S. 543

At the request of Mr. WELLSTONE, the names of the Senator from Hawaii (Mr. INOUYE) and the Senator from Georgia (Mr. CLELAND) were added as cosponsors of S. 543, a bill 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.

S. 548

At the request of Mr. HARKIN, the names of the Senator from Maine (Ms. COLLINS) and the Senator from Pennsylvania (Mr. SPECTER) were added as cosponsors of S. 548, a bill to amend title XVIII of the Social Security Act to provide enhanced reimbursement for, and expanded capacity to, mammography services under the medicare program, and for other purposes.

S. CON. RES. 14

At the request of Mr. CAMPBELL, the names of the Senator from Ohio (Mr. DEWINE) and the Senator from Hawaii (Mr. AKAKA) were added as cosponsors of S. Con. Res. 14, a concurrent resolution recognizing the social problem of child abuse and neglect, and supporting efforts to enhance public awareness of it.

S. RES. 16

At the request of Mr. THURMOND, the names of the Senator from North Carolina (Mr. HELMS), the Senator from Virginia (Mr. WARNER), the Senator from Maryland (Mr. SARBANES), the Senator from Texas (Mrs. HUTCHISON), the Senator from Minnesota (Mr. DAYTON), and the Senator from Alabama (Mr. SESSIONS) were added as cosponsors of S. Res. 16, a resolution designating August 16, 2001, as ''National Airborne Day.''

AMENDMENT NO. 112

At the request of Mr. DOMENICI, the names of the Senator from Texas (Mrs. HUTCHISON), the Senator from Kentucky (Mr. MCCONNELL), and the Senator from Kentucky (Mr. BUNNING) were added as cosponsors of amendment No. 112 proposed to S. 27, a bill to amend the Federal Election Campaign Act of 1971 to provide bipartisan campaign reform.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. SESSIONS (for himself, Mr. COCHRAN, and Mr. HUTCHINSON):

S. 568. A bill to amend the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2001, to respond to the severe economic losses being incurred by crop producers, livestock and poultry producers, and greenhouse operators as a result of the sharp increase in energy costs or input costs from energy sources; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 568

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

SECTION 1. EMERGENCY RELIEF FROM HIGH ENERGY COSTS FOR CROP PRODUCERS, LIVESTOCK AND POULTRY PRODUCERS, AND GREENHOUSE OPERATORS.

Section 815 of the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2001 (114 Stat. 1549, 1549A–55), is amended—

(1) in subsection (b)(1), by striking ''paragraph (2)'' and inserting ''paragraph (2) and subsection (c)(2)'';

(2) in subsections (b)(2) and (d), by striking ''subsection (c)(2)'' each place it appears and inserting ''subsection (c)(1)(B)'';

(3) in subsection (c)—

(A) by redesignating paragraphs (1), (2), and (3) as subparagraphs (A), (B), and (C), respectively, and indenting appropriately;

(B) by striking ''Assistance'' and inserting the following:

''(1) LOSSES DUE TO DAMAGING WEATHER AND RELATED CONDITIONS.—Assistance''; and

(C) by adding at the end the following:

''(2) ECONOMIC LOSSES DUE TO HIGHER ENERGY COSTS.—The Secretary shall also provide assistance under this section to crop producers, livestock and poultry producers, and greenhouse operators for any severe increased operating costs that the producers and operators have experienced, or are likely to experience, during calendar year 2000 or 2001 as the result of an increase in energy costs or input costs from energy sources.''; and

(4) in subsection (e), by striking ''Assistance'' and inserting ''Except as provided in subsection (c)(2), assistance''.

By Mr. BURNS:

S. 569. A bill entitled the ''Health Care Access Improvement Act''; to the Committee on Finance.

Mr. BURNS. Mr. President, I rise today to introduce the ''Health Care Access Improvement Act of 2001.'' This bill is designed to dramatically expand rural America's access to modern health care.

The Health Care Access Improvement Act creates a significant tax incentive, which encourages doctors, dentists, physician assistants, licensed mental health providers, and nurse practitioners to establish practices in underserved areas. Until now, rural areas have not been able to compete with the financial draw of urban settings and therefore have had trouble attracting medical professionals to their communities. The $1,000 per month tax credit will allow health care workers to enjoy the advantages of rural life without drastic financial sacrifices. But the real winners in this bill are the thousands of Americans whose access to health care is almost impossible due to a lack of doctors and dentists in small town America.

There are nine counties in the great state of Montana which do not have even one doctor. In these rural settings, agriculture is often the only employer. Farming and ranching is hard, dangerous work. Serious injuries can happen in an instant. And while Montanans have always been known as a heartier breed of people, we get sick too. It is unreasonable to expect the farmer who has had a run-in with an auger or the elderly rancher's widow to drive two hours or more to get stitched up or to have a crown on a tooth replaced. As doctors, dentists, physicians assistants, mental health providers, and nurse practitioners are attracted to the more urban areas, Montanans and others in isolated communities will suffer. We must do what we can to ensure that these health care providers come to rural America, we must give them some incentive to practice in these smaller communities so that citizens living in these areas can finally enjoy the medical treatment they deserve.

This problem is not unique to my State of Montana, alone. In fact, throughout the United States, we continue to experience scarcity in all or parts of 2,692 counties. In rural areas, serious shortages exist in the supply of primary care practitioners and specialty care practitioners. This is precisely the reason why this bill is so important.

Twenty-nine health care organizations believe strongly in this legislation, as well. They actively support the introduction of this legislation to provide a tax credit to health care providers establishing practices in underserved areas because they realize it will help thousands of health care providers make decisions to establish their practices in America's underserved communities. So many communities whose access to qualified health care professionals has been a constant ''revolving door'' will be greatly helped by this tax credit. Mr. President, I hold here in my hand a letter on behalf of these various groups which I ask to be inserted in the RECORD at the conclusion of my remarks.

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

(See exhibit 1.)

Mr. BURNS. It is important to note that less than 11 percent of the nation's physicians are practicing in non-metropolitan areas, less than 11 percent. This is a significant number, folks. We owe it to the men, women, children, elderly and families living in these non-urban communities to take steps necessary to increase this percentage and get more health care providers to their communities.

The Department of Health and Human Services uses a ratio of one primary care physician per 3,500 population as the standard for a primary care Health Professional Shortage Area, HPSA. More than 20 million Americans live in rural and frontier HPSAs. Most of the State of Montana is beyond rural, it's frontier. As of 1997, more than 2,200 physicians were needed nationwide to satisfy these non-metropolitan primary care HPSAs shortages. I think this bill is a step in the right direction.

Mr. President, I urge my colleagues to work with me and join in support of this legislation. Rural Montana, rural America, and health service providers all benefit from increased access, service and a better quality of life. In short, everyone wins with this legislation. I look forward to making this legislation work for so many of the men, women and children in need of quality health care.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 569

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Care Access Improvement Act''.

SEC. 2. NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS SERVING HEALTH PROFESSIONAL SHORTAGE AREAS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is amended by inserting after section 25A the following new section:

''SEC. 25B. PRIMARY HEALTH SERVICES PROVIDERS SERVING HEALTH PROFESSIONAL SHORTAGE AREAS.

''(a) ALLOWANCE OF CREDIT.—In the case of an individual who is a qualified primary health services provider for any month during the taxable year, there shall be allowed as a credit against the tax imposed by this chapter for such taxable year an amount equal to $1,000 for each month during such taxable year—

''(1) which is part of the eligible service period of such individual, and

''(2) for which such individual is a qualified primary health services provider.

''(b) QUALIFIED PRIMARY HEALTH SERVICES PROVIDER.—For purposes of this section, the term 'qualified primary health services provider' means, with respect to any month, any physician, physician assistant, or nurse practitioner, who is certified for such month by the Bureau to be a primary health services provider or a mental health provider licensed under applicable state law who—

''(1) is providing primary health services full time and substantially all of whose primary health services are provided in a health professional shortage area,

''(2) is not receiving during the calendar year which includes such month a scholarship under the National Health Service Corps Scholarship Program or the Indian health professions scholarship program or a loan repayment under the National Health Service Corps Loan Repayment Program or the Indian Health Service Loan Repayment Program,

''(3) is not fulfilling service obligations under such Programs, and

''(4) has not defaulted on such obligations. Such term shall not include any individual who is described in paragraph (1) with respect to any of the 3 most recent months ending before the date of the enactment of this section.

''(c) ELIGIBLE SERVICE PERIOD.—For purposes of this section, the term 'eligible service period' means the period of 60 consecutive calendar months beginning with the first month the taxpayer is a qualified primary health services provider.

