bill was as protected as we could make it from procedural motions on the floor. It is not effective until the year 2003. That cures a lot of procedural problems some might have had. It is not subject to a point of order, a 60-vote point of order, because of that change and 2 or 3 other changes we made in order to see to it we got a straight up-or-down vote.

For the mentally ill, the schizophrenic whose family is desperately trying to take care of them, or someone suffering the great delusions that are typical, the mammoth delusions that are common for a schizophrenic or for the bipolar suffering—for some unknown reason, they can be in a very low mood and then as high as they can get, and in between the highs and lows is a great inability to live a normal life—this is the best we can do for those families in America, for those millions suffering. We have to offer it today. We have to get the Senate to say yes or no on whether coverage by insurance policies is part of the normal, everyday coverage for health care, whether or not it will include that portion of Americans.

Obviously, these dread diseases are not typical only to America. In any particular area where a group of humans live, there is a certain percentage who will turn up with schizophrenia. There is a certain group that will turn up with the enormous ups and downs of the bipolar disease I described.

There is also clinical depression, which probably has more victims than any other in terms of numbers. What does depression bring, along with the other two diseases I mentioned? A total loss of hope; suicides, which are growing in numbers, especially among teenagers. More times than not when that event occurs, the trail of symptoms indicates if they had been treated for depression, it probably would not have happened.

In any event, I am prepared to go on much longer and in much more detail.

For those who want us to delay consideration of this measure, I urge you to come down. See if I am correct. I don't think you have a parliamentary way of avoiding having the Senate vote. I don't think there is a way that you can make it subject to a point of order where we will need 60 votes. I don't believe there is a point of order with reference to the budgetary impact because we are able to understand in advance those kinds of procedural approaches. The bill is no longer subject to those kinds of procedural attacks.

We feel good about it. We would like to spend some time talking about the reality of this bill and what it will and won't do.

I close by saying the last argument that will come from those who oppose

it is: Can we afford it? I assume they will also say: We are now in a recession. So we really can't afford it.

I just told you it is not effective until 2003. We give everyone time to get out of the recession. Besides that, in terms of budgetary problems, the best estimate we have, and we will put it in the RECORD shortly, is the Congressional Budget Office saying when fully implemented, this may increase the cost of health insurance by nine-tenths of 1 percent. That is what the Congressional Budget Office says.

I have given you the small business exemption. I have given you the experts' cost. I have given you when it will come into effect. Later on we will discuss who is covered by it. That is still something to be discussed. Some will want to know whether we made it too broad, whether we covered too many people, and whether we covered them in language that is so vague so that the disease is not adequately defined. We think we have done all of those things.

We are pleased to engage later in the day with anybody who would like to talk about that.

I yield the floor. I thank Senator WELLSTONE for his help. We will be here this afternoon defending this measure as long as we are needed.

I yield the floor.

Mr. WELLSTONE. Madam President, I believe the Senator from Pennsylvania wants to speak. I will defer to him. I ask unanimous consent that I follow the Senator from Pennsylvania.

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

Mr. SPECTER. Madam President, I compliment my distinguished colleague from New Mexico for his diligent work over a very long period of time on this very important issue. When he talks about the measure, it is Senator DOMENICI, for himself, Senator WELLSTONE, and Senator SPECTER. I am second on the cosponsor list on his substantive amendment. When he asked me before submitting it whether I would be a cosponsor, I said that I wanted to wait and see the discussion.

The concern that I have is the moving of this appropriations bill. My colleague from New Mexico understands that full well. He is on the Appropriations Committee and is the chairman of the subcommittee. I think it is a bill which ought to be enacted. I believe there ought to be mental health parity. The reasons which he has given are very persuasive.

The concern I have is it is legislation on an appropriations bill, and the concern as to whether there are tax implications to include deductibles, coinsurance, copayments, and catastrophic maximums which would provide a basis for a so-called blue slip by the House of Representatives. We can handle that in due course. I am going to await the arguments.

I would like to find some way to accommodate this amendment. I am just not sure at this point that it is possible. But I wanted to express those views at this time. I know the Senator from Minnesota is waiting to comment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Mr. WELLSTONE. Madam President, I thank my colleague from Pennsylvania. I know in discussions with the Senator from Pennsylvania and Senator HARKIN from Iowa that we can go over all of the points. We have made a special effort to deal with it.

First of all, I thank my colleague, Senator DOMENICI from New Mexico. It has been my honor to have worked with him now for over half a decade on this question.

I believe the Senate will pass this amendment. When we pass this amendment, I think it will be viewed favorably by historians. I am not trying to be melodramatic.

There are 67 Senators, Republican and Democrat alike, who support this piece of legislation. It passed out of the HELP Committee by a 21-to-0 vote. There are 150 organizations that support it. There are two reasons.

First of all, this legislation is major civil rights legislation. We are coming to November 2001. When this amendment and bill pass, I believe we can keep it in conference. We will have passed a major piece of civil rights legislation which will say that we will no longer permit discrimination against those people who struggle with mental illness in our country.

This legislation says, when it comes to those who are struggling with this illness, there will no longer be discrimination. It is modeled after the Federal Employees Benefits Plan.

It basically says there will be the same requirements when it comes to deductibles, copays, and days in the hospital and outpatient visits.

I thank the Senator from Massachusetts as chairman of the HELP Committee for helping us get this through the Health Committee on a 21-to-0 vote. He and his staff have been there throughout all of the negotiations and work on this bill.

I thank Senator DOMENICI. Next to Senator DOMENICI, I thank Senator KENNEDY.

I think there is going to be an overwhelmingly positive vote because it is just wrong for someone who is struggling with this kind of illness to be told they are going to have to pay a higher copay, and they are going to have to pay a higher deductible. No health insurance plan will let them stay a few days in the hospital. No. They can only have a certain number of outpatient visits.

We will not do that with someone who suffers from a heart condition, nor to someone who is suffering from diabetes, nor to someone who broke their ankle. We don't say to them they are going to be in the hospital only 1 day and that is it, or 2 days and that is it. Nor would we charge them high copays and deductibles to the point where they can't afford it.

We have to end the discrimination. It is 2001. The time has come for this idea.

The Surgeon General in his report said close to 20 percent of American people struggle with this illness and 18 million people struggle with depression.

I have had the honor of working with Al and Mary Kluesner from Minnesota. They started an organization. It is now a national organization. It is called SAVE. Two of their children committed suicide. They have two children who are doing spectacularly well.

Up until very recently, a lot of families, parents, brothers, sisters, husbands, and wives blamed themselves when they lost a loved one who took their life. There has been this shame. People have blamed themselves. But now we know a lot more. Now we know how much of that is biochemical. Now we know it can be diagnosed. Now we know it is treatable. The success rate for treatment of those who are struggling with depression is 80 percent.

Kay Jamison, a psychiatrist at Johns Hopkins who has tried to take her life twice, has written several powerful books. One book is called ''An Unquiet Mind'' about her own experiences. Just a month ago she received the McArthur Award—the genius grant —for her work. She has written about the gap between what we know and what we do. It is lethal.

The Kluesners became involved and people all across the country have become involved. They no longer will accept the stigma. They no longer will accept the discrimination. They have come out of the closet. They have come out of the closet to speak for their loved ones because they know it is a matter of life or death.

If we would end the discrimination, we would get the care to people; we would save some lives.

Suicide is the third leading cause of death among young people in our country. In Minnesota, it is the second leading cause of death.

So much of this can be diagnosed. So much of this is preventable. That is why this amendment and this legislation is so important.

It is not just a question of civil rights. It is not just a question of saying it is the end of discrimination. It is also a question of what we can now do as a nation. Because if our health care plans—modeled after the plan that we participate in, the Federal Employees Health Benefits Plan—say there will be no difference in terms of the way we treat this illness versus any physical illness, then, I say to Senator DOMENICI, the care will follow the money. Once the health care plans provide the coverage, you will have an infrastructure of care out there for people that we do not have right now.

There will be arguments and counterarguments, and I am ready for all of them.

Let me just make a couple more points because I will be in this Chamber for a while with this amendment,

and other Senators are in the Chamber right now.

There was a young woman named Anna Westin. Her mom and dad, Kitty and Mark Westin, have brought parents together as well. They have brought parents together because their daughter—a beautiful young woman—struggled with anorexia. Same issue: She tried to get coverage from the plan. It was the Blue Cross/Blue Shield plan in Minnesota. They could not get the coverage for the days in-hospital that she needed to be there. They lost their daughter.

By the way, Blue Cross/Blue Shield has made a settlement with them and is going to do much better in terms of providing the coverage. I cannot make a one-to-one correlation and say because she did not get coverage, therefore, Anna took her life. But I can tell you this: I have met with parents, I promise you, all across the country who have told me about what it means when they cannot get coverage to take care of their children.

I went down to Houston; and SHEILA JACKSON-LEE had a hearing she wanted to do with me. It dealt with mental health and children. It was unbelievable the number of people who came who wanted to speak about their desperate story with their own children. At this public hearing, the guy who was the head of the corrections system for one of the largest counties in the United States of America—I could not believe what he said—said: I am a law and order person. Nobody seemed to doubt that. And he said: I want to tell you, a lot of people believe that if these kids are locked up in our facilities, they have done something wrong. He said: I want to tell you—I think the figure he used was 40 percent—40 percent of these kids, if they had gotten some help, would not even be in jail. They should not be locked up. It is the only place the parents can get any help for them.

There was a time when we talked about how we institutionalized people, we warehoused people struggling with mental illness—adults and children in institutions. Now we are warehousing them in our jails, and many people should not be there—many children should not be there.

So this legislation ends the discrimination for a broad range of mental illnesses that affect adults and children.

This legislation has an exclusion for small business so that businesses are not covered unless they have 50 employees or more.

This bill has been scored by CBO as costing no more than a 1-percent increase in premium. Then there is the benefit of what happens when we finally end the discrimination and what happens when we finally provide the coverage for people.

We had testimony—my last point because I will have a chance to speak later—before the HELP Committee, I say to Senator KENNEDY. There were a number of people who came in—I wish I could remember all of their names: doctors, psychiatrists, social workers—and they were talking about the aftermath of September 11. I am not mixing agendas. I am being as intellectually honest as I can.

One woman, who worked with the firefighters, said: I want to tell you that given what people have gone through, you are going to have to have an infrastructure of mental health care. Her name is Dr. Kerry Kelly. She talked about her experiences with her onsite work as chief medical officer of the New York Fire Department. She just basically said: Look, we are going to need a lot of help for family members. And people have been saying that all across the country.

So, I say to colleagues, please consider this legislation civil rights in ending discrimination. Colleagues, please consider this legislation as a way of finally providing the care to men, women, and children who, if they are provided with the care, can go on and lead good, productive lives. And, colleagues, also please consider this legislation preparedness legislation. The truth is, no longer, when we talk about health care for adults or health care for children, or public health, or what we have to do, can we not consider mental health part of the cake. It is part of how we deliver humane and dignified and affordable health care to people in the country.

This is about as important a piece of legislation as I think we can pass. But, look, I have my biases. I came here as a Senator who has a brother who has struggled with this illness all of his life. When I was elected in 1990, I thought if there was one thing I would try to do, for sure, I would try to end this discrimination in coverage. For sure, I wanted to make sure that people were able to get the help they needed.

I have had a chance to work with Senator DOMENICI for over half a decade. And I have had a chance to work with Senator KENNEDY for over a decade. Now is the moment where we can pass this legislation as a part of this bill. And I think we can keep it in conference. This would be a huge step forward for our country.

We need each other as never before. There is an ethic going on in this country about the ways we can help one another. I think that is all for the good in the most difficult of times. This would be the best possible way of living up to this value and this ethic, to adopt this amendment with an overwhelming vote.

I yield the floor.

The PRESIDING OFFICER (Mr. JOHNSON). The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, first of all, I congratulate and thank our two leaders in this extremely important bill in the area of health policy—Senator DOMENICI and Senator WELLSTONE—for ensuring that the Senate will have an opportunity to address one of the most compelling health care issues we are faced with in our society. I thank them for their constant support on this issue over the years.

We have had debates on mental health parity on a number of different occasions, but with the shaping and the fashioning of this amendment, this really is the moment of truth on this issue. This is the time to take action.

Senator DOMENICI and Senator WELLSTONE deserve all of our thanks for their leadership and the work they have done. I would also thank those who have been a part of the process in helping us develop the legislation, the scores of families who came and testified and shared some of the great personal challenges they have faced as they have dealt with the challenges of mental illness in their families, deserve a great deal of credit.

We express to them that the best way we can ever thank them for being willing to share some of the great challenges they have faced over a lifetime of care and dedication and commitment—and in a number of instances financial ruin—is to have real parity in our health care system. This legislation will do that for us.

I was listening to both of our colleagues and remember so much of the similar debate we had back in 1996 on the HIPAA legislation, when both Senator DOMENICI and Senator WELLSTONE brought these matters to the floor of the Senate at that time. A number of our colleagues spoke with great passion and great commitment, and we thought we had made a substantial downpayment in moving us irrevocably in that direction. But, nonetheless, we were not able to do so because there were those who were able to find ways of circumventing the legislation and finding ways of subverting both the intent and, for me personally, even the letter of the law. The Senate voted for it overwhelmingly, Republican and Democrats alike.

Over the years, this body has been somewhat slow in finally responding to science rather than ideology. For years, those who were challenged mentally were too often put aside in our society and denied a position of respect and dignity. They were shunned. They were looked down on. They were pitied. They were, in many instances, abused. Their lot was not a good one in America.

Then, more recently, that attitude has changed. I would like to believe there has been a new sense of respect for the valuing of individuals on the basis of their character rather than, as was used with these words, ''the color of their skin'' or their gender or their ethnicity or their disability. We have made important progress.

What we have seen over time is corresponding progress in being able to deal with the challenges of mental illness. We have made real progress. Now there is really no excuse whatsoever. Now there is no reason whatsoever to deny the Senate the opportunity this

afternoon to move toward true equality and true parity in terms of mental health.