''(d) OTHER DEFINITIONS AND SPECIAL RULE.—For purposes of this section—

''(1) BUREAU.—The term 'Bureau' means the Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration of the United States Public Health Service.

''(2) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r) of the Social Security Act.

''(3) PHYSICIAN ASSISTANT.—The term 'physician assistant' has the meaning given to such term by section 1861(aa)(5)(A) of the Social Security Act.

''(4) NURSE PRACTITIONER.—The term 'nurse practitioner' has the meaning given to such term by section 1861(aa)(5)(A) of the Social Security Act.

''(5) PRIMARY HEALTH SERVICES PROVIDER.—The term 'primary health services provider' means a provider of basic health services (as described in section 330(b)(1)(A)(i) of the Public Health Service Act).

''(6) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' means any area which, as of the beginning of the eligible service period, is a health professional shortage area (as defined in section 332(a)(1) of the Public Health Service Act) taking into account only the category of health services provided by the qualified primary health services provider.

''(7) ONLY 60 MONTHS TAKEN INTO ACCOUNT.—In no event shall more than 60 months be taken into account under subsection (a) by any individual for all taxable years.''.

(b) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 25A the following new item:

''Sec. 25B. Primary health services providers serving health professional shortage areas.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

EXHIBIT 1

ADEA,
AMERICAN DENTAL EDUCATION ASSOCIATION,
Washington, DC, March 13, 2001.

Hon. CONRAD BURNS,
United States Senate,
Dirksen Senate Office Building,
Washington, DC.

DEAR SENATOR BURNS: The 29 undersigned organizations actively support your introduction of legislation to provide a tax credit to health care providers establishing practices in underserved areas. This tax credit will not only help thousands of health care providers make decisions to establish their practices in America's underserved communities, but also will provide sufficient time for them to establish roots in these communities.

Many communities whose access to qualified health care professionals has been a constant ''revolving door'' will be greatly helped by this tax credit. It is estimated that more than 20,000 clinicians are needed to eliminate all of the Primary Care Dental, Medical and Mental Health, Health Professional Shortage Areas (HPSAs) now designated across our nation.

Please accept our endorsement for this critical proposal that will improve America's public health and access to health care in underserved areas. Thank you for offering such an important proposal at the outset of the legislative session and for your continued leadership. Please let us know how we may be helpful to you as we work together to improve access to care. We are committed to provide sustained assistance as you move this proposal forward.

Sincerely,
RICHARD W. VALACHOVIC, D.M.D., M.P.H.
Executive Director.

On behalf of the: American Academy of Pediatric Dentistry; American Association of Colleges of Osteopathic Medicine; American Association of Colleges of Pharmacy; American Association of Community Dental Programs; American Association for Dental Research; American Association of Public Health Dentistry; American College of Nurse-Midwives; American College of Nurse Practitioners; American College of Osteopathic Emergency Physicians; American College of Osteopathic Family Physicians; American Dental Association; American Dental Education Association; American Dental Hygienists' Association; American Medical Student Association; American Optometric Association; American Osteopathic Association; American Psychological Association; American Student Dental Association; Association of Academic Health Centers; Association of American Medical Colleges; Association of American Veterinary Medical Colleges; Association of Schools of Allied Health Professions; Association of Schools and Colleges of Optometry; Association of Schools of Public Health; Clinical Social Work Federation; Coalition of Higher Education Assistance Organizations; National Association of Graduate-Professional Students; National League for Nursing and National Organization of Nurse Practitioners Faculties.

By Mr. BIDEN (for himself, Mr. DEWINE, Mr. LEVIN, Mr. SPECTER, Mrs. CARNAHAN, Mrs. HUTCHISON, Mr. MILLER, Ms. COLLINS, and Mr. CARPER):

S. 570. A bill to establish a permanent Violence Against Women Office at the Department of Justice; to the Committee on the Judiciary.

Mr. BIDEN. Mr. President, today, I address once more the subject of violence against women. It is still a problem.

According Justice Department statistics, violence against women by intimate partners is actually down, falling 21 percent from 1993 to 1998. Luckily, we can thank the programs created by the Violence Against Women Act, which I introduced almost a decade ago, and the efforts of advocates all across this country, from Dover to Denver, in educating us to confront domestic violence head-on.

Yet, unfortunately, we are far from eradicating this crime. It is a crime which harms women, leaving them battered and blue, sending them to the hospital, and causing them to miss work. We have also a crime that affects their children—children who cower while watching their mother get battered, children who too often then act out their own aggression.

I would love to say that, in my lifetime, we will break this cycle of family violence. But, we are not there yet.

One way of working towards this goal, however, is to preserve the Violence Against Women Office at the Justice Department. Today I, along with Senators DEWINE, LEVIN, SPECTER,

CARNAHAN, HUTCHISON, MILLER, COLLINS, and CARPER, have introduced a bill making the Office permanent.

This office is vital because it has been instrumental in our efforts to help women harmed by domestic violence. Since its inception, the Violence Against Women Office has distributed over one billion dollars in its first five years to states, localities, tribal governments, and private organizations. These governments and groups, in turn, have used these precious funds to improve the investigation and prosecution of crimes of domestic violence, stalking, and sexual assault; to train prosecutors, police officers, and judges on the special aspects of cases involving violence against women; and to offer the needed services to victims and their families.

In particular, this funding includes the incredibly successful STOP grants—grants which fund the Services for the Training of Officers and Prosecutors. These STOP grants—the largest grant program created by the Violence Against Women Act, are especially effective because each grant must be used to upgrade three vital areas: prosecution, law enforcement, and victim services.

Likewise, the Violence Against Women Office has awarded grants to encourage arrest policies, which seek to educate our police officers that, when they answer a call for help by a woman being battered, they should not turn away. This battery is not a private matter, to be left behind closed doors—where a man as king of his castle can do as he pleases. No, not anymore. That woman's abuser is committing a crime and he is subject to arrest and prosecution.

The Office has also distributed monies to our rural areas as part of the program for Rural Domestic Violence and Child Abuse Enforcement. I am sorry to say but this problem is in every part of this nation, and the Violence Against Women Office has sent funds to every corner of America, all the way from Orem, UT to Waterbury, VT. Yet, despite its pervasiveness, domestic violence itself is under attack.

And the Violence Against Women Office is leading the fight. Given the success of the many programs of the Violence Against Women Act as administered by the Office, I believe that the time has come to make the Violence Against Women Office permanent by statute. This Office is long overdue a strong foundation.

Moreover, the Office is due the prestige it deserves. My bill realizes this aim in a couple of ways. First, my bill provides that the Office be separate from any division or component of the Justice Department. In this regard, with the Office's Director reporting directly to the Associate Attorney General, as my bill requires, the Office will be shielded from any attempts to undo the great work it has historically accomplished. Why mess with success?

Second, my bill provides that the Director of the Office shall now be nominated by the President and confirmed by the Senate. This, too, raises the prestige of the work that the Violence Against Women Office seeks to accomplish day-in and day-out. It also subjects the selection of the Director, who performs the essential job of implementing the Violence Against Women Act, to the democratic process—thereby insuring that we attract the best candidates.

Yes, indeed, we are far from solving the crime of domestic violence. But let us take a step in the right direction. Join me in making the Violence Against Women Office permanent. The safety of women and their families depends on it.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 570

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Violence Against Women Office Act''.

SEC. 2. ESTABLISHMENT OF VIOLENCE AGAINST WOMEN OFFICE.

(a) IN GENERAL.—There is established in the Department of Justice a Violence Against Women Office (in this Act referred to as the ''Office'') under the general authority of the Attorney General.

(b) SEPARATE OFFICE.—The Office—

(1) shall not be part of any division or component of the Department of Justice; and

(2) shall be a separate office headed by a Director who shall report to the Attorney General through the Associate Attorney General of the United States, and who shall also serve as Counsel to the Attorney General.

SEC. 3. JURISDICTION.

The Office—

(1) shall have jurisdiction over all matters related to administration, enforcement, coordination, and implementation of all responsibilities of the Attorney General or the Department of Justice related to violence against women, including formula and discretionary grant programs authorized under the Violence Against Women Act of 1994 (title IV of Public Law 103–322) and the Violence Against Women Act of 2000 (Division B of Public Law 106–386); and

(2) shall be solely responsible for coordination with other offices or agencies of administration, enforcement, and implementation of the programs, grants, and activities authorized or undertaken under the Violence Against Women Act of 1994 (title IV of Public Law 103–322) and the Violence Against Women Act of 2000 (Division B of Public Law 106–386).

SEC. 4. DIRECTOR OF VIOLENCE AGAINST WOMEN OFFICE.