If we look at some of the mental disorders that are most common in terms of challenges to our communities, one is bipolar disorder, another is depression. Compare those to the physical disorders of hypertension and diabetes, common illnesses, common challenges we face; you find that the treatment success rates for these chronic diseases of bipolar disorder and depression far exceed those for hypertension and diabetes. This is true across the board. Not everyone understands it; not everyone believes it. But increasingly, the medical information and testimony and results indicate that mental illness is treatable. It is such a statement of hope for families to know that, if they get the appropriate treatment, they can free the individuals facing these challenges from some of the torments they are facing in the course of their lives. We have made enormous strides. We are making enormous strides.

Our two colleagues share my belief that we are at the time of the light science century—with the mapping of the DNA, stem cell research, and all sorts of recent exciting medical breakthroughs. We view the opportunities for continued progress in this area, such as in the year of the brain, where we have had very profound research and discoveries on what impacts thought process in people's minds. We have made enormous progress, not only in understanding but also in dealing with these issues.

The question is, why not have parity? It is so compelling and so necessary.

I will digress for a moment and thank our colleagues for bringing this to our attention at this time in our country's history. All of us still are sensing the powerful emotions we felt on September 11. We know anxiety still exists for so many families, not only as a result of the particular enormous tragedy that was so devastating to so many families but also its impact on our Nation as a whole and, more recently, the challenges we are facing in terms of the dangers of Anthrax. We know it has only directly affected some 15 of our fellow citizens, but we know that the fear and the anxiety among our fellow citizens is significant.

I dare say, this anxiety has impacted no group more than the children of our country. They are feeling this enormous anxiety. They are feeling it not only as a result of September 11; they are also feeling it with regard to the threats of Anthrax and the whole threat of bioterrorism. There is a lot of anxiety in America today.

We don't expect this bill to solve all of the problems, but what it will do is give the stamp of the U.S. Senate. Any fair review in the reading of the record is going to reflect very clearly that there are ways of providing assistance to those who need the attention and the care and the guidance and the support and the treatments that are out there for American families.

The most obvious ones are those that have been involved in the current rescue efforts at ground zero and their families. Having had an opportunity the other evening to talk to the head of the firefighters union and to listen to him for a short period of time, I could already see that the challenges that are going to be faced by so many of the families involved are going to be severe.

We know that challenges still exists. We know now in recent years enormous progress has been made in understanding the very challenge of mental illness and mental disease. We know extraordinary progress has been made.

The only reason for not accepting this amendment may be the issue of cost. It always comes around to the issue of cost. At least it comes around so often by those who want to resist legislation.

That argument does not stand up in this case. We have experience in a number of the States on this issue. In our committee, this was raised as an issue. And we agreed to raise the exemption from companies with 25 employees or less up to companies of 50 employees or less. That means approximately half of all working families in this country will effectively be covered, but there will still be many others left out. I regret that, quite frankly. But I am satisfied that if we get this in place and we have the results that I know will come, we will be right back in a very short period to extend the exemption from employers of less than 50 down to 25.

The fact is, 23 States have passed parity laws. There is absolutely no evidence that any of them have experienced any significant increase in costs. We know that now as fact. We are not dealing with theories, estimates, or judgments by those who are opposed to it. We are dealing with facts. The facts are as I have stated; there has not been a significant increase in cost.

The Senators from New Mexico and Minnesota would agree with me that with an effective program providing mental health parity, you are probably going to see a reduction in the cost of health care because when you treat the mental health challenges and the illnesses for individuals, more often than not, it has a very positive impact in terms of other physical disabilities.

Those studies have been presented before our committee, and I am absolutely convinced that even though this is going to provide additional kinds of treatment for individuals who need it, the overall bottom line is going to be savings in health care expenditures. We have seen examples of it. I won't take the Senate's time right now to go into those studies, but a very compelling case has been made.

If you think back to it logically, you will see the reasons for it. The first reason is to assist families and individuals by increasing the nation's capability to provide mental health services to Americans who need it. It is a grave mark on our national consciousness if we have the ability to assist these families and we do not do so. This legislation will ensure that we are going to do it.

Secondly, with the progress that has been made with these breakthrough treatments and medicines, we have the chance to make a important difference to our fellow citizens in their lives and the lives of their families and to have an enormous positive impact on our fellow citizens.

Finally, this is not going to be an additional burden in terms of cost. This is a compelling case. It has been made eloquently and passionately by two of those who have given their commitments and the force of their arguments—Senators DOMENICI and WELLSTONE. They have made this case time in and time out. It is time for the Senate to act. It is essential that we act, and I hope this will pass overwhelmingly.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Mr. President, I am happy to be a cosponsor of this amendment.

First of all, I wish to express my gratitude for the leadership shown by Senator WELLSTONE and Senator DOMENICI. They brought to the Senate, with this unique partnership they have formed, something that will be long remembered. They are from different political parties, two individuals with different views on almost everything in political life. In the last 6 or 7 years in the Senate, they have brought together something that has been very dynamic. As a result of their leadership, laws have been changed in this country, attitudes have been changed in this country, and the entire United States owes a debt of gratitude to these two men.

We have all had experiences with diseases where we may have said, yes, my cousin, my brother, my father, or my neighbor had this same disease—whether it is cancer, heart disease, whatever the condition—a medical problem with which we have all had experience. If we are honest with ourselves—and we are becoming so—if we talk about mental illness, it is the same thing.

How many of us have relatives who have clinical depression? Lots of us. How many know of members of our families who have bipolar disorders? That is a relatively new term but something we understand. The same applies—whether it is cancer or heart disease, it applies to this.

I have been stunned by how many people have been affected by a suicide. It is no secret in this body that my father committed suicide. It is no secret that it took a long time for me to acknowledge it publicly and talk about my father's death. But since I have, every place I go, people come to me and relate stories. For example, I was at a TV interview in Las Vegas. One of the anchors who did the interview said: May I speak to you afterward? I said sure, and I waited. Her brother committed suicide. Every place I go, people

come up to me and say their mother, father, brother, or sister committed suicide. We know at least 31,000 people each year kill themselves. There are really more because there are automobile accidents and other kinds of ''accidents'' that are not counted, but they are suicides.

Many people deny that their loved ones have committed suicide. I try to have them be as forthcoming as I should have been many years ago about my father. It affects us all.

That is what this amendment is all about—parity, making sure that heart disease is treated no differently than depression that leads to suicide.

There is a tendency of some to think these problems are identifiable at a given age. Well, the sad reality of it is that mental illness doesn't appear at any certain age. Children have mental disorders, mental problems. Teenagers develop them. People in their twenties and thirties have them.

Here are two examples. There is a woman I have gotten to know in Washington—a 78-year-old widow. She is a very pretty woman. Her husband was extremely well educated. She has two sons. They both were happy, with good jobs, in good professions. While in their forties, they developed mental illness—both of them. Now she cares for her two sons. She is 78 years old. I visit her at least once a month. Some months they are in better shape than in other months. They are under medication and treatment. But it has affected her life dramatically.

I often wonder what is going to happen. In fact, I don't know about the one son. One, I know, was happily married with children before he got sick. Now he is divorced. I often wonder what is going to happen to these men after this woman passes away.

Another example is somebody I knew who was a great athlete in high school, a high school all-American, college all-American, a professional athlete. I wonder what happened to him. All of a sudden, I didn't see him on the roster and wondered what happened to him. He is in an institution—a mental institution. Who would ever guess it? I will not mention his name. Who would ever guess he would have been in a mental institution—this fantastic athlete, tough, hard, and so good. He is in a mental institution.

I recognize that there needs to be more done so that we accept mental illness more. That is what this legislation is all about. That is what mental parity is. That is the name these two men—Senators WELLSTONE and DOMENICI came up with, ''mental parity,'' or mental fairness, to treat diseases the same, whether it is heart trouble or depression.

We are doing better than we were. One reason we are doing better, in my opinion—the one to which I have devoted so much time, suicide—is we have a man who is the Surgeon General who is a tremendous person. All we had to do was talk to him about suicide and he knew something had to be done. Dr. Satcher has worked tirelessly, since he became Surgeon General, to bring about change. He has worked with us to make sure there was money to study the causes of suicide. We don't know why people commit suicide.

You would think the suicide would be in States—and I say this without any denigration whatsoever—where it is dark and cold in the wintertime, such as North Dakota, Minnesota, South Dakota, these cold States, but it is not.

It is not. Suicide is west of the Mississippi, in States where the Sun shines a lot, wide open plains and places for people to get outdoors. The 10 leading States in suicide are west of the Mississippi. We do not know why, but we are studying why, and we hope to learn more.

In the Senate, we have passed resolutions recognizing the problems with suicide. We are appropriating some money now. We are doing better.

To show this is a serious problem, I have a statement that indicates that a telephone survey conducted by the Pew Research Center of the people and the press a few days after the attacks on September 11 found that 71 percent of respondents reported being depressed, 49 percent said they had difficulty concentrating, and 33 percent reported insomnia.

We have all talked to our friends and relatives who after this attack are having trouble sleeping. For the first time these people are having trouble sleeping.

In another study conducted 3 weeks after the attacks, respondents said they were depressed, and 20 percent 3 weeks after of the events said they were having trouble sleeping.

There should be full parity for mental illness. We have to make sure, as has been discussed today, that companies, businesses, and government do not try to figure out some way to get around this. They should not do that. It is the intent of this amendment that people with mental illness be treated as well, as fairly, and as equally as people with medical illnesses. That is the purpose of this legislation.

If, in some subsequent time, someone is trying to figure out the congressional intent, the intent of this is to have mental parity, to have people who have mental illness treated the same as people with a medical illness.

Again, I express my appreciation to the people who have us talking about this issue, Senator WELLSTONE and Senator DOMENICI. But for their advocacy, we would not be here today and we would not have been doing things in the past 5 years. It is because of them we are considering this amendment. I am personally indebted to them for the work they have done to help those with no voice, to help those with no lobbyists, to help those who cannot help themselves.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I ask unanimous consent to be added as a cosponsor of the amendment.

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

Ms. STABENOW. Mr. President, I am proud to be a cosponsor of the legislation and to add my name to this amendment. I join with others who have thanked Senator DOMENICI and Senator WELLSTONE for their diligence and dedication on what is an extremely important issue. It is extremely important to all of our families.

I have been involved with mental health issues all of my adult life, starting when I was in the State House of Representatives in Michigan chairing the Mental Health Committee and writing legislation we have in place in Michigan for children, families, and adults. But today I rise in support of this amendment because of my personal situation.

My father, who was an extremely loving and wonderful man, a businessman in business with my grandfather in a car dealership in Eau Claire, MI, when I was growing up, in his mid-thirties found himself being diagnosed a manic-depressive. At first, we did not know what that meant in terms of the highs and lows he was experiencing.

At that time—it was the midsixties—there was very little available in the community. It mostly was hospitalization for anyone who had any kind of mental health problems. We did not have a lot of money. Our family was not a wealthy family, and we struggled with attempts to get my father adequate care.

One of the things we learned as we moved through this disease with him was that mental illness is as physical as any disease that is now covered by our insurance system. If you are a manic-depressive, that means you have chemicals in your brain that are off balance. They provide too much of a stimulus that causes one to be awake, to go into a manic state; it causes then too less of a stimulus, so one goes into a depression and they may swing back and forth.

Just as we have now developed medicines to help those who have cancer and diabetes or those who have Parkinson's or Alzheimer's disease—and we are moving on all kinds of fronts to develop new medications—we have medicine now for those who are diagnosed manic-depressive.

When my father was finally able to find someone who understood his disease, there was something developed called Lithium, and he had the opportunity to begin taking that medication each month. He was able to go back to his normal life. He was able to work and function and be a part of the community because this was a physiological disease that was treatable by medication.

We know, whether it is schizophrenia, manic-depression, or other diseases, that we are talking about imbalances in the brain. These are physiological changes. These are health problems, as much of a health problem as diseases that are covered by insurance.

I cannot think of anything more basic than finally, in 2001, understanding in our health insurance system what we have now known in the medical community for years, and that is: If we provide treatment, we can treat those with mental illnesses as well as physical illnesses with great success.

My colleagues have spoken to the fact if we do not do that, we will treat them in our jails, we will treat folks who are homeless and under the bridges sleeping at night. There will be some way that those who have mental illnesses will find themselves in situations where they will be reaching out, and we will be addressing it in some way in the community. The question is, do we do it in a positive way in the health care system where it needs to be addressed or will we be addressing it in some other way that is not positive?

I hope we will all come together. It would be wonderful to see everyone coming to the Chamber and supporting this long overdue amendment on mental health parity. I hope my colleagues understand this has been worked out. This is a bill that has been balanced. For those concerned about small business, this is legislation addresses those companies with less than 50 employees being exempt, that there is a year delay—there is a lot that has been put together in this amendment.

I compliment my colleagues who have worked so hard to come up with a balanced approach and yet proceed with the principle of mental health parity. In this day and age, shame on us if we do not understand the variety of ways in which someone can become ill and require our health system to address those equally. It is long overdue. I strongly urge adoption of this amendment.

I again thank my colleagues who have come forward and have fought so diligently for this principle for so many years.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, I say to the Senator before she leaves the Chamber, I thank her very much for her remarks. I have been very amazed in the 5 or 6 years I have been involved with mental illness issues as it pertains to Federal policy, as it pertains to State law, the more I go out and meet people, whether it is in a townhall meeting where a lot of people from all walks of life come, or whether it is a special event where somebody is being honored and there is a lot of glitter around, or even if you go to New York for some kind of event and you are meeting the people of swank New York, wherever and whenever, you always have more than one person walk up and tell you about their family—schizophrenia, manic depression, clearly depression, especially among young people, always somebody brings that up.

To be honest, it is so common as an illness that it is hard for this Senator to believe we are in this year, 2001, still letting people write insurance policies and act as if heart conditions and all the research that goes with it should be covered, even build hospital clinics because insurance companies are so willing to pay because that insurer carries all of his resources on his back and builds new hospitals, builds new clinics, builds new techniques, builds more research, but all of these people who walk up to us and tell us their story, there is no money, there is no coverage.

Some people will take that as this is a big philosophical difference. They would say to Senator DOMENICI on the Republican side, why do you want to tell anybody what to do? Why do you want to tell insurance companies what to do?