(a) APPOINTMENT.—The President, by and with the advice and consent of the Senate, shall appoint a Director for the Violence Against Women Office (in this Act referred to as the ''Director'') to be responsible for the administration, coordination, and implementation of the programs and activities of the office.

(b) OTHER EMPLOYMENT.—The Director shall not—

(1) engage in any employment other than that of serving as Director; or

(2) hold any office in, or act in any capacity for, any organization, agency, or institution with which the Office makes any contract or other agreement under the Violence Against Women Act of 1994 (title IV of Public Law 103–322) or the Violence Against Women Act of 2000 (Division B of Public Law 106–386).

(c) VACANCY.—In the case of a vacancy, the President may designate an officer or employee who shall act as Director during the vacancy.

(d) COMPENSATION.—The Director shall be compensated at a rate of pay not to exceed the rate payable for level V of the Executive Schedule under section 5316 of title 5, United States Code.

SEC. 5. REGULATORY AUTHORIZATION.

The Director may, after appropriate consultation with representatives of States and units of local government, establish such rules, regulations, and procedures as are necessary to the exercise of the functions of the Office, and are consistent with the stated purposes of this Act and those of the Violence Against Women Act of 1994 (title IV of Public Law 103–322) and the Violence Against Women Act of 2000 (Division B of Public Law 106–386).

SEC. 6. OFFICE STAFF.

The Attorney General shall ensure that there is adequate staff to support the Director in carrying out the responsibilities of the Director under this Act.

SEC. 7. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as are necessary to carry out this Act.

By Mr. THURMOND (for himself, Mr. WARNER, and Mr. ALLEN):

S. 571. A bill to provide for the location of the National Museum of the United States Army; to the Committee on Armed Services.

Mr. THURMOND. Mr. President, today I am introducing legislation to create a National Museum for the United States Army. This endeavor is important to every American, every veteran, and all Members of Congress.

I would be greatly pleased to have my colleagues join me in sponsoring this worthy legislation.

Our great Capital City and its surrounding countryside host every kind of museum imaginable, but not one for one of this Nation's greatest institutions, the United States Army. Area museums serving the American public today are all worthy museums, but this great city and this great Nation are sadly without a museum for its citizen-soldiers who have sacrificed so much for their country.

The purpose of the legislation which I introduce today is to designate a place for the Army Museum to be built to preserve, interpret, and display the important role the Army has played in the history of our Nation.

What I propose is not new. Over the past two decades many sites have been suggested and most are unsatisfactory because they have unrealistic development requirements, because their locations are unsuitable for such an esteemed building, or they lacked an appropriate Army setting. Since 1983, the process of choosing a site for the Army Museum has been a long cumbersome undertaking. A site selection committee was organized and it developed

a list of 17 criteria which any candidate site is required to possess before it was to be selected as home to the Army Museum. Among other requirements, these criteria required such things as: an area permitting movement of large military vehicles for exhibits and tractor trailer trucks for shipments, commanding and aesthetically pleasing vistas, positive impact on environment, closeness to public transportation, closeness to a Washington Tourmobile route, convenience to Fort Myer for support by the 3rd Infantry, The Old Guard, accessibility by private automobile, adequate parking for 150 staff and official visitors, adequate parking for a portion of the 1,000,000 visitors per year that do not use public transportation, food service for staff and visitors, area low in crime and safe for staff and visitors, suitable space, 300,000 square feet, for construction, a low water table, good drainage and no history of flooding and suitability for subterranean construction.

Since 1984, more than 60 sites have been studied, yet only a handful has been worthy of any serious consideration.

The most prominent recent site suggestions have included Carlisle, Pennsylvania; Gettysburg, Pennsylvania; the Washington Navy Yard; and Fort Belvoir, Virginia. Of these sites, most clearly have characteristics which are directly contrary to the established criteria for site selection. The extraordinary distance of Carlisle from Washington speaks for itself. The suggestion that the Army locate its museum in Washington's Navy Yard is also directly contrary to prerequisites for site selection. The Washington Navy Yard is situated in a dangerous and difficult-to-get-to part of Washington, on the Anacostia River and on a precarious 50-year flood plain. Because this area floods so often, a ''Washington Navy Yard Army Museum'', let me pause to repeat this awkward location a ''Washington Navy Yard Army Museum'', might well suffer the embarrassment of being closed ''due to flooding.'' This would not be the way America should honor Army history. The Navy Yard over the years has become less military in character and a patchwork home to various government offices. To locate the Army Museum in an old Navy yard, which is sometimes under water, would send a clear signal to visitors that choosing a home to their history was nothing more than an afterthought.

In 1991, the Deputy Secretary of Defense directed that the site searches include the Mount Vernon Corridor as a possible location for the Army Museum. Fort Belvoir quickly became a very attractive location. Fort Belvoir offers a 48-acre site, only 5 minutes from Interstate 95, which is traveled by over 300 million vehicles annually, it is 3 minutes from the Fairfax County parkway, and is served by Metro Bus, the Fort Belvoir site fronts on US Route 1, Richmond Highway and is next to the main gate of Fort Belvoir.

The Fort Belvoir site is also a winner historically. It is on a portion of General George Washington's properties when he was Commander in Chief of the Continental Army. It is located on the historical heritage trail of the Mount Vernon Estate, The Grist Mill, Woodlawn Plantation, Pohick Church, and Gunston Hall. Situating the Army Museum at Fort Belvoir is a natural tie to a long established military and historic installation that has already been approved by the National Capitol Planning Commission to be used for community activities, which includes museums, as a part of the Fort Belvoir Master Plan. The Fort Belvoir site meets all 17 criterions originally established by the Army.

The bill I am introducing today names Fort Belvoir as the site for the Army Museum. Fort Belvoir is the best location in the Washington area to host an Army museum. Army veterans want to remember and show their contribution to history in an Army setting and culture in which they themselves once served. Fort Belvoir is the perfect place to do this and it qualifies on every criterion established in 1983 by the Army's Site Selection Committee. For Belvoir is Army and should host Army history. Therefore, I ask that my colleagues support this bill and bring the 18-year search for a home for the Army Museum to a close by selecting a worthy home for one of this Nation's greatest institutions.

Thomas Jefferson wrote to John Adams in 1817, ''A morsel of genuine history is a thing so rare as to be always valuable.'' I am pleased to see that the National U.S. Army Museum is a task for this Congress at the beginning of a new century, at a time when all Americans are proud of their Nation's accomplishments and those who made it all possible. I am absolutely concerned that all our veterans are honored, and honored honorably. Every year Army veterans bring their families to Washington and are disappointed that no museum exists as a tribute to their service and sacrifice. Time is running out for many Army veterans, especially those of World War II. I urge my colleagues to review this important piece of legislation and support its passage. Mr. President, I ask unanimous consent that the text of this bill and the site selection criteria be printed in the RECORD.

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

S. 571

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''National Museum of the United States Army Site Act of 2001''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress makes the following findings:

(1) The Nation does not have adequate knowledge of the role of the Army in the development and protection of the United States.

(2) The Army, the oldest United States military service, lacks a primary museum with public exhibition space and is in dire need of a permanent facility to house and display its historical artifacts.

(3) Such a museum would serve to enhance the preservation, study, and interpretation of Army historical artifacts.

(4) Many Army artifacts of historical significance and national interest which are currently unavailable for public display would be exhibited in such a museum.

(5) While the Smithsonian Institution would be able to assist the Army in developing programs of presentations relating to the mission, values, and heritage of the Army, such a museum would be a more appropriate institution for such programs.

(b) PURPOSES.—The purposes of this Act are—

(1) to provide for a permanent site for a museum to serve as the National Museum of the United States Army;

(2) to ensure the preservation, maintenance, and interpretation of the artifacts and history collected by such museum;

(3) to enhance the knowledge of the American people of the role of the Army in United States history; and

(4) to provide a facility for the public display of the artifacts and history of the Army.

SEC. 3. LOCATION OF THE NATIONAL MUSEUM OF THE UNITED STATES ARMY.

The Secretary of the Army shall provide for the location of the National Museum of the United States Army at Fort Belvoir, Virginia.

ARMY'S NMUSA SITE SELECTION CRITERIA

1. Site large enough for building of 300,000 square feet.
2. Suitable soil and other physical properties.
3. Low water table, good drainage, no history of flooding and suitable for subterranean construction, if necessary.
4. Topography of site permits building design to include north light for labs and graphics branch.
5. Area will permit movement of large military vehicles for exhibits and tractor trailer trucks for shipments.
6. Commanding and aesthetically pleasing vistas.
7. Positive impact on environment.
8. Close to public transportation.
9. Close to Tourmobile route.
10. Convenient to National Archives and Library of Congress for staff use.
11. Convenience to the Pentagon for staff coordination.
12. Close enough to Fort Myer for support by the 3d Infantry, The Old Guard.
13. Accessible by private automobile.
14. Adequate parking for 150 staff and official visitors or space for same.
15. Adequate parking for a portion of the 1,000,000 visitors per year that do not use public transportation or space for same.
16. Food service for staff and visitors, if not provided in new building.
17. Area low in crime and safe for staff and visitors.

By Mrs. FEINSTEIN (for herself, Mr. CHAFEE, Mr. DURBIN, Mr. REED, Mrs. MURRAY, and Mrs. BOXER):

S. 573. A bill to amend title XIX of the Social Security Act to allow children enrolled in the State children's health insurance program to be eligible for benefits under the pediatric vaccine distribution program; to the Committee on Finance.

Mrs. FEINSTEIN. Mr. President, I rise today with my colleagues Senators CHAFEE, DURBIN, REED, MURRAY, and BOXER to introduce a bill to clarify that children receiving health insurance under the State Children's Health Insurance Program, SCHIP, in States like California are eligible for free vaccines under the federal Vaccines for Children, VFC, program.

Providing low-income children with access to immunizations is a high priority of mine. I believe that we must work to ensure that our nation's youngsters begin life protected against the diseases for which there are vaccinations available.

The Centers for Disease Control, CDC, estimates that in many areas of the U.S. immunization rates continue to fall below 75 percent among children under 2 years old. This is unacceptable.

In 1993, the U.S. experienced the largest outbreak of whooping cough in over 20 years. Additionally, from 1989 to 1991, a measles outbreak resulted in 123 deaths and 55,000 cases. These are diseases for which vaccinations are available.

While we are doing a better job of educating families about the importance of receiving timely immunizations, we must now focus our efforts on ensuring access to immunizations for those most in need.

The federal Vaccines for Children program, created by Congress in 1993, P.L. 105–33, is an excellent example of a program that provides vaccines at no cost to low-income children.

To be eligible for the VFC program under current federal law, a child must be a Medicaid recipient, uninsured, or of American Indian or Alaskan Native heritage.

The U.S. Department of Health and Human Services, HHS, argues that a child participating in SCHIP, called Healthy Families in California, is not eligible for the free immunizations provided by the VFC program because that child is ''insured.''

I believe the interpretation of ''insured'' is not consistent with Congress's intent in establishing SCHIP. I believe that in defining the term ''insured'' at that time Congress clearly meant private health insurance plans.

Children enrolled in SCHIP, or in my State the Healthy Families program, are participating in a federal-state, subsidized insurance plan. Healthy Families is a state-operated program. Families apply to the State for participation. They are not insured by a private, commercial plan, as traditionally defined or as defined in the Vaccine for Children's law (42 U.S.C. sec. 1396s(b)(2)(B).

Several California based provider groups agree. For example, in February 1999 the California Medical Association wrote to then-HHS Secretary Donna Shalala: ''As they are participants in a federal and state-subsidized health program, these individuals are not ''insured'' for the purposes of 42 U.S.C. sec. 1396s(b)(B).''

HHS has interpreted the law so narrowly that as many as 630,000 children in California under California's Healthy Families program have lost or will lose their eligibility to receive free vaccines. Approximately 428,641 kids have lost eligibility to date.

The VFC program is particularly important to California in ensuring access to life-saving immunizations for two reasons.

First, California ranks 40th overall among states having children fully immunized by the age of 19 to 35 months. In 1996, however, California ranked 32nd. Clearly the situation in California is getting worse rather than better. Allowing SCHIP children to access immunizations through the VFC program could increase the number of children receiving vaccinations in the State.

Second, in creating SCHIP in California, the State chose to set up a program under which the State contracts with private insurers, rather than providing eligible children care through Medicaid, Medi-Cal in California.

The California Managed Risk Medical Insurance Board, which is administering the new program with the Department of Health Services, wrote to HHS in February 1999: ''It is imperative that states like California, who have implemented SCHIP using private health insurance, be given the same support and eligibility for the Vaccines for Children, VFC, program at no cost as States which have chosen to expand their Medicaid program.''

A study conducted by the California Medical Association found that pediatric capitation rates for children ages 0–21 averages $24.24 per child per month. However, a 1998 Towers Perrin Study of physician costs for children ages 0–21 years found averages to be $47.00 per child per month. These numbers demonstrate the discrepancy between payment and costs for children enrolled in a capitation plan, which includes all children enrolled in California's Healthy Families program.

Add to this discrepancy in payments the fact that children need 18 to 22 immunizations before the age of 6. This process becomes quite costly!

The discrepancy in payment and costs means that many California physicians cannot afford to provide patients with the necessary life-saving immunizations, so children in my State are often going without vaccinations.

This reality has caused serious problems for children in California.

For example: From 1993 to 1997, Orange County California had 85 hospitalizations and four deaths related to chicken pox. Across the State in 1996 there were 15 deaths and 1,172 hospitalizations related to chicken pox. The Immunization Branch in California reported over 1,000 whooping cough cases, including 5 deaths, in 1998—the largest number of cases and deaths since the 1960s.

Whooping cough and chicken pox are two examples of diseases for which there are vaccinations available.

We must do more to increase access to vaccinations for our nation's children.

In 1998, as many 743,000 poor children in California, who were uninsured or on Medicaid, received these vaccines. This number is down by approximately 32,000 children in comparison to the 1997 immunization figures for California's poor children.

What can be so basic to public health than immunization against disease? Do we really want our children to get polio, measles, mumps, chicken pox, rubella, and whooping cough, diseases for which we have effective vaccines, diseases which we have practically eradicated by widespread immunization?

Congress recognized the importance of immunizations in creating the VFC program, with many Congressional leaders at the time arguing that childhood immunization is one of the most cost-effective steps we can take to keep our children healthy.

It makes no sense to me to withhold immunizations from children who 1. have been getting them when they were uninsured and 2. have no other way to get them once they become insured.

According to an Annie E. Casey Foundation report, 22 percent of California's two-year olds are not immunized. Add to that the fact that we have one of the highest uninsured rates in the country.

Over 28 percent of California's children are without health insurance, compared to 25 percent nationally, according to the Annie E. Case Foundation. Clearly, there is a need.

The San Francisco Chronicle editorialized on March 10, 1998: ''More than half a million California children should not be deprived of vaccinations or health insurance because of a technicality . . .,'' calling the denial of vaccines ''a game of semantics.''

Children's health should not be a ''game of semantics.'' Proper childhood immunizations are fundamental to a lifetime of good health. I urge my colleagues to join me in supporting this legislation, to help me keep our children healthy.

By Mrs. FEINSTEIN:

S. 574. A bill to amend titles XIX and XXI of the Social Security Act to allow States to provide health benefits coverage for parents of children eligible for child health assistance under the State children's health insurance program, to the Committee on Finance.

Mrs. FEINSTEIN. Mr. President. Today, I am introducing legislation to allow States, at their option, to enroll parents in the State Children's Health Insurance Program, known as S- CHIP.

This bill could provide insurance to 2.7 million uninsured parents nationwide and 356,000 parents in California at a time when the uninsured rate in

the country and in California continues to rise.

Congress has appropriated a total of $17.2 billion for SCHIP for Fiscal Years 1998, 1999, and 2000, or about $4.3 billion for each Fiscal Year.

SCHIP is a low-cost health insurance program for low-income children up to age 19 that Congress created in the Balanced Budget Act of 1997. After three years, SCHIP covers approximately two million children across the country, out of the three to four million children estimated to be eligible.

Congress created SCHIP as a way to provide affordable health insurance to uninsured children in families that cannot afford to buy private insurance. States can choose from three options when designing their SCHIP program: 1. expansion of their current Medicaid program; 2. creation of a separate State insurance program; or 3. a combination of both approaches.

California's SCHIP is known as the Healthy Families program and is set up as a public-private program rather than a Medicaid expansion. Healthy Families allows California families to use federal and State SCHIP funds to purchase private managed care insurance for their children.

Under the federal law, States generally cover children in families with incomes up to 200 percent of poverty, although States can go higher if their Medicaid eligibility was higher than that when SCHIP was enacted in 1997 or through waivers by the Department of Health and Human Services. In California, eligibility was raised to 250 percent of poverty in November 1999, which increased the number of eligible children by 129,000.

Basic benefits in the California SCHIP program include inpatient and outpatient hospital services, surgical and medical services, lab and x-ray services, and well-baby and well-child care, including immunizations. Additional services which States are encouraged to provide, and which California has elected to include, are prescription drugs and mental health, vision, hearing, dental, and preventive care services such as prenatal care and routine physical examinations.