Frankly, I think when we started this process of what will insurance companies cover and what they will not, I asked a question of those who think this is philosophical: What if we would have said a heart condition is not covered by insurance. Why? Because the heart is part physical and it is part spiritual, and we do not know enough about it so let us not cover it.

What do you think we would be doing today? Do you think we would get to 2001 in American chronology and we would still be having insurance companies say they are not covering heart conditions because 41 years ago they should not have covered heart conditions because, after all, it is part spirit and part physical?

Those who oppose this legislation want to leave the millions of Americans with severe mental illnesses right where they have been for decades. They do not want to acknowledge there is treatment, that it is costly, that one can get well, and that it is defined as brain disease in many parts of the medical community.

It is not something that is unlike any other illness. It is very much like a lot of illnesses. It has a huge number of qualities that are the same as mental illnesses that we are so concerned about that we would not let an insurance company get by without covering them to the maximum. We would have them here and we would be citing them for some kind of contempt of America if they did that, I would think.

So when the Senator from Michigan joins us and tells us the real facts, it begins to show signs that the message is getting through.

Let me give one more example. When President Kennedy was the President, we were engaged in a very serious national effort with the severely mentally ill who were locked in cages. We could tell a whole story about that terrible part of American health care. As an ironic situation, I might say they are no longer locked in cages as they were. At that point in history, we decided that could not be done, they had to be let out.

Now more of the seriously mentally ill are in jails in America than they are in hospitals. They are not in the cages. They are in jails because there is no place else to put them. They are getting arrested for malfeasance, most of it small. When it gets to the big crimes, we have a national argument about whether or not they are mentally insane when they commit mass murder.

In any event, the reality of it is we decided way back then that we were going to treat the mentally ill differently. But what we thought would happen was that across America there would be clinics, there would be facilities built that would let the doctors treat the mentally ill in a modern, hospitable, decent manner, not in the dungeons of the past.

Guess what happened. Nobody put up any money. Now one would say: Well, who should put up money? Either the Government ought to pay for some facilities or there ought to be some coverage if it is an illness so that the insurance companies would pay for it based upon it being carried by the mentally ill person. When they get sick, the insurance comes into play. With that, the private sector may build many facilities for the mentally ill. It is not going to happen until we do that.

I thank the Senator so much for her remarks today. They were right on, from this Senator's standpoint, and very relevant.

Ms. STABENOW. Will my friend yield?

Mr. DOMENICI. I yield.

Ms. STABENOW. One more time, I thank the Senator from New Mexico for his commitment on this issue and the way he is able to explain the importance of it.

I stress, along with the Senator, if we had private insurance coverage, then the facilities would be there. They would know there is a way for this to be paid for and, in fact, as we do with other kinds of health insurance, the hospitals would know there is a reimbursement system, the physicians would know there is a reimbursement system, and they would know as well there would be for these mental illnesses.

I thank the Senator for his wonderful commitment and leadership, as well as Senator WELLSTONE. I am hopeful we can move forward and that this can truly be a historic day.

Mr. DOMENICI. I send to the desk a list of cosponsors. There were 65, plus the Senator from Minnesota and the Senator from New Mexico.

The PRESIDING OFFICER. The cosponsors will be added to the amendment.

The list is as follows:

COSPONSORS

Wellstone, Kennedy, Reid, Stabenow, Akaka, Baucus, Bayh, Bennett, Biden and Bingaman.

Boxer, Breaux, Byrd, Cantwell, Carnahan, Carper, Chafee, Cleland, Clinton, Cochran and Collins.

Conrad, Corzine, Daschle, Dayton, DeWine, Dodd, Dorgan, Durbin, Edwards, Feinstein and Frist.

Graham, Grassley, Harkin, Hatch, Hollings, Inouye, Jeffords, Johnson, Kerry, Kohl and Landrieu.

Leahy, Levin, Lieberman, Lincoln, Lugar, Mikulski, Miller, Murray, Nelson (FL), Reed and Roberts.

Rockefeller, Sarbanes, Schumer, Shelby, Snowe, Specter, Thomas, Torricelli, Warner, Wyden and Stevens.

Mr. DOMENICI. There are 154 organizations that indicate the time has come when we ought to do this, and I ask unanimous consent that this list of organizations be printed in the RECORD at this point.

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

154 ORGANIZATIONS SUPPORTING S. 543, THE DOMENICI-WELLSTONE MENTAL HEALTH EQUITABLE TREATMENT ACT OF 2001

Alliance for Children and Families, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Neurology, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, American Academy of Physician Assistants, American Academy for Geriatric Psychiatry, American Association for Marriage and Family Therapy, and the American Association for Psychosocial Rehabilitation.

American Association of Children's Residential Centers, American Association of Pastoral Counselors, American Association of School Administrators, American Association of Suicidology, American Association on Mental Retardation, American Board of Examiners in Clinical Social Work, American Congress of Community Supports and Employment Services (ACCSES), American Counseling Association, American Family Foundation, and the American Federation of State, County and Municipal Employees.

American Federation of Teachers, American Foundation for Suicide Prevention, American Group Psychotherapy Association, American Hospital Association, American Jail Association, American Managed Behavioral Healthcare Association (AMBHA), American Medical Association, American Medical Rehabilitation Providers Association, American Mental Health Counselors Association, and the American Music Therapy Association.

American Network of Community Options and Resources, American Nurses Association, American Occupational Therapy Association, American Orthopsychiatric Association, American Osteopathic Association, American Political Science Association, American Psychiatric Association, American Psychiatric Nurses Association, American Psychoanalytic Association, and the American Psychological Association.

American Public Health Association, American School Counselor Association, American School Health Association, American Society of Clinical Pharmacology, American Therapeutic Recreation Association, American Thoracic Society, America's HealthTogether, Anxiety Disorders Association of America, Association for the Advancement of Psychology, and the Association for Ambultory Behavioral Healthcare.

Association for Clinical Pastoral Education, Inc., Association of Jewish Aging Services, Association of Jewish Family & Children's Agencies, Association of Maternal and Child Health Programs, Bazelon Center for Mental Health Law, Catholic Charities USA, Center for Women Policy Studies, Center on Disability and Health, Center on Juvenile and Criminal Justice, and the Central Conference of American Rabbis.

Children and Adults with Attention-Deficit/Hyperactivity Disorder, Childrens' Defense Fund, Child Welfare League of America, Christopher Reeve Paralysis Foundation, Clinical Social Work Federation, Commission on Social Action of Reform Judaism, Corporation for the Advancement of Psychiatry, Council for Exceptional Children, Council on Social Work Education, and Dads and Daughters.

Disability Rights Education and Defense Fund, Inc., Division for Learning Disabilities (DLD) of the Council for Exceptional Children, Easter Seals, Eating Disorders Coalition for Research, Policy & Action, Employee Assistance Professionals Association, Epilepsy Foundation, Evangelical Lutheran Church in America Lutheran Ofc. for Governmental Affairs, Families for Depression Awareness, Families U.S.A, Family Violence Prevention Fund, Family Voices, and the Federation of American Hospitals.

Federation of Behavioral, Psychological & Cognitive Sciences, Federation of Families for Children's Mental Health, Friends Committee on National Legislation (Quaker), Inclusion Research Institute, International Association of Jewish Vocational Services, International Association of Psychosocial Rehabilitation Services, International Community Corrections Association, International Dyslexia Association, Jewish Federation of Metropolitan Chicago, and Kids Project.

Learning Disabilities Association of America, MentalHealth AMERICA, Inc., NAADAC, The Association for Addiction Professionals, National Association for the Advancement of Colored People (NAACP), National Association for the Advancement of Orthotics & Prosthetics, National Association for Rural Mental Health, National Association of Anorexia Nervosa and Associated Disorders—ANAD, National Association of Children's Hospitals, and the National Association of Counties.

National Association of County Behavioral Health Directors, National Association of Developmental Disabilities Councils, National Association of Mental Health Planning & Advisory Councils, National Association of Protection and Advocacy Systems, National Association of Psychiatric Health Systems, National Association of Psychiatric Treatment Centers for Children, National Association of School Nurses, National Association of School Psychologists, National Association of Social Workers, and the National Association of State Directors of Special Education.

National Association of State Mental Health Program Directors, National Center on Institutions and Alternatives, National Coalition Against Domestic Violence, National Coalition for the Homeless, National Committee to Protect Social Security and Medicare, National Council for Community Behavioral Healthcare, National Council on Suicide Prevention, National Depressive and Manic-Depressive Association, National Down Syndrome Congress, and the National Education Association.

National Foundation for Depressive Illness, National Health Council, National Hopeline Network, National Law Center on Homelessness & Poverty, National Mental Health Association, National Mental Health Awareness Campaign, National Multiple Sclerosis Society, National Network for Youth, National Organization of People of Color Against Suicide, and the National Partnership for Women and Families.

National PTA, National Therapeutic Recreation Society, NISH (National Industries for the Severely Handicapped), Presbyterian Church (USA), Washington Office, Samaritans of The Capital District, Inc. Suicide Prevention Center, School Social Work Association of America, Service Employees International Union, Shaken Baby Alliance, Society for Personality Assessment, and the Society for Public Health Education.

Suicide Awareness Voice of Education, Suicide Prevention Advocacy Network, The Arc of the United States, Tourette Syndrome Association, Unitarian Universalist Association of Congregationalists, United Cerebral Palsy Association, United Church of Christ, Justice and Witness Ministry, United Jewish Communities, Volunteers of America, Yellow Ribbon Suicide Prevention Program, and the Youth Law Center.

Mr. STEVENS. Will the Senator yield?

Mr. DOMENICI. I am pleased to yield to the Senator.

Mr. STEVENS. Mr. President, I ask the Senator from New Mexico if this has been scored by the Office of Management and Budget?

Mr. DOMENICI. Yes, it has.

Mr. STEVENS. What would be its impact on fiscal year 2002?

Mr. DOMENICI. No impact on the year 2002. We have made the bill operative and effective in 2003.

Mr. STEVENS. Mr. President, I want to confer with the distinguished chairman of our committee, but we reached a firm agreement we would not exceed 686 for this year, and I do not know how that impacts taking on a bill that will start impacting 2003. What would be the impact in 2003?

Mr. DOMENICI. Over $150 million a year. We knew of the agreement and the binding nature of our agreement, and I felt bound by it in terms of how much money for 2002, and I think that is literally for 2002 but not 2003, 2004, or 2005. So we changed the effective date to 2003 in the amendment before it was sent to the desk.

Mr. STEVENS. I must express my reservation until we reach an understanding about how this will impact the agreement we made with the Office of Management and Budget and with the House on this bill. It does add outyear expenditures, as I understand it. The Senator has indicated it does not impact 2002. I reserve judgment on this amendment.

I am a cosponsor of it. I think the bill itself is a worthy bill, and it basically is an entitlement program. It is not an appropriation, as I understand it.

Mr. DOMENICI. The Senator asked me a question, and I want to answer this way: Frankly, most of this bill is going to be taken care of by insurance companies paying insurance bills, but there is some U.S. Government responsibility because it reduces the receipts in certain areas that would have otherwise come in because of the overall costs. We knew in 2002 it was subject to a point of order because, in fact, there is a cap in 2002. There is no cap for 2003 and the years beyond, and for that reason we do not believe a point of order lies in the outyears, nor do we think anybody is bound to reduce appropriations by that amount in the outyears.

We are prepared at some point to exchange serious discussions, if anyone wants to do it, on this issue.

I yield my time, and I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, I, too, thank the Senator from Michigan.

Mr. WELLSTONE. Above and beyond the National Mental Health Association and the National Alliance for the Mentally Ill, there is a Fairness Coalition of Mental Health, and other children, education, law enforcement, and labor organizations all behind this legislation. There is a broad range of organizations supporting the legislation.

I point out to colleagues the legalistic language of the bill. This bill is modeled after the Federal Employees Health Benefits Program in which we participate. It says to a group health plan: Do not treat mental health benefits differently from the coverage of medical and surgical benefits. You have to treat it the same way. The legislation does not mandate that a plan provide mental health coverage but says if you have mental health coverage, you have to treat it the same way or have the same coverage as for physical illness. That is why it is called a parity bill.

There are still important steps to take, which I hope someday we will, so all the people in our country who have no coverage will be treated. This legislation for over 100 million would make an enormous difference.

The cost to the Nation is enormous. Additional health care costs occur when people cannot get the coverage they need, and they wind up in the emergency room or it leads to other illnesses. There is a productivity loss from people who struggle with illness and get no help. There are the social costs of crime: When people do not get treatment, they cannot work or they wind up homeless. We have a lot of homeless people struggling with mental illness. When we treat children at a young age, it will have a huge impact on whether they have a life of misery where they could end up in trouble, more trouble, then incarceration, or whether they are treated and they can go on and live a very productive, happy, and healthy life.

I visited a correction facility—and there are many facilities—in Tallulah, LA. I could talk about this forever. Mr. President, 95 percent of the kids had not committed a violent crime. Too many were kids who struggled with mental illness. They should have been checked at the front end of assessment when a kid breaks and enters a house or steals a car. Remember, we are talking about anywhere from 10 percent to 20 percent of children in this country who struggle with this illness.

Too many kids all across the country—and your police, law and order communities, law enforcement communities, will tell you this—do not get any treatment, there is no coverage, and they wind up incarcerated when they should not be incarcerated. Then what happens is almost indescribable. The kids are not able to defend themselves. Quite often they are brutalized. Then they come out of these facilities dysfunctional. But they never should have been in the facility in the first place. We never provided the care for them. There never was the coverage.

I am sure there can be some good negotiation and things can be worked out in conference on offset, but I argue for $150 million more a year, or whatever the final costs would be. Is it not worth it to end the discrimination and provide the coverage to so many people, including a good number of whom are our loved ones, with the difference being life or death?

In the words of Rabbi Hillel: If not now, when? When are we going to end the discrimination? This is a matter of civil rights. When are we going to have the health care plans that provide the coverage for people who are struggling with this illness, including many children? When are we going to make sure, with the plans now no longer able to discriminate, there will be an infrastructure of care in our communities, the delivery of the care will follow the money, and the money will be in the plans?

This is more than worth it. We have 65 Senators supporting this legislation. This is bipartisan. If Senator DOMENICI and I are working on something together, it has to be bipartisan. I cannot even think of anything else on which we agree—I don't mean that; I am kidding.

I urge my colleagues to support this measure.

We use the word ''message.'' I hate the word. Everybody says: What is our message? What is our message. This would not be a bad statement. I think it would be good for our country—much less the people we can help, it would be good for our country—if the Senate went on record today supporting an amendment that I think is all about helping people, all about helping some vulnerable people, all about ending discrimination, all about calling for our country, America, to be a better country, all about calling on all of us to be our own best selves, all about making sure we provide care to people, many of whom up to now have not received any care.

The consequences of the plans discriminating and not providing care are so tragic. People who struggle from depression and get no care take their lives. Children don't get any care and they wind up incarcerated when they could have a good life.

The highest percentage of suicides is in the elderly population. Sometime soon I would like to get to Medicare. With Medicare, if you see your doctor apart from in-home care, you pay a 20 percent copay. But if you are struggling with depression—and the highest rate of suicide is in the elderly population—and you go to see a doctor, you pay a 50-percent copay. That is in Medicare. That is blatant discrimination. Why is depression less important than any other illness?

We can help a lot of elderly people. We can help a lot of children. We can help a lot of people in our country. Most important of all, we can help ourselves as Senators. It would not be such a bad thing to have a strong bipartisan vote for something all about values, people helping one another and recognizing we can do better. As Bobby Kennedy would have said, we can do better as a nation.

Please Senators, give this amendment your support. Let's pass it with an overwhelming vote.

I yield the floor.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant bill clerk proceeded to call the roll.

Mr. CORZINE. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. REED). Without objection, it is so ordered.

Mr. CORZINE. Mr. President, I rise today in strong support of the amendment offered by Senators DOMENICI, WELLSTONE, and KENNEDY. It is an amendment which will ensure that people with mental illnesses are treated equally, fairly, and equitably, on parity with people who have physical illnesses. I do not think there are words that are strong enough to point out the rightness of this in our American health care system.

Today, in America, two-thirds of our citizens with mental illness do not have access to mental health treatment, despite the fact that many have health insurance. For far too long, mental health consumers have been discriminated against in the health care system—subjected to discriminatory cost-sharing, limited access to specialties, and other barriers to needed services. In fact, many of them are just flat left out of the system.

I have had some personal experience with this in my life. I know it is a very difficult trial even if one is not without resources. That is why I am pleased to be a cosponsor of the Mental Health Equitable Treatment Act, legislation that represents a critical step toward equal coverage for mental health services. This amendment, the one we are debating today, incorporates the text of that legislation. And I hope to be a cosponsor, as well, of the amendment.

This amendment builds upon legislation enacted 5 years ago which sought to ensure parity between mental and other types of health care.

That law took the first steps toward recognizing that mental illness is a serious yet treatable disease. I served on the board of the NYU Child Study Center which worked for the better part of a decade to diagnose, to learn diagnosis, and to make sure that we had treatment regimens that actually could attack this disease, based on science and with great and positive outcomes.

It is because of those experiences and some in my own life that I commend

Senators WELLSTONE and DOMENICI for their great leadership on this movement. It is a very powerful statement to our country that we care about everyone, and their tireless efforts should truly be commended because they will ensure that Americans with mental illness will have equal access to mental health services.

Unfortunately, the law enacted several years ago has now expired. Frankly, everyone would agree that it included some loopholes that allowed health care plans to evade many of its goals. This amendment is designed to restore the law and to close those loopholes.

Perhaps most importantly, the amendment would ensure true mental health parity by prohibiting inequitable copayments, deductibles, and inpatient and outpatient visit limits for mental health services.

These are real issues for real people who are in these circumstances, not unlike circumstances people might have with their physical health. We know that people would not be tolerant of those kinds of activities.

These are commonsense proposals which will make a real difference in people's lives and I hope my colleagues will support them.

Earlier this year, many of us worked hard to pass a strong Bipartisan Patient Protection Act that would provide for strong health care protections for all uninsured Americans, the Patients' Bill of Rights. Many of these protections, however, will do nothing for mental health consumers if group health plans are allowed to continue discriminating between mental and other medical and surgical health care coverage.

Advances in medical research have made great strides in our ability to treat mental illness. As a nation, we need to make sure that our insurance covers those advances. Without proper coverage, the benefit of this research will be unable to reach those who need it most.

As a country, I heard Senator WELLSTONE say, we lose $300 million in missed days of work, health care costs and criminal justice costs in a given year as a result of untreated mental illness. We simply cannot afford to do that. It is a simple cost/benefit equation that tells us that we need to move forward on this.

It is overwhelmingly on the side of making sure that parity is attended to. In attempting to find a treatment, those suffering with mental illness face countless obstacles, as we have discussed over and over. This amendment would reverse those discriminatory practices, ensuring that health insurance coverage is strong and fair.

I am pleased that my home State of New Jersey has enacted a mental health parity law, but, frankly, it does not go far enough and flat out excludes children, our most vulnerable, from its coverage.

In addition, because of the ERISA preemption, not everyone in New Jersey is covered by our own State law. Therefore, we need a strong Federal law that ensures mental health parity for all Americans.

In a few weeks I will be introducing legislation that goes a step further. My bill will address the fragmentation of the delivery system by providing increased support to community mental health services. But this is a step we should take and we should take it now.

I am proud of the leadership Senators DOMENICI, WELLSTONE, and KENNEDY have provided to make sure that our Nation has addressed this issue through the years. It is imperative that we now bring to closure this debate about parity by including this amendment in this appropriations bill.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, before the Senator from New Jersey leaves the floor, might I say that there is no need to be personal about legislation, but I thank him for his comments.

It is obvious that there are many who have been here for a short time, such as the Senator, who already understand that we can't go on as a nation fooling ourselves that schizophrenics are not sick, they don't have a disease; that serious depression, which is now causing suicide in numbers that just go off the map, we can't run around and say, well, for some reason, some purposes, it is an illness or a difficult disease, but for other purposes, well, in terms of whether they should have insurance, we will look the other way and act as if it isn't.

We have had Senators who understand manic depression take the floor. Those are just two nice words. One means high; one means low. But you put that in the brain of a person, and it is not very normal. They have to be sick, and they are diagnosable. They are treatable. But here we are, the millennium is here, we are one year into it, and some people would still say: Let's play like it ain't so. Let's just wish it away. And certainly when it comes to health insurance, we just can't. We have to leave things alone no matter how backward it is, how disjointed it is, how unreal it is. We just have to look the other way.

When will be soon enough? I think now. I will tell the Senator, in order to get it through here, we had to put it off a year in terms of its effectiveness. I would like it to be effective as soon as it gets passed, but it won't because we wouldn't have gotten a bill out of the Senate that would be subjected to some technical objections. I shouldn't say we wouldn't, but it would be difficult. We made a call and said that it is better 2 years from now than to leave it as it has been forever.

So tonight you will be part of voting in an appropriations bill, and we will put on it covering the mentally ill of this land with parity or nondiscrimination of health insurance. We are going to exempt some small businesses. Somebody will argue about that: Why are you doing that? We can't get everything in one swoop. We really think the coverages by big corporations are where we are going to find out how to do this. So they are all going to be under it, whether it be Ford or Intel or whomever. Many of them include coverage already. But no more excuses. No more looking the other way.

Frankly, in the State of the Senator from New Jersey, in 8 or 9 years, there will be new mental health facilities built. You are going to ask: Who built this? We know not all are going to be built by the Federal Government because we don't build them. We never did enough since John Kennedy decided we should go another way with the mentally ill and try to be more humane. What is going to happen is private entrepreneurs are going to say, what is the insurance company going to pay when we take care of that depressive person for a week?

If they pay enough, they are going to build the clinics just as they have built hospitals, just as they have built other health facilities. As of now, nobody accepts the responsibility. Everyone wants to look the other way. I am grateful that Senators who have been here a while, such as this Senator, the Senator who has just arrived, are all coming to the same conclusion this afternoon. Perhaps by 6 o'clock we will have passed this bill.

It is very strange. It goes out in the country. I have been working for it. I expect the debate to go on for a couple weeks. That isn't going to happen. The reason it isn't is because 67 Senators signed this bill and we brought it up. I thank each one of them.

I have a detailed statement that includes a number of approaches to this issue, including an analysis and summary of what the New York Times found when they analyzed mass killers. They analyzed 25 mass killers and found half of them had serious mental illnesses such as schizophrenia. There was no place to put them. They had been put in jails. Cops had arrested them. People had tried them on in prisons. But nobody took care of them. Then they ended up over in one of the Texas cities killing all the people in that Baptist church.

We find that half of the mass killers in America are those kinds of people. There is no place to put them. Relatives don't know what to do. Neighbors say: Look at all this behavior. Isn't it strange? We will call a cop. The third time the cop is called, he says don't call anymore. What does that person who is desperately ill do?

We invite these kinds of murders and mass killings that occur in our country. It is time to try something that may give these sick people another option.

I have a quick set of facts about mental illness, the numbers on the kinds of mental illnesses that exist. I think it will help Senators who want to read the RECORD to understand the scope of this problem.

I ask unanimous consent that it be printed in the RECORD.

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

QUICK FACTS ON MENTAL ILLNESS

Major Depressive Disorder—9.9 million American adults age 18 and older suffer from this disorder in a given year;

Bipolar Disorder—2.3 million American adults age 18 and older suffer from this disorder in a given year;

Schizophrenia—2.2 million American adults age 18 and older suffer from this disorder in a given year; and

Obsessive—Compulsive Disorder (OCD)—3.3 million American adults age 18–54 suffer from this disorder in a given year.

16% of all inmates in State and local jails suffer from a mental illness; 600,000–700,000 mentally ill individuals are booked into a jail every year; 25% to 40% of America's mentally ill will come into contact with the criminal justice system.

Suicide is currently a national public health crisis, with approximately 30,000 Americans committing suicide every year.

Of the 850,000 homeless individuals in the United States, about ⅓ or 300,000 of those individuals suffer from a serious mental illness.

In the developed world, including the U.S., 4 of the 10 leading causes of disability for individuals over the age of five are mental disorders. In the order of prevalence the disorders are major depression, schizophrenia, bipolar disorder, and obsessive compulsive disorder.

The direct cost to the United States per year for respiratory disease is $99 billion, cardiovascular disease is $160 billion, and finally $148 billion for mental illness.

EFFICACY OF TREATMENT

Treatment for bipolar disorders have an 80 percent success rate.

Schizophrenia has a 60-percent success rate in the United States today if treated properly.

Major depression has a 65 percent success rate.

Compared to several surgical procedures:

Angioplasty has a 41-percent success rate.

Atherectomy has a 52-percent success rate.

Mr. DOMENICI. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. THOMAS. Mr. President, I rise to support the Senator from New Mexico in his effort. I have been an original sponsor of the bill he has had. In years past, I was chairman of this bill in Wyoming and worked on this for some time. As a good focus on rural health care is unique, this is another unique issue with which we need to deal. I urge support for the amendment. I thank the sponsors for their efforts.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Mr. WELLSTONE. I thank the Senator from Wyoming for his support. It means a lot. His voice is important. I appreciate his mentioning that is not something that only applies to metropolitan America; it is important in rural America. I thank Senator CORZINE as well. I will not take much time now.

Senator CORZINE asked that he be a cosponsor of the amendment. I believe Senators BYRD and STEVENS, with the agreement that we now have, asked to be included as cosponsors. I ask unanimous consent they all be added as cosponsors.

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

Mr. WELLSTONE. I thank the Chair.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. SPECTER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. SPECTER. Mr. President, I compliment the Senator from New Mexico and the Senator from Minnesota for their advocacy on this amendment. As I commented earlier in the debate on this amendment, I have cosponsored the authorizing legislation for the past two Congresses and had withheld cosponsorship of this amendment as a manager of this appropriations bill until I could see how it was going to be worked out. We are now in the process of working it out. I think we will be successful, but it is still too early to make a final commitment.

What is occurring here is on the scoring for budgetary purposes, if it is on this bill, it is scored against this bill; and we are now up to the limit of our authorization. But we are now looking into the remedy of having it scored in another direction—that is technical—and an amendment is now being prepared that may cure that problem. It is not a commitment to cure the problem, but we will know shortly.

In the interim, as a comanager of the bill, I do not intend to raise any point of order that this is legislation on an appropriations bill. Technically, that point of order can be raised. It does not have to be raised because of the difficulties of getting Senate consideration on this bill for a very protracted period of time. As the Senator from New Mexico, Mr. DOMENICI, outlined, I think it is not appropriate to raise a point of order that this is legislation on an appropriations bill. At least I do not intend to raise that point of order.

This is a proposal that I believe has great merit. That is why I have cosponsored the authorization bill for the last two Congresses.

At this time, I ask unanimous consent that I be added as a cosponsor to the Domenici amendment.

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

Mr. SPECTER. Mr. President, Senator HARKIN, the chairman of the subcommittee, and I are urging colleagues to come forward to offer amendments. It is now 4:25. We have only had one amendment offered all day. It is very important that we move ahead with the disposition of this bill.

Last year, we had the bill out of committee on June 30 and it passed the Senate on July 27. Then we had months of negotiation in the conference committee, so that if we are to get this matter into conference and have a conference report, it is urgent that we proceed at this time.

There is substantial funding for education, which has the consensus of the Senate. There is substantial money for the National Institutes of Health, and the public interest requires that we move ahead. If we do not finish our appropriations bills, there is the possibility—or perhaps probability—that the bills that are unfinished will be folded into a continuing resolution. That means that important funding will not be provided.

Again, on behalf of Senator HARKIN, my comanager, I urge our colleagues who have amendments to come to the floor. Perhaps Senator HARKIN would like to italicize my urging.

Mr. HARKIN. Mr. President, I will respond to my distinguished ranking member, my friend, that I believe we are making some good progress. A major amendment is being worked out right now. I hope we go to a voice vote shortly. I only know of one other amendment that might be pending. Quite frankly—hope springs eternal—I think we might be through with this shortly.