In California, enrollees pay a $5.00 copayment per visit which generally applies to inpatient services, selected outpatient services, and various other health care services.

The United States faces a serious health care crisis that continues to grow as more and more people go without insurance. The U.S. has seen an increase in the uninsured by nearly five million since 1994.

Currently, 42 million people, or 17 percent, of the non- elderly population in the country are uninsured. In California, 22 percent, or 6.8 million, of the nonelderly are uninsured.

A study cited in the May 2000 California Journal found that as many as 2,333 Californians lose health insurance every day. A May 29, 2000 San Jose Mercury article cited California's emergency room doctors who ''estimate that anywhere from 20 percent to 40 percent of their walk-in patients have no health coverage.''

Among the 1.85 million uninsured children in California, nearly two-thirds or 1.3 million are eligible for Medicaid or SCHIP, called Healthy Families in the state, according to the University of California at Los Angeles.

Last year, we passed legislation enabling California to keep approximately $350 million of the $600 million unspent SCHIP funds. My state and others were at risk of losing funds because the law required states to use all their funds in three years and time was running out on the 1998 funds. Since my state and others still have these funds, as well as funds allotted in fiscal years 1999, 2000 and 2001, enrolling parents and more children could be a good way to increase enrollment.

The bill we are introducing today would gives States the option to expand SCHIP coverage to parents whose children are eligible for the program at whatever income eligibility level the state sets. In my State, that would mean a family of four earning up to $42,625 would be eligible for coverage.

This bill would retain current funding formulas, State allotments, benefits, eligibility rules, and cost-sharing requirements. The only change is to allow States the option to enroll parents.

An SCHIP expansion should be accomplished without substituting SCHIP coverage for private insurance or other public health insurance that parents might already have. The current SCHIP law requires that State plans include adequate provisions preventing substitution and my bill retains that. For example, many States require that an enrollee be uninsured before he or she is eligible for the program. This bill does not change that requirement.

This bill is important for several reasons. More than 75 percent of uninsured children live with parents who are uninsured. Many experts say that by covering parents of uninsured children we can actually cover more children.

If an entire family is enrolled in a plan and seeing the same doctors, in other words, if the care is convenient for the whole family, all the members of the family are more likely to be insured and to stay healthy. This is a key reason for this legislation, bringing in more children by targeting the whole family.

Private health insurance in the commercial market can be very expensive. The average annual cost of family coverage in private health plans is around $6,000. California has some of the lowest-priced health insurance, yet the State ranks fourth in uninsured.

In California, high housing costs, high gas and electricity prices, expensive commutes, and a high cost-of-living make it difficult for many California families to buy health insurance. Over eight in ten of uninsured Californians are working, but they do not earn enough to buy private insurance. SCHIP is a practical and attractive alternative.

Many low-income people work for employers who do not offer health insurance. In fact, forty percent of California small businesses, those employing between three and 50 employees, do not offer health insurance, according to a Kaiser Family Foundation study in June 2000. Californians in 1999 were 6.6 percentage points less likely to receive health insurance through employers than the average American, 62.8 percent versus 69.4 percent, according to UCLA experts.

We need to give hard-working, lower income American families affordable, comprehensive health insurance, and this bill does that.

The California Medical Association and Alliance of Catholic Health Care agree with us and support this legislation.

I urge my colleagues to join me in supporting and passing this bill. By giving States the option to cover parents—whole families—we can reduce the number of uninsured, encourage the enrollment of more children, and help keep people healthy by maximizing this valuable, but currently under-utilized program.

By Mrs. FEINSTEIN (for herself and Ms. SNOWE).

S. 575. A bill entitled the ''Hospital Length of Stay Act of 2001'', to the Committee on Health, Education, Labor, and Pensions.

Mrs. FEINSTEIN. Mr. President, today, Senator OLYMPIA SNOWE and I are introducing a bill to guarantee that the decision of how long a patient stays in the hospital is left to the attending physician. Our legislation would require health insurance plans to cover the length of hospital stay for any procedure or illness as determined by the physician to be medically appropriate, in consultation with the patient.

The bill is endorsed by the American Medical Association, the American College of Surgeons, the American College of Obstetricians and Gynecologists, and the American Psychological Association.

We are introducing this bill because many people, patients and physicians, have told us that HMOs set limits on hospital stays that are shorter than what the attending physicians believe are medically necessary. In my view, only the physician who is taking care of the patient understands the patient's full medical history and the patient's medical condition and needs. Every patient's condition and course of illness varies. Patients respond differently to treatments. Complications arise. The doctor should decide when patients are medically ready to be discharged, not an insurance plan.

The American Medical Association has developed patient-based discharge criteria which say: ''Patients should not be discharged from the hospital

when their disease or symptoms cannot be adequately treated or monitored in the discharge setting.''

A number of physicians have shared with me their great frustration with the health care climate, in which they feel they spend too much of time trying to get permission and justify their decisions on medical necessity to insurance companies.

A California pediatrician told me of a child with very bad asthma. The insurance plan authorized 3 days in the hospital; the doctor wanted 4–5 days. He told me about a baby with infant botulism (poisoning), a baby with a toxin that had spread from the intestine to the nervous system so that the child could not breathe. The doctor thought a 10–14 day hospital stay was medically necessary for the baby; the insurance plan insisted on one week.

A California neurologist told my staff about a seven-year-old girl with an ear infection and a fever who went to the doctor. When her illness developed into pneumonia, she was admitted to the hospital. After two days she was sent home, but she then returned to the hospital three times because her insurance plan only covered a certain number of days. The third time she returned she had meningitis, which can be life threatening. The doctor said that if this girl had stayed in the hospital the first time for five to seven days, the antibiotics would have killed the infection and the meningitis would never have developed.

Another California physician told my office about a patient who needed total hip replacement because her hip had failed. The doctor believed a seven-day stay was warranted; the plan would only authorize five.

A Chico, California, maternity ward nurse put it this way: ''People's treatment depends on the type of insurance they have rather than what's best for them.'' A Laguna Niguel, California woman, Gwen Placko, wrote this to me: ''. . . doctors have become mere employees of for-profit insurance companies. They are no longer captains of their own 'ships' so to speak. . . Only doctors should be the ones to make decisions for the direct treatment and benefit of their patients.''

Physicians say they have to wage a battle with insurance companies to give patients the hospital care they need and to justify their decisions about patient care.

A study by the American Academy of Neurology found that the Milliman and Robertson guidelines used by many insurance companies on length of stay are ''extraordinarily short in comparison to a large National Library of Medicine database . .. And that [the guidelines] do not relate to anything resembling the average hospital patient or attending physician. . . .'' The neurologists found that these guidelines were ''statistically developed'' and not scientifically sound or clinically relevant.

The arbitrary limits HMOs and insurance plans have set are resulting in unintended consequences. Some 7 in 10 physicians said that in dealing with managed care plans, they have exaggerated the severity of a patient's condition to ''prevent him or her from being sent home from a hospital prematurely.''

The American College of Surgeons said it all when this prestigious organization wrote: ''We believe very strongly that any health care system or plan that removes the surgeon and the patient from the medical decision-making process only undermines the quality of that patient's care and his or her health and well being. . . . specifically, single numbers [of days] cannot and should not be used to represent a length of stay for a given procedure'', April 24, 1997. ACS wrote, ''We believe very strongly that any health care system or plan that removes the surgeon and the patient from the medical decision making process only undermines the quality of that patient's care and his or her health and well being.''

The American Medical Association wrote, ''We are gratified that this bill would promote the fundamental concept, which the AMA has always endorsed, that medical decisions should be made by patients and their physicians, rather than by insurers or legislators. . . We appreciate your initiative and ongoing efforts to protect patients by ensuring that physicians may identify medically appropriate lengths of stay, unfettered by third party payers.''

The American Psychological Association wrote me, ''We are pleased to support this legislation, which will require all health plans to follow the best judgment of the patient and attending provider when determining length of stay for inpatient treatment.''

Americans are disenchanted with the health insurance system in this country, as HMO hassles never seem to end and physicians are effectively overruled by insurance companies. Doctors and patients feel that patient care is compromised in a climate in which anonymous insurance clerks interfere with medical decision- making.

This bill is one step toward returning medical decision- making to those medical professionals trained to make medical decisions.