Mr. SPECTER. Is the Senator suggesting that only one other amendment is pending and we may be in a position to go to third reading?

Mr. HARKIN. I believe that might be the case. People may want to go home early tonight and have dinner with their families.

Mr. SPECTER. What time does he think we might go to third reading?

Mr. HARKIN. It depends on how long it takes to work out this language. We are waiting for Senator DORGAN. He had an amendment. I saw him a minute ago. Perhaps he will be out here shortly. I don't think that will take too long.

Mr. SPECTER. Mr. President, we urge colleagues, if they have amendments to offer, to come to the floor and do so now.

In the absence of any Senator seeking recognition, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. DURBIN. Mr. President, I know pending before the Senate now is landmark legislation. I commend my colleagues, Senator PAUL WELLSTONE and Senator PETE DOMENICI, truly a political odd couple, one from the State of Minnesota and the other from New Mexico, who have come together on this important cause, both understanding the importance of our maturing as a nation when it comes to the issue of mental health.

I am a strong supporter of the Mental Health Equitable Treatment Act which they are bringing to this legislation. I am pleased it is finally going to come for a vote. I know those two Senators, as well as Senators DASCHLE and KENNEDY, have worked tirelessly to make this happen. I know advocates for the mentally ill have waited, frustrated and disappointed time and again, and had hoped this day might someday come. I recognize it is equally imperative we do not threaten this bill's passage by attaching amendments that may make it even more difficult in conference.

With this in mind, I do, however, want to raise the subject of another amendment relating to mental health, and I ask my colleagues to consider it in the context of the underlying Wellstone-Domenici amendment.

The issue I am about to discuss affects literally thousands of Americans every single year. This amendment of which I speak would be an improvement on the bill we are currently debating. However, I want to make it clear I will not be offering this as a second-degree amendment. I want to give to Senators WELLSTONE and DOMENICI every opportunity to bring their important bill through conference intact. Although I believe my amendment would be a worthy addition to theirs, I am going to save that cause until another day.

Let me talk about this amendment and why I would have brought it to the floor. Some time ago I received a letter from a constituent in Illinois who in the 1980s suffered severe depression and received the kind of treatment which allowed her to return to work. I will call her Mary Smith. At the time, Mary had employer-sponsored health insurance through her husband's job, but in the fall of 1998 Mary and her husband lost this employer-based insurance coverage when her husband lost his job.

Mary applied for comprehensive health insurance plans offered to individuals. Her application was declined because, as the insurance company noted, ''Due to her medical history of depression she did not meet the company's underwriting requirements.''

Mary was turned down for health insurance due to a medical history of depression. She wrote me, and this is what her letter said:

> As I see it, we are being punished for accessing health care. In 1987, when I was clinically depressed, I could have chosen to avoid proper medical care, become unemployed and received Social Security disability. I did not. I obtained the help I needed and continued to support myself, my family and contribute positively to society. Depression is a treatable medical illness. Insurance companies must stop their indiscriminate denial of this coverage.

Sadly, Mary Smith is not alone. Each year more than 50 million adults in the United States suffer from mental illness, 25 percent of our adult population. Some 18 million Americans are affected by depression annually. One in five Americans has a mental disorder in any one year. Fifteen percent of the adult population use some form of mental health service during the year. Eight percent have a mental disorder. Seven percent have a mental health problem. Twenty-one percent of children ages 9 to 17 receive mental health services in a year.

The problem Mary Smith faced is, under the current system of care in the United States, individuals who are undergoing treatment or have a history of treatment for mental illness may find it difficult, if not impossible, to obtain private health insurance, especially if they have to purchase it on their own and cannot rely upon group insurance through an employer.

In part, this is a result of the Health Insurance Portability and Accountability Act that protects millions of Americans in the group health insurance market and affords very few protections for individuals who apply for private nongroup insurance. Approximately 9.6 percent, or 26 million Americans, are insured in this private nongroup insurance market—26 million people.

A 1996 GAO study found that insurance carriers denied up to 33 percent of applicants for private health insurance because they had a preexisting health condition, including, of course, mental health conditions. HIPAA provides few protections for individuals who apply for insurance in the individual insurance market. Individuals without at least 18 months of prior continuous group coverage are not protected against discrimination and red lining. This issue is not about parity. It is not about mental health benefits. It is about discrimination. It is about red lining.

Mary Smith was being told she could not get any health benefits, not just mental health benefits. She was denied all health insurance coverage because many years before she had successfully treated a condition of depression. She was not eligible to get hospital coverage if she needed surgery. She was not eligible for preventive care, such as a flu shot. She was not eligible for a doctor's visit. Had she become injured or ill, she would have received no care.

Efforts to improve health care parity have focused on providing equality between mental health covered services and other health benefits, and I salute Senators WELLSTONE and DOMENICI for their leadership. These efforts are very important, and I strongly support them.

Parity will not help individuals who do not have access to any affordable insurance coverage due to preexisting mental illness discrimination. Think of that for a moment. We are saying if you cover a person for other illnesses, in the Wellstone-Domenici amendment, you also have to provide mental health protection as well. I believe that is sound.

Mary Smith never reaches that point. Mary Smith, whose husband lost his job, ends up in the private insurance market. She cannot even get into a private health insurance plan because the company, under the law today, can discriminate against her because she had treatment for a mental health problem.

Individuals who seek insurance in the individual market are people such as Mary who are in periods of transitional employment, but they are also people who are self-employed. They are family farmers. I have many of them in my State. They are small business owners. They are recent college graduates who lose coverage under their parents' plan, and they are the children and spouses of self-employed people and those in transitional employment.

Every person at risk, needing to buy private health insurance, is subject to this discrimination. If they had been treated for a mental illness, they could run into the same experience Mary Smith did.

This type of discrimination is precisely why many Americans do not seek treatment for mental illness. Despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have severe mental illness do not seek treatment. They are not only concerned about the stigma in society, they are clearly concerned about the discrimination which is allowed under the law for those people who have turned for help.

This reluctance to seek care is an unfortunate outcome of very real barriers. Foremost of these is the stigma that many in our society attach to mental illness and to people who have it. How many of us, or our family members or friends, have thought about what might happen if we went to seek therapy for anxiety, depression, or even marriage counseling? It is unconscionable that persons should have to consider not being able to get health insurance coverage because they did the right thing and were treated for a mental condition.

Repeated surveys have shown that concerns about the cost of care are among the foremost reasons that people do not seek care.

My amendment prohibits insurers from charging persons with preexisting health conditions higher premiums. This is because insurers use higher premiums to keep certain people locked out of the plan.

The GAO interviewed one insurance carrier in my home State of Illinois which only charges 2 to 3 percent of its enrollees a nonstandard rate, but the rate they charge is double the standard rate.

In some States, including Illinois, high-risk pools have been created to act as a safety net to ensure the uninsured have access to coverage. These safety nets are often expensive. For Mary Smith, this safety net would have cost her and her husband $700 a month for health insurance. They are a great deal for insurers; all sick people are in one pool.

Risk pools undermine the underlying function of insurance to include a broad pooling of risk. They relieve insurers of responsibility.

Mental disorders impose an enormous emotional and financial burden on ill individuals and their families. And when they go untreated, costs escalate. Mental disorders are costly for our Nation in reduced or lost productivity and in medical resources used for care, treatment, and rehabilitation.

The National Institute of Mental Health estimates the annual cost of untreated mental illness exceeds $300 billion, primarily due to productivity losses of $150 billion, health care costs of $70 billion, and societal costs of $80 billion.

Two years ago the Surgeon General issued a report on mental health. The report concludes that a broad range of treatments of documented efficacy exists for most mental disorders.

Diagnoses of mental disorders are as reliable as those of general medical disorders. In fact, the success rate of treatment for disorders such as schizophrenia is at 60 percent; depression, 70 to 80 percent; and manic disorder, at 70 to 90 percent, surpassing those of other medical conditions. Heart disease, for example, has a treatment success rate of about 50 percent.

Here is what we know: We know mental health is fundamental to our health. We know millions of Americans suffer from mental illness. We know treatment exists for mental illness. We know the treatment works. We know, despite the efficacy of treatment options, nearly half of Americans who have mental illness do not seek medical care. We know that reluctance to seek care is a result of real barriers, including stigma, discrimination, and of course financial obstacles which are treated by the Wellstone-Domenici amendment. We know mental disorders impose an enormous emotional and financial burden on sick individuals and their families and that untreated mental illness is costly for our Nation in lost productivity and medical resources. We know the private insurance system perpetuates barriers, reinforces stigma, throws up financial roadblocks, and undermines the health of millions of Americans who do the right thing and seek treatment.

The amendment I was prepared to offer today, because of Mary Smith, would try to do the right thing. It is common sense. It doesn't cost anything. It does not solve all the inequities that individuals with mental health conditions face. But it does remove one of the many barriers to health care faced by those who have been treated for a mental condition. I think there is no more appropriate context in which to address this than a patient protection act.

This amendment prohibits any health insurer that offers health coverage in the individual insurance market from denying an individual coverage because of a preexisting mental illness unless a diagnosis, medical advice, or treatment was recommended or received within the 6 months prior to the enrollment date. Health plans can exclude coverage for mental health services but not for more than 12 months. The exclusion period must be reduced by the total amount of previous credible insurance coverage.

It also prohibits plans in the individual market from charging higher premiums to individuals based solely on the determination that such an individual had a preexisting mental health conditions. It defines a preexisting mental health condition as including all clinical disorders and personality disorders diagnosed on Axis I or Axis II of the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. This broad definition would include mood, anxiety, eating, sleep, and adjustment disorders, clinical disorders such as mental retardation and autism, cognitive disorders such as amnesia and dementia, and sexual and gender identity disorders.

These provisions apply to all health plans in the individual market, regardless of whether a State has enacted an alternative mechanism, such as a risk pool, to cover individuals with preexisting health conditions.

The amendment does not mandate that insurers provide mental health services if they do not already offer such coverage. It does not prohibit health plans from establishing a waiting period for mental health services for individuals with a preexisting mental health condition of up to 12 months.

All we are trying to do is to ensure that if you should go to a therapist or a psychiatrist or a psychologist or seek other mental health services, you do not have to worry that you or your family will not be able to get health insurance because you asked for help. It simply does not make sense, just because a person seeks treatment for mental illness, he or she is rendered uninsurable.

I hope my colleagues will join me in this important initiative to ensure that such individuals are not discriminated against when applying for health insurance coverage. It is just the right thing to do.

Mary Smith's letter is one of many we receive in our Senate offices. I am glad we picked this one and read it carefully and closely. I thought for a moment about how we could help this woman who did the right thing. Faced with a mental illness, she went to a doctor, and having gone to that doctor her life has improved. She stayed on the job and had a much better life. She could have applied for a government program and didn't do it. She wanted to stay in the workplace. Little did she know that a few years later when her husband lost his job, the fact that she was successfully treated for depression would ultimately mean they could not buy health insurance in the private market.

How can we stand by as a nation and allow this kind of discrimination against people who are no more guilty of their condition than a person is guilty for the color of their eyes? It is something God has sent to them. In this situation I think we should consider the passage of legislation which would prohibit this discrimination once and for all and make certain, as the underlying Wellstone-Domenici amendment, this amendment would say we are going to treat mental illness in the 21st century much differently than we have in years gone by.

I thank you for the floor and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. SPECTER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. WELLSTONE. Mr. President, I ask unanimous consent that Senator DASCHLE be included as a cosponsor of this amendment.

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

Mr. WELLSTONE. Mr. President, since there was news today that Dr. Hyman is stepping down as Director of the National Institute of Mental Health, and since I believe we are going to pass legislation on antidiscrimination in mental health coverage which will be landmark and will make a real difference in the lives of people—and I have spoken plenty about the amendment already—I wanted to thank Dr. Hyman for all of his leadership. He has been an exceptional director.

I have had a chance to work very closely with him through Ellen Gerrity, a fellow in my office. We are lucky enough to have her working with us. She worked for the IMH. I think Dr. Hyman has done a good job, along with Dr. Satcher, who is Surgeon General. He has done magnificent work. The two of them have done perhaps the best job we have seen in the history of our country of providing an education for people in the country. So much of mental illness is a brain disease. It can be diagnosed. It is very treatable.

That is the good news. The bad news is there is a huge gap between what we know and what we don't know. We are trying to close that gap—not all of it but a good part of it—with this piece of legislation.

I thank Dr. Hyman. He is one of the people I have had a chance to work closely with in Washington. He is a good example of someone who, with a highly developed sense of public service, has made a huge difference.

I thought I would use this opportunity to thank Dr. Hyman and wish him the very best as he moves on to be, as I understand, provost at Harvard University.

We have had a number of Senators—I don't need to speak more—who have

come to the floor and have spoken. I think what they have said is not only significant, but the way they have said it is significant.

Senator DOMENICI always speaks about this issue with a tremendous amount of eloquence and a lot of knowledge. His wife Nancy Domenici—I don't think he would be offended if I said it—is probably every bit the leader he is. I don't want to say more, but she is every bit the leader he is.

We have two Senators out here managing the appropriations bill who want to move us forward. After we have done the work to make sure we deal with rule XVI and germaneness—and we have done a lot of work on the budget point of order—I think they have been very gracious in letting us go forward. Senators HARKIN and SPECTER are very supportive of this piece of legislation. Senator THOMAS from the State of Wyoming came and spoke.

It reminds me of 1996, I think it was, when we passed partial legislation. I remember Senator Simpson came out on the floor and spoke about a tragedy within his own family. I believe it was a niece who took her life at a young age. Senator CORZINE came out on the floor and made it very clear that this issue means a great deal to him.

Senator REID spoke about his own experience, that his father took his life. Senator HARRY REID has been absolutely, in his own very quiet way, perhaps the most powerful Senator, in a positive way, on the whole issue of treating depression than anybody in the Senate.

Senator KENNEDY came out and spoke. He has devoted a good part of his career to this issue. He is the health care Senator, but, actually, long before we had this kind of coalition—and we have 150 organizations supporting this piece of legislation. We have organizations such as the National Mental Health Association and NAMI—the National Alliance for the Mentally Ill—that deserve a lot of credit, along with the whole coalition. If I went through all 150 organizations, it would take a lot of time. But I personally think Senator KENNEDY deserves a great deal of credit for being willing to light a candle a long time ago to speak to this awful discrimination.

I also thank all of these different organizations because the truth is, when we started out on this matter over a half a decade ago, it was then an issue—it still is an issue of discrimination—but the problem was there was not exactly a political constituency that had any real clout. Then I think what has happened in the last 6, 7, 8, 9 years is that a lot of families have said: We are the ones who struggle with this illness—or we have a loved one who struggles with this illness—and we refuse to be treated as men and women of lesser worth. We are men and women of worth and dignity. We struggle with an illness just as any other illness. We are going to be advocating for ourselves.

It has been the citizen politics, the citizen lobbying that has led to the result of—we have a dispute as to whether it is 65 or 67 Senators who now support this. This piece of legislation passed out of the HELP Committee on a 21–0 vote. We made some compromises, but it is still an enormous step forward. I do not think it would have happened without the citizen politics.

I say to the Presiding Officer—because we both represent the State of Minnesota—we represent a State that is a model State, as we are in many ways, but we passed full parity for both substance abuse addiction, which I think is terribly important—and I think that is the next piece of legislation on which we ought to work—and mental health and, by the way, with very little cost but with great benefit.

The estimates of the amount of money we have saved in our State for people who now get the treatment and, therefore, are productive and go to work or do well in school and do well in their families verses what was going on before is just stunning and important. The problem is because of ERISA, a lot of the self-insured plans are not covered, so we still have 50 percent of the people not covered and, thus, the need for national community regulation.

But I thank a lot of the people in Minnesota who both the Presiding Officer and I know well; and certainly Sheila and I have gotten to know them very well because we have had so many meetings with so many people.

I mentioned the Kluesners earlier, Mary and Al Kluesner. I mentioned the Westins. But there are so many others who have met with us, who have met in public. There have been so many picnics on our lakes that I have attended with people. There are so many people who have told their own stories. They have made a huge difference.

So again, colleagues, we have 65 or 67 Senators who support this measure. It is strongly bipartisan. We now have the support of the chair and ranking chair of the Appropriations Committee, and the chair and ranking chair of the Budget Committee. We have the whip who has spoken, and Senator DASCHLE, the Senate majority leader, who has asked to be a cosponsor. We have 150 organizations: Religious, children, labor, and health.

We are close to adopting an amendment that I believe we can keep in conference. I am not trying to be coy, but I think if I had to have somebody in my corner, I would want TOM HARKIN more than anybody else. He chairs this committee. If I had to have one person to fight for me, he would be the one.

So I thank colleagues. We may have a lot more debate yet, but I think we are going to take this journey. I believe we are going to wind up in a good place where we are going to make our country better. We are going to make our country better by passing this.

I see other colleagues in this Chamber, so I do not want to take any more time. I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, I rise to speak on the pending Domenici amendment. I am opposed to the Domenici amendment. I am not going to force the Senate to vote on it this afternoon. I think it is clear where the votes are, but I want to explain the issues. I want to raise the issues in this debate so that they can be looked at by the House.

I believe, based on what I have been told, the administration is opposed to the amendment. There is also a point of order against the second-degree amendment that will be offered directing scoring. That point of order will lie against the conference report if the bill comes back from conference with the directed scoring provision in it. I want to reserve my right to raise that point of order at that time.

I want to be brief, but let me basically explain what we have here. What we have is an amendment that imposes a new mandate on the private sector of the economy. That mandate is a mandate where we decide what kind of health insurance Americans should have, and they are going to have it whether they want it or not; and we are going to override some 70 years of negotiations between private employers and private employees as to what their health insurance looks like.

We are going to mandate that if a company provides health insurance that has any mental health provisions in it, those benefits have to be treated the way benefits are for physical health or else the company may be prohibited from providing the policy.

The Congressional Budget Office, in looking at this mandate, has estimated that what will happen is, premiums will go up, some companies will drop mental health coverage altogether, and others will continue to provide it under these new circumstances. Remarkably, they estimate that the adoption of this amendment, over a 5-year period of implementation, will drive up costs on the private sector of the economy by $23 billion. So we are about to impose $23 billion in costs on the private sector of the economy because we think we know better what private health contracts, negotiated between employers and employees, ought to look like.

There is a budget problem here because the Congressional Budget Office estimates that by paying the $23 billion in additional health insurance premiums, that American industry and agriculture will end up paying lower wages than they would have paid, and that we will collect, over a 10-year period, over $5 billion less in taxes because of this amendment.

The distinguished chairman of the Budget Committee informed the Senate that he would charge, in future budgets, that $5 billion against the Appropriations Committee if the amendment were adopted.

We are now, as I understand it, in the process of writing an amendment that

says that for the purposes of the budget, even though this amendment will cost over $5 billion, we are not going to count it.

Without going on and on, let me raise the list of particulars. No. 1, who are we to be telling American workers and American business what kind of health insurance benefits they should have and how that package should be made up and what they should choose? What about workers who would rather have higher wages than to have this new benefit that we are deeming to be in their interest?

What about the $23 billion of cost that we are going to impose on the private sector? I know the amendment is written so it does not start until 2003. The point is, that is $23 billion of cost over a 5-year period that will be borne by the private sector, $23 billion that could have gone to create more jobs, more growth, more opportunity.

I simply raise two questions regarding the $5 billion of lost tax revenue because companies, as estimated by CBO, will pay lower wages when they are mandated to pay for these benefits: first, what about workers that would rather have those wages than the benefit? Shouldn't they have a choice, or are we granted such wisdom that we make the choice for them?

Second, if it is going to cost $5 billion, have we not made an absolute mockery out of the budget process, made it a complete fraud by passing a law that says, yes, it costs $5 billion, but we are going to pretend that it does not cost $5 billion?

That is basically the proposition that is before us. We are going to say, if you are going to provide mental health coverage, you have to provide it on par with physical health coverage or you can't provide it.

The logical question is, isn't that something that people should decide about their own insurance? Isn't that the same decision that people make, in deciding do they want a new refrigerator, or do they want to send Johnny to college. They have tradeoffs on which they have to make hard decisions? What about the people who are going to lose income? We are going to lose $5 billion in taxes over a 5-year period. What about the people who lose billions of income?

Maybe they would have wanted to spend on it something that would have had greater value to them. Maybe nobody cares whether they could have spent those billions better because we are going to spend it for them.

Then the question becomes, if we are going to spend it, instead of being honest about it, we are simply going to pass a law that says, it costs $5 billion, everybody knows it costs $5 billion, and there is no debate about it costing $5 billion. But so that we don't have to worry about it, we are going to pass a law that says, while it costs $5 billion, for budgetary purposes, we are going to act as if it doesn't cost $5 billion so we don't have to count it against appropriations in the future.

I simply have to say, I would be ashamed of this amendment. This is bad law, bad principle, and bad precedent.

If I thought we had more than 15 people who would vote against it, I would demand a vote. I would be happy for the world to know I am against it. I don't want to put my colleagues on the spot, but I am hoping that the House will not accept this amendment. The Senator who offered the amendment, 5 or 6 years ago, had a similar amendment that cost only $300 million a year. Rather than extending that, we are adding a full-blown mandate on the private sector.

I am hoping something can be worked out. I hope we will not have directed scoring. We ought to pay for this in appropriations if we are going to do it.

Finally, I am hoping the administration and the House will not go along with this amendment.

I am sorry to have taken people's time. But I wanted to come to the Chamber and basically outline what is wrong with this amendment, and what is wrong with the procedure that we are following by directed scoring when we say we know it is going to cost $5 billion but we have decided that we are going to pretend that it doesn't. We are going to charge it against mandatory spending.

In any case, I hope it will be fixed. It should be fixed. This is bad policy. It sets a bad precedent.

I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. I will respond very briefly, as one of the co-managers of the amendment. I thank the Senator from Texas. I actually don't mean that as sort of fake Senatorial courtesy. He has intellectual integrity, and I understand exactly what he is saying.

Two quick points I will say to him: There is an argument on the CBO scoring of $1.3 billion over 10 years. I say to my colleague, I would challenge that. I believe Senator DOMENICI would as well. He is in a markup right now on another bill.

I understand my colleague is going to reserve final judgment on the conference report, but the quarrel I have with it is with the assumption. The assumption that CBO is making, not $5 billion, $1.4 billion over 10 years, the assumption that is being made is that with the mental health coverage ending the discrimination, that what employers will do is, therefore, in order to make up the cost, which CBO, by the way, said is minuscule, less than a 1 percent increase in premiums, will cut wages for employees. That is the assumption. And then, with less wages, there will be less that will be contributed to Social Security.

For the record, I would challenge that assumption. I will challenge that assumption on the basis of what we have seen in States that have the mental health parity where that has not happened. For a lot of companies and a lot of employers, it is a very attractive proposition to offer this coverage because families are crying out for it.

As to the second point, that the money is not going to be spent, we are not saying that there isn't going to be the expenditure of money. We are saying it is not going to lie against this bill. We are going to handle this just as anything else we do. We paid for the tax cuts. We will pay for this.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, I will be brief. I am reading from the Congressional Budget Office cost estimate of August 22, 2001. The Congressional Budget Office estimates that the proposal will reduce Federal revenues in the initial year by $230 million and $5.4 billion over a 10-year period. That was the number I was using.

I think there is no question about the fact that one of three things will happen. From my point of view, they are all bad.

No. 1, some people will lose health coverage they already have because the company, in trying to escape the $23 billion of cost over 5 years, can simply drop mental health coverage. That is bad.

No. 2, the company can simply decide to not provide health insurance at all, which is perfectly legal. That is also bad.

Then third, if companies lower wages or if wages don't grow as much as they would have grown because these higher premiums have to be paid, for many workers that is bad because there are obviously many who would rather have that income than to have the coverage, and we are making the decision for them.

I respect the opinion of my colleague from Minnesota, who is for this benefit, but all I am saying is he may think it is a great idea, but there are probably a lot of working people in America who would rather not risk that coverage, or would rather keep the mental coverage they have, or would rather have higher wages.

Finally, is the question about how we are going to do the budget. It seems to me that is a point where clearly—and I don't know the argument on the other side, other than the Appropriations Committee doesn't want to be saddled with the cost of paying for this program, which they view as a rider to the appropriations process, which I understand—that the taxpayers are going to be saddled with the costs. Somebody is going to have to end up paying that $5.4 billion.

I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, again, I appreciate what my colleague said. Initially, I was talking about the Social Security cost, not the overall cost. We have been very clear about the fact that it would require some investment of resources. The fact is, I again

say to my colleague from Texas, there are plenty of examples of States that have moved forward. Quite to the contrary of wages going down, people have been supportive of it because this is not a small thing. This affects about 50 million adults in the country. Depression alone affects 18 million.

The reason we have 150 organizations—religious, labor, law enforcement, children, you name it—and the reason we have 65 Senators on this bill is that they have heard from people across the country, including Democrats, Republicans, and others, who have said this is what happened to me and my family because of the discrimination and because there is no coverage.

If a health care plan is going to have mental health coverage, it ought to be treated the same as any physical illness. It is a matter of discrimination, of basically civil rights. Ending the discrimination and making sure people get coverage is what this is about.

I yield the floor.

The PRESIDING OFFICER. The Senator from Missouri is recognized.

Mrs. CARNAHAN. Mr. President, the attacks against America have unified our nation. There is a new spirit of bipartisanship, of civility, and of common purpose.

Republicans, Democrats, and Independents are working together with the President to expedite legislation important to our efforts at home and abroad. Contentious issues have been set aside, in order to focus on the issues that unite us.

Thus, it is with disappointment that I feel compelled to come to the Senate floor today to discuss a dispute between the State of Missouri and the Health Care Financing Agency (HCFA) now known as the Center for Medicare and Medicaid Services, or CMS.

The details of the dispute are complex, but the consequences are enormous. At stake is the health of Missouri's children, seniors, and other vulnerable citizens.

The subject of this dispute is Missouri's provider assessment program, which is a tax on hospitals.

States use the money generated from these taxes as their ''match'' for federal Medicaid dollars. Medicaid funds are then paid out to providers according to formulas established by state law.

Over a decade ago, Congress became concerned that states were using provider taxes improperly to increase the federal contributions to Medicaid programs. In response, Congress enacted a law in 1992 that placed limitations on provider assessment programs.

One specific limitation is that a provider assessment must not contain a ''hold harmless'' provision. This means that states may not guarantee that a hospital will receive back from Medicaid the amount of funds it paid to the state in provider taxes.

In 1992, under the leadership of Governor John Ashcroft, now the Attorney General, Missouri complied with the federal law by enacting the Federal Reimbursement Allowance Program law. This law created a tax on hospitals, but contained no ''hold harmless'' provision. Governor Ashcroft signed the bill into law. Governor Carnahan continued the program, and Governor Holden is continuing it.

For almost a decade, the program has been operating under the auspices of HCFA now CMS. During this time, 100 percent of the revenues generated by the tax have been dedicated to Missouri's Medicaid program. The program has made Missouri a national model for using Federal, State, and private resources to provide health care to as many needy citizens as possible.

This long-standing and legal tax has assisted Missouri in creating a strong healthcare safety net for its children, pregnant women, and most vulnerable seniors.

Much of Missouri's success can be attributed to expanded enrollment of eligible citizens in Medicaid. During the 1990's, the number of Missourians covered by Medicaid more than doubled, increasing from 364,000 in 1990 to 839,000 in 2001.

The number of children enrolled in Medicaid has grown at an even faster rate, increasing from 180,000 in 1990 to 474,000 in 2001.

An important step in covering more children was the enactment of the State's Children's Health Insurance Program, also known as MC Plus. Under the leadership of Governor Carnahan, MC Plus was designed to cover children up to 300 percent of the poverty level. It is a national model. Due to MC Plus, parents who were working, but did not have access to health insurance through their employer, could now provide this precious resource to their children.