To summarize, the Hospital Length of Stay Act of 2001:

Requires plans to cover hospital lengths of stay for all illnesses and conditions as determined by the physician, in consultation with the patient, to be medically appropriate;

Prohibits plans from requiring providers (physicians) to obtain a plan's prior authorization for a hospital length of stay;

Prohibits plans from denying eligibility or renewal for the purpose of avoiding these requirements;

Prohibits plans from penalizing or otherwise reducing or limiting reimbursement of the attending physician because the physician provided care in accordance with the requirements of the bill; and

Prohibits plans from providing monetary or other incentives to induce a physician to provide care inconsistent with these requirements.

It includes language clarifying that: nothing in the bill requires individuals to stay in the hospital for a fixed period of time for any procedure; plans may require copayments but copayments for a hospital stay determined by the physician cannot exceed copayments for any preceding portion of the stay.

It does not pre-empt state laws that provide greater protection.

It applies to private insurance plans, Medicare, Medicaid, Medigap, federal employees' plans, Children's Health Insurance Plan, the Indian Health Service.

By Mrs. FEINSTEIN:

S. 576. A bill to require health insurance coverage for certain reconstructive surgery; to the Committee on Health, Education, Labor, and Pensions.

Mrs. FEINSTEIN. Mr. President, today, I am introducing a bill to require health insurance plans to cover medically necessary reconstructive surgery for congenital defects, developmental abnormalities, trauma, infection, tumors, or disease.

This bill is modeled on a California law and responds to reports that insurance plans are denying coverage for reconstructive surgery that doctors say is medically necessary. Too many plans are too quick to label it ''cosmetic surgery.'' The American Medical News has called the HMOs stance, ''a classic health plan word game. . . .''

Dr. Henry Kawamoto, testifying before the California Assembly Committee on Insurance stated:

> It used to be that if you were born with something deforming, or were in an accident and had bad scars, the surgery performed to fix the problem was considered reconstructive surgery. Now, insurers of many kinds are calling it cosmetic surgery and refusing to pay for it.

Many doctors have told me that before the heavy penetration of managed care, repairing a person's abnormalities was considered reconstructive surgery and insurance companies reimbursed for the medical, hospital, and surgical costs. But today, many insurance companies and managed care organizations will not pay for reconstruction of many deformities because they deem them to be ''cosmetic'' and not a ''functional'' repair.

This bill is endorsed by the March of Dimes, Easter Seals, the American Academy of Pediatrics, the National Organization for Rare Disorders, the American College of Surgeons, the American Society of Plastic and Reconstructive Surgeons, the American Association of Pediatric Plastic Surgeons and the American Society of Maxillofacial Surgeons.

The children who face refusals to pay for surgery are the true evidence that this bill is needed. Here are some of the examples that were brought to the California legislature:

Hanna Gremp, a 6-year old from California, was born with a congenital birth defect, called bilateral microtia, the absence of an inner ear. Once the first stage of the surgery was complete, the Gremp's HMO denied the next surgery for Hanna. They called the other surgeries ''cosmetic'' and not medically necessary.

Michael Hatfield, a 19-year old from Texas, has gone through similar struggles. He was born with a congenital birth defect that is known as a midline facial cleft. The self-insured plan his parents had only paid for a small portion of the surgery which reconstructed his nose. The HMO also refused to pay any part of the surgery that reconstructed his cheekbones and eye sockets. The HMO considered some of these surgeries to be ''cosmetic.''

Cigna Health Care denied coverage for surgery to construct an ear for a little California girl born without one and only after adverse press coverage reversed its position saying that, ''It was determined that studies have shown some functional improvement following surgery.''

Qual-Med, another California HMO, initially denied coverage for reconstructive surgery for a little boy who also had microtia, authorizing it only after many appeals and two years delay.

The bill uses medically-recognized terms to distinguish between medically necessary surgery and cosmetic surgery. It defines medically necessary reconstructive surgery as surgery ''performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to (1) improve functions; or (2) give the patient a normal appearance, to the extent possible, in the judgment of the physician performing the surgery.'' The bill specifically excludes cosmetic surgery, defined as ''surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.''

Examples of conditions for which surgery might be medically necessary are the following: cleft lips and palates, burns, skull deformities, benign tumors, vascular lesions, missing pectoral muscles that cause chest deformities, Crouson's syndrome (failure of the mid-face to develop normally), and injuries from accidents.

This bill is an effort to address the arbitrariness of insurance plans that create hassles and question physicians' judgments when people try to get coverage under the plan they pay premiums for every month.

We need our body parts to function and, fortunately, modern medicine today can often make that happen. We can restore, repair, and make whole parts which by fate, accident, genes, or whatever, do not perform as they should. I hope this bill can make that happen.

By Mrs. FEINSTEIN:

S. 577. A bill to limit the administrative expenses and profits of managed care entities to not more than 15 percent of premium revenues; to the Committee on Health, Education, Labor, and Pensions.

Mrs. FEINSTEIN. Mr. President, today, I am introducing the Health Benefits Integrity Act to make sure that most health care dollars that people and employers pay into a managed care health insurance plan get spent on health care and not on overhead.

Under my bill, managed care plans would be limited to spending 15 percent of their premium revenues on administration. This means that if they spend 15 percent on administration, they could spend 85 percent of premiums revenues on health care benefits or services.

This bill was prompted by a study by the Inspector General (IG) for the U.S. Department of Health and Human Services reported under a USA Today headline in February, ''Medicare HMOs Hit for Lavish Spending.'' The IG reviewed 232 managed care plans that contract with Medicare and found that in 1999 the average amount allocated for administration ranged from a high of 32 percent to a low of three percent. The IG recommended that the Department establish a ceiling on the amount of administrative expenditures of plans, noting that if a 15 percent ceiling had been place in 1998, an additional $1 billion could have been passed on to Medicare beneficiaries in the form of additional benefits or reduce deductibles and copayments.

The report said, ''This review, similar OIG reviews, and other studies have shown that MCOs' [managed care organizations'] exorbitant administrative costs have been problematic and can be the source for abusive behavior.'' Here are some examples cited by the Inspector General on page 7 of the January 18, 2000 report: $249,283 for food, gifts and alcoholic beverages for meetings by one plan; $190,417 for a sales award meeting in Puerto Rico for one plan; $157,688 for a party by one plan; $25,057 for a luxury box at a sports arena by one plan; $106,490 for sporting events and/or theater tickets at four plans; $69,700 for holiday parties at three plans; $37,303 for wine gift baskets, flowers, gifts and gift certificates at one plan.

It is no wonder that people today are angry at HMOs. When our hard-earned premium dollars are frittered away on purchases like these, we have to ask whether HMOs are really providing the best care possible. Furthermore, in the case of Medicare, we are also talking about wasted taxpayer dollars since Part B of Medicare is funded in part by the general treasury. One dollar wasted in Medicare is one dollar too much. Medicare needs all the funds it can muster to stay solvent and to be there for beneficiaries when they need it.

I was also encouraged to introduce the bill because of annual studies prepared by the California Medical Association, CMA, called the ''Knox-Keene Health Plan Expenditures Summary.'' The March 2001 CMA report covering Fiscal Years 1999 to 2000 found a range of administrative expenditures from plans in my state from a low of 2.7 percent, Kaiser Foundation Health Plan, Southern California, to a high of 22.1 percent, OMNI Healthcare, Inc.

If HMOs are to be credible, they must be more prudent in how they spend enrollees' dollars. Administrative expenses must be limited to reasonable expenses.

An October 1999 report by Interstudy found that for private HMO plans, administrative expenses range from 11 percent to 21 percent and that for-profit HMOs spend proportionately more on administrative cost than not-for-profit HMOs. This study found the lowest rate to be 3.6 percent and the highest 38 percent in California! In some states the maximums were even higher.

The shift from fee-for-service to managed care as a form of health insurance has been rapid in recent years. Nationally, 86 percent of people who have employment-based health insurance (81.3 million Americans) are in some form of managed care. Around 16 percent of Medicare beneficiaries are in managed care nationally (40 percent in California), a figure that doubled between 1994 and 1997. By 2010, the Congressional Budget Office predicts that 31 percent of Medicare beneficiaries will be in managed care. Between 1987 and 1999, the number of health plans contracting with Medicare went from 161 to 299. As for Medicaid, in 1993, 4.8 million people (14 percent of Medicaid beneficiaries) were in managed care. Today, 17.8 million (55.6 percent) are in managed care, according to the Kaiser Family Foundation. In California, 52 percent or 2.6 million out of 5 million Medicaid beneficiaries are in managed care.

In California, the state which pioneered managed care for the nation, an estimated 88 percent of the insured are in some form of managed care. Of the 3.7 million Californians who are in Medicare, 40 percent, 1.4 million, are in managed care, the highest rate in the U.S. As for Medicaid in California, 2.5 million people, 50 percent, of beneficiaries are in managed care.

And so managed care is growing and most people think it is here to stay.

I am pleased to say that in California we already have a regulation along the lines of the bill I am proposing. We have in place a regulatory limit of 15 percent on commercial HMO plans' administrative expenses. This was established in my state for commercial plans because of questionable expenses like those the HHS IG found in Medicare HMO plans and because prior to the regulation, some plans had administrative expense as high as 30 percent of premium revenues.

This bill will never begin to address all the problems patients experience with managed care in this country.

That is why we also need a strong Patients Bill of Rights bill. I hope, however, this bill will discourage abuses like those the HHS Inspector General found and will help assure people that their health care dollars are spent on health care and are not wasted on outings, parties, and other activities totally unrelated to providing health care services.

I call on my colleagues to join me in enacting this bill.

By Mr. DORGAN:

S. 578. A bill to prohibit the Secretary of Transportation from amending or otherwise modifying the operating certificates of major air carriers in connection with a merger or acquisition for a period of 2 years, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Mr. DORGAN. Mr. President, I am very concerned about the current state of affairs in our nation's airline industry. The way airlines have remade themselves since deregulation is very troubling to me and should be very troubling to most of the traveling public in this country.

Since deregulation we have seen an unprecedented number of mergers in the airline industry. What used to be 11 airlines is now 7, and now with United wanting to buy US Airways, and American wanting to buy TWA out of bankruptcy, there is a very high risk that we will quickly be reduced to three mega-carriers in this country. I am afraid of what this will mean to competition which is already almost nonexistent in so many parts of the country.

That is because the major carriers have spent the last 20 years retreating into regional hubs, such as Minneapolis, Denver, and Atlanta, where one airline will control 50 percent, 70 percent, 80 percent of the hub traffic. The result has been that a dominant airline controlling the hub traffic sets its own prices, and it is the people in sparsely populated areas in the country that end up paying for it with outrageously high prices.

These proposed mergers fly directly in the face of public interest and ought not to be allowed. We need more than three airlines. Increased consolidation would be moving in the wrong direction. We need more competition, not more concentration.

That is why I am introducing legislation today to place a moratorium on airline mergers above a certain size for a couple years so we can take a breath and evaluate what kind of air transportation system we want in this country.

I hope my colleagues will join me in expressing loudly that we must avoid having this country go to three major airline carriers. It would be a step backward, not forward.

By Mr. BIDEN:

S. 579. A bill to amend the Mutual Educational and Cultural Exchange Act of 1961 to authorize the Secretary of State to provide for the establishment of nonprofit entities for the Department of State's international educational, cultural, and arts programs; to the Committee on Foreign Relations.

Mr. BIDEN. Mr. President, today I am reintroducing legislation to authorize the establishment of nonprofit entities to provide grants and other assistance for international educational, cultural and arts programs through the Department of State. This is an initiative that was developed last year in discussions with officials of the Department of State. I am pleased to be joined by Representative JIM LEACH of the other body, who is introducing the same bill today.

We are in an era in which cultural issues are increasingly central to international issues and diplomacy. Trade disputes, ethnic and regional conflicts, and issues such as biotechnology all have cultural and intellectual underpinnings.

Cultural programs are increasingly necessary to promoting international understanding and achieving U.S. national objectives. American multinational companies and other Americans doing business overseas welcome opportunities to support the unique cultures of nations in which they do business, as well as telling the story of America's diversity in other countries.

One way they could do this is by helping to sponsor cultural exchange programs arranged through the Department of State. Department officials tells us, however, that there is apparently no easy way to do that. Moreover, many people in our own government are uncertain whether they should engage in presenting the creative, intellectual and cultural side of our nation.

Under this legislation Congress would authorize the Secretary of State to provide for the establishment of private nonprofit organizations to assist in supporting international cultural programs, making it both easy and attractive for private organizations to support cultural programs in cooperation with the Department of State. In so doing, we would affirm support for the promotion and presentation of the nation's intellectual and creative best as part of American diplomacy.

This initiative would support a broad range of cultural exchange programs. Its priority would be to support the organization and promotion of major, high-profile presentations of art exhibitions, musical and theatrical performances which represent the finest quality of creativity our nation produces. These should be presentations that reach large numbers of people, which contribute to achieving our national interests and which represent the diversity of American culture.

The bill would provide authority to solicit support for specific cultural endeavors, offering individuals, foundations, corporations and other American businesses engaged overseas the opportunity to publicly support cross-cultural understanding in countries where they do business.

The non-profit entity would work with the Bureau of Educational and Cultural Affairs as well as the Under Secretary for Public Diplomacy at the Department of State.

I understand that the House International Relations Committee is planning to consider a version of this bill later this week. I look forward to working with my colleagues in the Senate on this legislation in the coming weeks.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 579

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

SECTION 1. FINDINGS.

The Congress makes the following findings:

(1) It is in the national interest of the United States to promote mutual understanding between the people of the United States and other nations.

(2) Among the means to be used in achieving this objective are a wide range of international educational and cultural exchange programs, including the J. William Fulbright Educational Exchange Program and the International Visitors Program.

(3) Cultural diplomacy, especially the presentation abroad of the finest of the creative, visual, and performing arts of the United States, is an especially effective means of advancing the United States national interest.

(4) The financial support available for international cultural and scholarly exchanges has declined by approximately 10 percent in recent years.

(5) There has been a dramatic decline in the amount of funds available for the purpose of ensuring that the excellence, diversity, and vitality of the arts in the United States are presented to foreign audiences by and in cooperation with United States diplomatic and consular representatives.

(6) One of the ways to deepen and expand cultural and educational exchange programs is through the establishment of nonprofit entities to encourage the participation and financial support of multinational companies and other private sector contributors.

(7) The United States private sector should be encouraged to cooperate closely with the Secretary of State and the Secretary's representatives to expand and spread appreciation of United States cultural and artistic accomplishments.

SEC. 2. AUTHORITY TO ESTABLISH NONPROFIT ENTITIES.

Section 105(f) of the Mutual Educational and Cultural Exchange Act of 1961 (22 U.S.C. 2455(f)) is further amended—

(1) by inserting ''(1)'' after ''(f)''; and

(2) by adding at the end the following new paragraphs:

''(2) The Secretary of State is authorized to provide for the establishment of private, nonprofit entities to assist in carrying out the purposes of the Act. Any such entity shall not be considered an agency or instrumentality of the United States Government, nor shall its employees be considered employees of the United States Government for any purposes.

''(3) The entities may, among other functions—

''(A) encourage United States multinational companies and other elements of the private sector to participate in, and support, cultural, arts, and educational exchange programs, including those programs that will enhance international appreciation of the cultural and artistic accomplishments of the United States;

''(B) solicit and receive contributions from the private sector to support these cultural arts and educational exchange programs; and

''(C) provide grants and other assistance for these programs.

''(4) The Secretary of State is authorized to make such arrangements as are necessary to carry out the purposes of these entities, including—

''(A) the solicitation and receipt of funds for the entity;

''(B) designation of a program in recognition of such contributions; and

''(C) designation of members, including employees of the United States Government, on any board or other body established to administer the entity.

''(5) Any funds available to the Department of State may be made available to such entities to cover administrative and other costs for their establishment. Any such entity is authorized to invest any amount provided to it by the Department of State, and such amount, as well as any interest or earnings on such amount, may be used by the entity to carry out its purposes.''.

By Mr. HUTCHINSON:

S. 580. A bill to expedite the construction of the World War II memorial in the District of Columbia; to the Committee on Governmental Affairs.

Mr. HUTCHINSON. Mr. President, I rise today to introduce legislation that would expedite construction of the World War II Memorial. Some of our colleagues may not be aware that even after having had the opportunity to argue their case before the twenty-two public hearings over the last five years regarding the site and design of the memorial, opponents have now turned to the courts to overturn the Memorial's approval.

Regrettably, it is now clear that legislation will be needed if the World War II Memorial is to be constructed before all the patriots who fought in defense of liberty have passed on. The ugly truth is that every day we lose more than a thousand members of our greatest generation. How many more will be deprived of the joy of seeing this richly deserved tribute to their heroic service completed?

According to the American Battle Monuments Commission, the World War II Memorial will be the first national memorial dedicated to all who served in the armed forces and Merchant Marine of the United States during World War II and acknowledging the commitment and achievement of the entire nation. All military veterans of the war, the citizens of the home front, the nation at large, and the high moral purpose and idealism that motivated the nation's call to arms will be honored.