The MC Plus program has made a difference in the lives of 75,000 children in Missouri.

This combination of initiatives has sharply reduced the number of Missouri citizens that lack health insurance. Between 1996 and 1999, the percentage of uninsured in Missouri dropped by more than one-third, falling from 13.2 percent to 8.6 percent. In 1999, Missouri has the fourth lowest percentage of uninsured citizens in the country.

These tremendous accomplishments, however, could be in jeopardy from a bureaucratic squabble over the technicalities of Missouri's provider tax.

For many years, HCFA has complained that the manner in which Missouri's provider tax revenues are distributed to health care providers violates federal law. During this entire period, HCFA has been threatening to terminate the program and recoup $1.6 billion from the State. Such action would devastate Missouri's health care program.

Let's be clear about what is in dispute. HCFA has never alleged that the provider tax itself contains a ''hold harmless'' provision.

Rather, HCFA—and now CMS—appear to believe that the State, under the leadership of then Governor Ashcroft, made a collusive arrangement with health care providers. CMS has suggested that state officials illegally agreed that each hospital would get back in Medicaid reimbursement at least the amount it paid in taxes.

Missouri strongly disputes the allegation that there is a hold harmless arrangement between the State and its hospitals. And, in fact, the Federal Government has never provided Missouri with a shred of evidence that state officials engaged in illegal collusion with the hospitals. I repeat, not a shred of evidence.

Instead of proving its case, HCFA continues to complain about the provider tax, threaten Missouri with legal action, and uses bureaucratic leverage to force Missouri to change its incredibly successful program.

Mr. President, this is truly a case of form over substance. Missouri has created a program that pumps millions of dollars into health care coverage for its citizens. Missouri then distributes tax dollars to health care providers according to a state formula, which everyone agrees is consistent with Federal law.

Yet, a set of health care bureaucrats in Washington seek to destroy this program. Why? Because they have a hunch—without any concrete evidence—that the people who designed the program almost 10 years ago, secretly conspired to circumvent the technicalities of federal law. This is a case of bureaucracy run amok.

Ironically, this is the same agency that has recently changed its name so to shed its image that it cares more about rules and regulations than people. As a matter of fact, this administration announced when it took office that it would measure performance by looking at health care outcomes, not by compliance with bureaucratic requirements.

Nonetheless, it is this administration that is now threatening to take action against the State of Missouri. It is doing so even when there can be no doubt that our program is working to provide better health care to kids, to seniors, and our most needy citizens.

Of course, the timing of this threatened action could not come at a worse time. Our economic downturn is causing a great deal of distress in our communities. We are seeing significant job losses. State revenues are declining, and at the same time our citizens' needs are increasing.

Why, I ask, at this time of national emergency, would the administration choose to attack a successful program that has provided health care security for so many?

And why would the administration want to divert the State's attention from the task of helping Missouri get through this economic downturn?

There really are no good answers to these questions.

Senator BOND and I, Governor Holden, and other Members of the Congressional delegation are unified in opposition to the threatened CMS action. I strongly urge Secretary Thompson, CMS Administrator Scully, and other leaders in the administration to examine this issue with great care before taking an action that would cause so much harm to our State.

Mr. President, I stand here with my fellow Missouri Senator to draw awareness to this important issue. I hope that CMS understands that we intend to take aggressive action to protect a highly successful program in Missouri.

Mr. BOND. Mr. President, this is an issue that I brought to the attention of the chairman and ranking member of the Appropriations Committee when we marked up this bill in committee. I have been working over the past few years to protect the Missouri Medicaid program from the devastating impact of a potential recoupment of almost $2 billion. Confronted with such a recovery—or even a fraction of that amount—Missouri would inevitably be forced to cut back on its Medicaid program, putting health care for many Missourians in jeopardy. I am hopeful that the State of Missouri and CMS can work together in good faith to find a resolution that protects the care that the Missouri Medicaid program provides to 479,091 children, 21,517 seniors in nursing homes, and close to 30,000 pregnant women across the state.

Mr. HARKIN. I appreciate and thank Senator CARNAHAN and Senator BOND for bringing this important issue to our attention. I am concerned that attempts to recoup Medicaid dollars from their state could jeopardize the health care it provides for hundreds of thousands of children, senior citizens, and pregnant women.

Clearly, our first priority has to be the beneficiaries of the Medicaid program. At this time of economic uncertainty, the last thing this Government should do is put our most vulnerable citizens at greater risk.

Again, I thank the Senators from the State of Missouri for raising this issue, and I look forward to working with them on this matter.

Mr. SPECTER. I thank my colleagues from Missouri for bringing this important issue to the Senate's attention. I support their efforts and encourage CMS to work in good faith with the State to find a resolution to this matter that allows Missouri to continuing making progress in providing health insurance to its citizens.

Mrs. CARNAHAN. I thank Senator HARKIN and Senator SPECTER for their support on this issue.

The PRESIDING OFFICER. The senior Senator from Missouri.

Mr. BOND. I thank the Chair and my colleague, Senator CARNAHAN. We have talked about this a great deal. Over the last decade, Missouri's Medicaid Program has faced a series of difficult but important challenges.

Not only has the program been forced to struggle with internal issues, such as transitioning to managed care, reaching out to Missourians who are eligible but not yet enrolled in the program, and providing adequate payment to health care providers who care for Medicaid patients. It has had to deal with a number of important challenges presented at the Federal level as well. Not the least were efforts by Congress, attempted in both 1995 and 1997, but foiled by me and other legislators and people in similar circumstances in other States, to limit States' abilities to make disproportionate share hospital payments to safety net hospitals.

Another challenge has been to expand coverage to children in working poor families as called for by the creation of the Children's Health Insurance Program, or CHIP. I was an early supporter of this program and its efforts to expand coverage for low-income children. Missouri achieved this as part of its 1997 Medicaid waiver which is now in effect.

In addition, in 1999, under the previous administration, the Centers for Medicare and Medicaid Services, CMS, then called the Health Care Financing Administration, HCFA, initiated an investigation of the Missouri Medicaid Program.

Since HCFA began the process, CMS has carried on this effort, moving down the path to contend that Missouri may owe the Federal Government portions of the Medicaid funding the State received beginning in 1992 based on concerns about whether the tax imposed on hospitals and nursing homes by the State of Missouri to help finance the Medicaid Program actually complies with Federal law.

We all know that many States prior to 1992 tried to squeeze extra Federal funding by taking or accepting money from health care providers, essentially nursing homes and hospitals, in order to inflate artificially State level medical spending and, thus, increase the Federal share of costs in the joint State-Federal Medicaid Program.

In 1991, of course, Congress passed the law to outlaw these contributions and to establish strict new controls on provider taxes. This law imposed a requirement on States that provider taxes be uniform and broad based, and it prohibited States from instituting hold harmless Medicaid schemes in which payments to a health facility, particularly including DSH payments, were directly or indirectly related to the amount of provider tax a facility pays.

The State of Missouri believes it is fully in compliance with that law. CMS disagrees. Missouri does impose a tax on hospitals and nursing homes to finance a State's share of Medicaid expenses, but the State insists the tax is uniform and broad based.

Furthermore, the payments the State makes to Medicaid providers recognize their proportion of indigent payments, but these payments are targeted to needy facilities and are in no way intended to facilitate or pay for compensation for the provider taxes by the facilities that receive the reimbursement.

This is a unique setup in which the State sends Medicaid payments for some hospitals to a subsidiary of HMA, the hospital association, which then acts as an agent in distributing the funds.

The CMS concerns about the Missouri situation center on this arrangement, and we have reason to believe they were on a course to attempt to seek $1.6 billion in repayments. This would be an enormous sum for the Missouri Medicaid Program whose annual budget in 2001 was only $3.5 billion, including both Federal and State funds.

If this action were to be taken, it would devastate the Medicaid Program of the State of Missouri and the care it currently provides for over 479,000 children, 21,000 seniors in nursing homes, and close to 30,000 pregnant women. That is absolutely unacceptable, and that cannot go forward.

The State of Missouri already faces huge budget shortfalls due to overspending and, in the near term, will have difficulty even in maintaining the current programs and services which are so vitally needed. If CMS were to succeed in taking these funds back, Missouri's Medicaid Program and over 800,000 people currently served could be grievously harmed.

I come to the Chamber today with my colleague from Missouri to raise this issue for the Senate. We have entered into a colloquy with the managers of the bill because we believe, as a result of raising this issue when we discussed it in the Appropriations Committee markup, that we started the process of bringing the State of Missouri and CMS together in good faith negotiations on the issue.

We strongly urge them to come to a resolution that meets CMS's concerns but that protects the integrity of Missouri's Medicaid Program and the care it provides to some of Missouri's most vulnerable citizens.

I appreciate the time of the Senate, and I appreciate the understanding of the managers of the bill. My colleague from Missouri, Senator CARNAHAN, and I look forward to seeing a successful resolution that will take care of the concerns of CMS, but also not take away the vitally needed Medicaid support for needy children, for the seniors in nursing homes, and for the pregnant women.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from West Virginia.

AMENDMENT NO. 2035 TO AMENDMENT NO. 2020

Mr. BYRD. Mr. President, on behalf of the distinguished senior Senator from Alaska and myself, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The senior assistant bill clerk read as follows:

The Senator from West Virginia [Mr. BYRD], for himself and Mr. STEVENS, proposes an amendment numbered 2035 to amendment No. 2020.

At the end of the amendment add:

(a) Notwithstanding Rule 3 of the Budget Scorekeeping Guidelines set forth in the joint explanatory statement of the committee of conference accompanying Conference Report 105–217, the provisions of the amendment that would have been estimated by the Office of Management and Budget as changing direct spending or receipts under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 were it included in an Act other than an appropriations Act shall be treated as direct spending or receipts legislation, as appropriate, under section 252 of the Balanced Budget and Emergency deficit Control Act of 1985, and by the Chairman of the Senate Budget Committee, as appropriate, under the Congressional Budget Act.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. BYRD. Mr. President, the amendment by Mr. DOMENICI is the text of S. 534, the Mental Health Equitable Treatment Act of 2001. This amendment would prohibit group health plans and group health insurance issuers that provide both medical and surgical benefits and mental health benefits from imposing treatment limitations or financial requirements for coverage of mental health benefits that are different from those used for medical and surgical benefits.

The problem Senator STEVENS and I encountered in processing this amendment is that the Senate Appropriations Committee would be charged with approximately $1.5 billion over the next decade if this amendment, worthwhile as it may be, were to be adopted. Both Senator STEVENS and I, I believe, are cosponsors of the underlying legislation, S. 534. I did not realize that legislation was going to be offered as an amendment to an appropriations bill, however, or I might not have cosponsored it. Because of the adverse impact on discretionary spending, we would be forced to oppose this amendment in its current form. In an effort to find a workable solution to the problem, this amendment would direct that any expenditures resulting from this amendment be charged to the committee of jurisdiction under the budget process. If this amendment is adopted, I will drop my opposition to the underlying amendment.

Senator STEVENS and I have spoken with the chairman and ranking member of the Budget Committee, and they are in agreement.

I yield the floor.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. STEVENS. I am pleased to join with the distinguished chairman of our committee in offering this amendment to the Domenici amendment.

Senator BYRD and I have made a firm agreement to hold the line on the understanding we reached with the House of Representatives and the President of the United States to hold the total spending to $686 billion this year. This amendment does not breach that agreement. I am talking about the Domenici amendment does not breach this agreement.

Further, the amendment to the Domenici amendment will assure in future years, if there are caps continued under the Budget Control Act, that this amendment will not result in monies being assessed to our committee, as Senator BYRD has stated. They should properly be asserted to the committee of jurisdiction.

I am of the firm opinion this is a good bill. I was a cosponsor of the bill. I did not expect it to be offered to an appropriations bill, but under the parliamentary situation I do not express objection to that. I do, however, think the Senate should be reminded once again we have a firm understanding with regard to the appropriations process this year, and if we hold to that understanding I think we will finish our bills in time to enjoy the holidays with our relatives. If we breach that agreement, we will be here for a long time.

I am proud to serve with Senator BYRD, who is chairman, because we are two people who I believe keep our word. We have in this instance convinced the Senate to follow us in that regard. So I thank the Senator very much and am pleased to cosponsor the amendment.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Very quickly, I know Senator DOMENICI is in a markup on the energy and water bill, along with Senator HARKIN.

I thank my two colleagues for their amendment. I think it just adds to the strength of the bill. It is very important to have their support. So I thank both of them for their work.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, I thank the distinguished chairman of the full committee, Senator BYRD, and the ranking member, Senator STEVENS, for their assistance in moving ahead with this very important amendment.

Parity for mental health has been an objective of about two-thirds of the Senators for many years. Through today's action, I think we are on the road to getting that accomplished. So I salute my colleagues and thank my colleagues for their cooperation and good work.

The PRESIDING OFFICER. Is there further debate on the second-degree amendment?

If not, the question is on agreeing to amendment No. 2035.

The amendment (No. 2035) was agreed to.

Mr. STEVENS. I move to reconsider the vote.

Mr. SPECTER. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The question is on agreeing to amendment No. 2020, as amended.

The amendment (No. 2020), as amended, was agreed to.

Mr. SPECTER. I move to reconsider the vote.

Mr. WELLSTONE. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. SPECTER. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll. Mr. HARKIN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Ms. CANTWELL). Without objection, it is so ordered.

UNANIMOUS CONSENT AGREEMENT

Mr. HARKIN. Madam President, I ask unanimous consent that the list I will send to the desk, once this consent has been granted, be the only first-degree amendments to H.R. 3061, the Labor-HHS appropriations bill; that these amendments be subject to relevant second-degree amendments; that upon disposition of all amendments, the bill be read the third time and the Senate vote on passage of the bill. That upon passage, the Senate insist on its amendments, request a conference with the House on the disagreeing votes of the two Houses, and the Chair be authorized to appoint conferees on the part of the Senate, with this action occurring with no intervening action or debate.

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

The list of amendments follows:

FIRST DEGREE AMENDMENTS

Bayh: Mark to market.

Bingaman: Retirement; Hispanic education programs.

Byrd: Relevant; relevant to the list.

Clinton: SAMSHA—mental health for public safety officers; mental health services for children.

Daschle: Relevant; 3 relevant to the list; firefighters' collective bargaining.

Dorgan: Customs related.

Dodd: Children's Mental Health; EMS; Kids and terrorism.

Feingold: Defibrillators.

Graham: Ecstasy use.

Harkin: Relevant; relevant to the list; managers' amendments.

Kennedy: Bioterrorism.

Reed: Relevant; mark to market

Reid: Relevant; relevant to the list.

Torricelli: 3 lead poisoning; 2 assistance for dislocated workers; SOS anthrax emergency response.

Wellstone: Mental health parity.

T. Hutchinson: Charitable giving.

B. Smith: Research; relevant; relevant to list.

DeWine: 4 Safe and Stable Families.

Collins: LIHEAP; substance abuse/homeless; relevant.

Sessions: Wage index; foreign school loans; misuse of AIDS funds.

Murkowski: Relevant; national security

Nickles: 2 Relevant; 2 relevant to list.

Brownback: Human cloning ban; embryo research; human-animal hybrid embryo; 12 relevants.

Domenici: Mental health parity (S. 543).

Enzi: School construction; mental health.

Gramm: Diabetes research funding; relevant; relevant to list.

Gregg: 2 mental health; school renovation; relevant/health.

Kyl: Impact aid; relevant.
Specter: 2 Relevant.
Lott: 3 relevant; 3 relevant to list.
Cochran: Relevant.
Snowe: 3 relevant.
Santorum: HUD.
Grassley: Relevant.

Mr. HARKIN. This is a finite list of amendments we now have before the committee.

I am authorized by the majority leader to announce there will be no further votes this evening.

Mr. SPECTER. Madam President, I urge all of our colleagues to move ahead promptly tomorrow to offer amendments. The list is a very long list and, as is frequently the case, a great many of the amendments listed are placeholders. We would appreciate our colleagues advising which amendments they intend to offer and specify what amendment it is so we can move ahead. It is very important we complete action on this bill if we are to complete a conference in a time where we will finish during the current session before the holiday season.

Last year, it took months for the conference to be resolved between the House and Senate. We urge our colleagues to come to the floor tomorrow when we start action on the bill, which I understand is to be at 10:30, to proceed to offer amendments.

I yield the floor.

AMENDMENT NO. 2024

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. I have an amendment at the desk for immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from North Dakota [Mr. DORGAN] proposes an amendment numbered 2024.

Mr. DORGAN. Madam President, I ask unanimous consent reading of the amendment be dispensed.

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

The amendment is as follows:

(Purpose: To provide for mandatory advanced electronic information for air cargo and passengers entering the United States)

At the end of the bill, insert the following:

TITLE ____—INFORMATION ON PASSENGERS AND CARGO

SEC. ___01. MANDATORY ADVANCED ELECTRONIC INFORMATION FOR AIR CARGO AND PASSENGERS ENTERING THE UNITED STATES.

(a) AIR CARGO INFORMATION.—

(1) IN GENERAL.—Section 431(b) of the Tariff Act of 1930 (19 U.S.C. 1431(b)) is amended—

(A) by striking ''(b) PRODUCTION OF MANIFEST.—Any manifest'' and inserting the following:

''(b) PRODUCTION OF MANIFEST.—

''(1) IN GENERAL.—Any manifest'';

(B) by indenting the margin of paragraph (1), as so designated, two ems; and

(C) by adding at the end the following new paragraph:

''(2) ADDITIONAL INFORMATION.—

''(A) IN GENERAL.—In addition to any other requirement under this section, every air carrier required to make entry or obtain clearance under the customs laws of the United States, the pilot, the master, operator, or owner of such carrier (or the authorized agent of such owner or operator) shall provide by electronic transmission cargo manifest information specified in subparagraph (B) in advance of such entry or clearance in such manner, time, and form as the Secretary shall prescribe. The Secretary may exclude any class of air carrier for which the Secretary concludes the requirements of this subparagraph are not necessary.

''(B) INFORMATION REQUIRED.—The information specified in this subparagraph is as follows:

''(i) The port of arrival or departure, whichever is applicable.

''(ii) The carrier code, prefix code, or, both.

''(iii) The flight or trip number.

''(iv) The date of scheduled arrival or date of scheduled departure, whichever is applicable.

''(v) The request for permit to proceed to the destination, if applicable.

''(vi) The numbers and quantities from the master and house air waybill or bills of lading.

''(vii) The first port of lading of the cargo.

''(viii) A description and weight of the cargo.

''(ix) The shippers name and address from all air waybills or bills of lading.

''(x) The consignee name and address from all air waybills or bills of lading.

''(xi) Notice that actual boarded quantities are not equal to air waybill or bills of lading quantities.

''(xii) Transfer or transit information.

''(xiii) Warehouse or other location of the cargo.

''(xiv) Such other information as the Secretary, by regulation, determines is reasonably necessary to ensure aviation transportation safety pursuant to the laws enforced or administered by the Customs Service.

''(3) AVAILABILITY OF INFORMATION.—Information provided under paragraph (2) may be shared with other departments and agencies of the Federal Government, including the Department of Transportation and the law enforcement agencies of the Federal Government, for purposes of protecting the national security of the United States.''.

(2) CONFORMING AMENDMENTS.—Subparagraphs (A) and (C) of section 431(d)(1) of such Act are each amended by inserting before the semicolon ''or subsection (b)(2)''.

(b) PASSENGER INFORMATION.—Part II of title IV of the Tariff Act of 1930 is amended by inserting after section 431 the following new section:

''SEC. 432. PASSENGER AND CREW MANIFEST INFORMATION REQUIRED FOR AIR CARRIERS.

''(a) IN GENERAL.—For every person arriving or departing on an air carrier required to make entry or obtain clearance under the customs laws of the United States, the pilot, the master, operator, or owner of such carrier (or the authorized agent of such owner or operator) shall provide, by electronic transmission, manifest information specified in subsection (b) in advance of such entry or clearance in such manner, time, and form as the Secretary shall prescribe.

''(b) INFORMATION.—The information specified in this subsection with respect to a person is—

''(1) full name;

''(2) date of birth and citizenship;

''(3) sex;

''(4) passport number and country of issuance;

''(5) United States visa number or resident alien card number, as applicable;

''(6) passenger name record; and

''(7) such other information as the Secretary, by regulation, determines is reasonably necessary to ensure aviation transportation safety pursuant to the laws enforced or administered by the Customs Service.

''(c) AVAILABILITY OF INFORMATION.—Information provided under this section may be shared with other departments and agencies of the Federal Government, including the Department of Transportation and the law enforcement agencies of the Federal Government, for purposes of protecting the national security of the United States.''.

(c) DEFINITION.—Section 401 of the Tariff Act of 1930 (19 U.S.C. 1401) is amended by adding at the end the following new subsection:

''(t) AIR CARRIER.—The term 'air carrier' means an air carrier transporting goods or passengers for payment or other consideration, including money or services rendered.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect 45 days after the date of enactment of this Act.

Mr. DORGAN. Madam President, this is an amendment I discussed on the floor briefly earlier today. I shall be brief again. I understand under ideal circumstances this amendment would be placed somewhere else, at some other time, perhaps in some other bill. It is an amendment that is critically important and should have been done last week. It should now be law. It should already be providing protection to the American people today but is not.

I am angry about that because the Congress should not have missed this opportunity last week. I don't intend to let the Congress miss this opportunity at any point along the way. I will offer it, and if it is not finally a part of this bill when signed by the President, I will offer it to every bill.

Let me describe the circumstance. I am chairman of an appropriations subcommittee and I held a hearing a few weeks ago and had the Commissioner of the Customs Service and the Commissioner of the Immigration Service testifying before that subcommittee. One of the things they talked about was the need to provide security with respect to who is coming into our country. A country cannot be secure unless it has some notion of border security. We have millions of people coming into our country each and every year. They are guests of ours, coming in on a visa given by our country.

When people come to our country, we welcome them. We want them to visit our country, but we also want to be sure the people who are coming to our country from foreign lands are people we want to have as guests. There are some we want to keep out: Those involved in terrorist activities, those who have had association with terrorist groups, known and suspected terrorists. We do not want to welcome them into our country. We want to keep them out. That is the whole purpose of border security.

We have around 80 million people who come to this country every year on some 400,000 international flights. I repeat, on 400,000 international flights we have some 80 million people disembark to visit the United States.

There are just over 100 major air carriers flying those passengers into our country. We have an arrangement with 95 of those air carriers to voluntarily provide the United States Customs Service with advance passenger lists of who is coming to visit our country. The Customs Service runs that list against a list the FBI has, the Customs Service has, and 21 different agencies of law enforcement, to evaluate which of these passengers, if any, should not be allowed into our country, which of them are on the suspect list, and which are on the list of known or suspected terrorists.

We have the majority of the airline carriers and the majority of the names of passengers being given to our law enforcement authorities in the form of an advance electronic passenger list. It is called the Advance Passenger Information System. It is a voluntary, not mandatory, system covering 85 percent of the international air passengers that are not already pre-cleared by Customs. It works fine except we have a number of carriers from countries that do not participate.

Let me list a few: Saudi Arabia, Egypt, Jordan, and Pakistan, just to name a few.

One would ask whether we should be getting advanced passenger information from these countries. The answer is yes. In fact, the Senate said yes last week. The Senate was prepared to adopt this amendment last week as part of the counter-terrorism bill, which is where it should have been. In conference it was knocked out. It went to conference with the U.S. House. Some were worried more about committee jurisdiction than they were about security. So they knocked it out.

The result was, when the President signed that counter-terrorism bill, it did not have this provision that makes mandatory the Advanced Passenger Information System.

What does that mean? It means that today about 219,000 international air passengers arrived in the United States—today, Tuesday. About 34,000 are pre-cleared by U.S. Customs agents stationed abroad who run an APIS-type check as part of the clearing process, 156,000 are pre-screened through APIS while they are in flight, leaving approximately 29,000 whose names are not provided to the Customs Service until they arrive because their carriers do not participate in the Advanced Passenger Information System. Why? Because the Congress last week decided not to include that requirement in a conference report.

The President wants this requirement. The Customs Service wants the requirement. All the Federal law enforcement authorities want the requirement. We get it on 85 percent of international air passengers. And the ones we don't get it from are Pakistan, Kuwait, Saudi Arabia, Egypt, and Jordan, just to name a few.

I ask the question: Does it promote this country's security to require those air carriers to provide the same information that virtually every other air carrier in the world provides to us? The answer is clearly yes.

We are less secure today than we should be because the Congress knocked out my provision in that conference committee. That provision was not in the counter-terrorism bill when the President signed it, despite the fact that the Senate supported it. The Senate said yes. But it was knocked out in conference.

I intend to offer this to any vehicle I have the opportunity to offer it to. I know that it doesn't necessarily belong on an appropriations bill. But it belongs in law in this country. It belongs there now. It should be there now. It should be providing security for this country now with respect to the 29,000 people who entered this country today whose names were not provided under the Advanced Passenger Information List. It makes no sense to me to be in this situation.

Some would say, well, this really inconveniences and mandates the air carriers to do this. No, it does not. Most of the air carriers do it voluntarily, and they have a good relationship with our country. But some air carriers decided that they will not do it. The Customs Commissioner and others indicate that we ought to make it mandatory. I agree with that.

Since September 11, things have changed. It is not profiling. It is not profiling in any way to ask for an advanced list of passengers who are going to visit our country as guests in our country. But we are trying to profile those who are terrorists and suspected terrorists. Let's admit to that.

One of the goals that we have in all of our efforts with respect to increasing security at our borders is to determine who the people are who associate with terrorists and known terrorists or suspected terrorists, and try to keep them out of our country. Unfair? I don't think so, not in the circumstance where thousands of Americans have been killed— cold-blooded murder by terrorists who decided to use an airplane as a weapon of destruction; not at a time when terrorists sent anthrax-laced letters around this country through the mail system and people die.

I ask that we include this amendment in this appropriations bill. I hope those who are talking about their committee jurisdiction will understand that this isn't about jurisdiction. It is about security. This isn't about trying to protect your little area. It is about common sense to try to protect this country's borders. The Advanced Passenger Information System works. It has worked for a long while. It provides this country names that are important to secure our borders, except that it doesn't do it in all instances. In the instances where it fails, it is critically important to give this country critically important information in order to give this country some assurance and some comfort.

I understand that we will probably deal with this amendment tomorrow. I wanted to offer it this evening.

Mr. HARKIN. Madam President, I believe this amendment which I am pledged to cosponsor should become law. It is very reasonable for the United States to require that airlines provide information about their international travelers coming to the United States so customs can be able to check if any of the passengers are of special concern.

We are going to considerable lengths to improve the safety of our aviation system and to improve our ability to better protect our borders. Requiring that international airlines provide some basic information about their passengers and their cargo is very reasonable.

I understand some airlines are concerned about the small costs involved. Some airlines might have other reasons to not comply. But with 85 percent compliance with the voluntary requirements, clearly the burden is well within reason. There is no question, given the realities of our world, this should be required information for any international flight coming to the United States.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. REID. Madam President, I ask unanimous consent the order for the quorum call be rescinded.

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

MORNING BUSINESS

Mr. REID. Madam President, I ask unanimous consent that there now be a period of morning business, with Senators allowed to speak therein for a period not to exceed 5 minutes each.

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

TERRORISM

Mr. SPECTER. Madam President, the terrorist attacks carried out by Osama bin Laden and al-Qaida on September 11 require a reevaluation of our national policy on what the government should be doing on its primary responsibilities: the security of the people.

The United States was stunned by that diabolical attack. It was thought impossible to make the country, with special emphasis on the Congress, more ''fighting mad''; but that was done with the anthrax attacks. As a nation, we are determined to respond thoughtfully and forcefully to win the war against terrorism. This floor statement briefly reviews some of the responses by the U.S. to terrorism for the past two decades to learn from our mistakes of the past and to guide us on what to do in the future.

The United States has been slow to assert extraterritorial jurisdiction to