Symbolic of the defining event of the 20th century in American history, the memorial will be a monument to the spirit, sacrifice, and commitment of the American people, to the common defense of the nation and to the broader causes of peace and freedom from tyranny throughout the world. It will inspire future generations of Americans, deepening their appreciation of what the World War II generation accomplished in securing freedom and democracy. Above all, the memorial will stand for all time as an important symbol of American national unity, a timeless reminder of the moral strength and awesome power that can flow when a free people are at once united and bonded together in a common and just cause.

Construction of this memorial is long overdue. Opponents have had ample opportunity to make their case, and while I respect their opinions, the simple truth is that the site has been selected and the time to begin to move dirt has arrived. I hope all of my colleague swill join me in sponsoring this resolution. Let us, as a nation, prevent the cheapening of this tribute by putting a stop to frivolous legal challenges. Let us say thanks to those who fought to save the babes of humanity from the wolves of tyranny. Let's build the World War II memorial, let's build it upon the National Mall, and let's build it now.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 580

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

SECTION 1. EXPEDITED COMMENCEMENT BY AMERICAN BATTLE MONUMENTS COMMISSION OF CONSTRUCTION OF WORLD WAR II MEMORIAL.

Section 2113 of title 36, United States Code, as added by section 601(a) of the Veterans Millennium Health Care and Benefits Act (Public Law 106–117; 113 Stat. 1576), is amended by adding at the end the following new subsection:

''(i) CONGRESSIONAL DIRECTION TO COMMENCE CONSTRUCTION.—(1) Subject to paragraph (2), the Commission shall expeditiously proceed with the construction of the World War II memorial at the dedicated Rainbow Pool site in the District of Columbia without regard to the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.), the Commemorative Works Act (40 U.S.C. 1001 et seq.), or any other law pertaining to the siting or design for the World War II memorial.

''(2) The construction of the World War II memorial by the Commission shall be consistent with—

''(A) the final architectural submission made to the Commission of Fine Arts and the National Capital Planning Commission on June 30, 2000, as supplemented on November 2, 2000; and

''(B) such reasonable construction permit requirements as may be required by the Secretary of the Interior, acting through the National Park Service.

''(3) The decision to construct the World War II memorial at the dedicated Rainbow Pool site, and the decisions regarding the design for the World War II memorial, are final and conclusive and shall not be subject to further administrative or judicial review.''.

By Mr. FITZGERALD (for himself and Mrs. CLINTON):

S. 581. A bill to amend title 10, United States Code, to authorize Army arsenals to undertake to fulfill orders or contracts for articles or services in advance of the receipt of payment under certain circumstances; to the Committee on Armed Services.

Mr. FITZGERALD. Mr. President, I rise today to introduce S. 581, a bill that will help United States Army arsenals remain competitive and productive in the 21st century. The Army arsenals have long been an important military resource. They have not only served as a cost-effective supplier of high-quality military equipment, they have also proven to be an invaluable supplier of last resort, providing mission-critical parts when private contractors have lacked the capacity to meet emergency needs or have breached their contracts with the government. This bill will help ensure that these important facilities do not fall into disuse during the periods between national emergencies and heightened military needs.

Rock Island Arsenal, in my home state of Illinois, was acquired by the United States in 1804. Located on an island in the Mississippi River, the area was converted to its current function, and named Rock Island Arsenal, in 1862. Since then, Rock Island Arsenal has built weapons and military equipment for all of our nation's wars, developing a specialty in the manufacture of howitzers.

Today, Rock Island Arsenal is the Department of Defense's only general-purpose metal-manufacturing facility, performing forging, sheet metal, and welding and heat-treating operations that cover the entire range of technologically feasible processes. Rock Island Arsenal also contains a machine shop that is capable of such specialized operations as gear cutting, die sinking, and tool making; a paint shop certified to apply Chemical Agent Resistant Coatings to items as large as tanks; and a plating shop that can apply chrome, nickel, cadmium, and copper, and can galvanize, parkerize, anodize, and apply oxide finishes.

These capabilities have proven essential to the functioning of the United States military. In recent years, Rock Island Arsenal has been called on to produce M16 gun bolts when a private contractor defaulted on a contract. It has also produced mission-critical pins and shims for Apache helicopters when outside suppliers have proven unresponsive to the Army's needs.

S. 581 will help guarantee that United States arsenals will be there again when the military needs them in an emergency, by helping to ensure that arsenals have an adequate workload in normal times. During the 1990s, the Department of Defense shifted away from direct funding of arsenals to the Working Capital Fund, ''W.C.F.'', system,

under which private companies compete with the arsenals for government service and production contracts. This system has improved the efficiency of the military by promoting cost transparency and discouraging the overconsumption of arsenal goods and services.

Unfortunately, implementation of the W.C.F. system has also produced some unintended consequences. As arsenals have been placed in competition with private firms, they have remained tied down by government rules that place the arsenals at a competitive disadvantage—and that hamper their efforts to secure a full workload. One of these rules is the requirement that arsenals be paid in advance for all services and products that they provide. Private firms are not required to operate under such conditions, they routinely receive payment only once they have delivered on their contract. As a result, a military department seeking goods or services, or a private contractor seeking help in supplying the government—is discouraged from contracting with an arsenal. Even when an arsenal can provide higher quality or at lower cost, the requirement of upfront payment may prove burdensome enough to convince purchasers to meet their needs elsewhere.

The legislation that I introduce today will place United States Army arsenals on a more equal footing with their private competitors. It will limit the advance-payment requirement to only those circumstances where payment is less than certain, and will otherwise allow arsenals to accept payment after performance. Specifically, arsenals will be allowed to accept later payment when the United States purchases directly from an arsenal, when an arsenal supplies a contractor serving the United States, or when payment for foreign military purchases is guaranteed by the United States. In these cases, an advance-payment requirement is unnecessary—it serves only to put the arsenals at a competitive disadvantage. Application of the requirement in these circumstances should be ended.

S. 581 will help ensure that Army arsenals will be able to secure an adequate workload in periods between supply emergencies. This bill will also serve taxpayers' money by encouraging efficient use of reserve resources, which must be maintained regardless of whether or not they are fully in use. Therefore, in the interest of encouraging optimal utilization of an invaluable national resource, and to help integrate the Army arsenals into the private-competition system of the Working Capital Fund, I today introduce s. 581.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 581

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

SECTION 1. PERFORMANCE OF ORDERS FOR ARTICLES OR SERVICES BY ARMY ARSENALS BEFORE RECEIPT OF PAYMENT.

(a) AUTHORITY.—(1) Chapter 433 of title 10, United States Code, is amended by inserting after section 4541 the following new section:

''§ 4541a. Army arsenals: performance before receipt of payment

''(a) AUTHORITY.—Regulations under section 2208(h) of this title shall authorize the Army arsenals to undertake, with working-capital funds, to fulfill orders or contracts of customers referred to in subsection (b) for articles or services in advance of the receipt of payment for the articles or services.

''(b) TRANSACTIONS TO WHICH APPLICABLE.—The authority provided in subsection (a) applies with respect to an order or contract for articles or services that is placed or entered into, respectively, with an arsenal by a customer that—

''(1) is—

''(A) a department or agency of the United States;

''(B) a person using the articles or services in fulfillment of a contract of a department or agency of the United States; or

''(C) a person supplying the articles or services to a foreign government under sections 22, 23, and 24 of the Arms Export Control Act (22 U.S.C. 2762, 2763, 2764); and

''(2) is eligible under any other provision of law to obtain the articles or services from the arsenal.''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 4541 the following new item:

''4541a. Army arsenals: performance before receipt of payment.''.

(b) REGULATIONS.—The Secretary of Defense shall prescribe the regulations to carry out section 4541a of title 10, United States Code (as added by subsection (a)), not later than 60 days after the date of the enactment of this Act.

By Ms. LANDRIEU:

S.J. Res. 8. A joint resolution designating 2002 as the ''Year of the Rose''; to the Committee on the Judiciary.

Ms. LANDRIEU. Mr. President, I rise today to bring to the attention of the Senate, the continuing beauty and appeal that flowers bring to our nation. Americans have always loved the flowers which God has chosen to decorate our land. In particular, we hold the rose dear as symbols of life, love, devotion, beauty, and eternity. For the love of man and woman, for the love of mankind and God as well as for the love of country, Americans who would speak the language of the heart do so with a rose.

We see evidence of this everywhere. The study of fossils reveals that the rose has existed in America for ages. We have always cultivated roses in our gardens. Our first President, George Washington bred roses and a variety he named after his mother is still grown today. The White House itself boasts of a beautiful Rose Garden. We find roses in our art, music, and literature. We decorate our celebrations and parades with roses. Most of all, we present roses to those we love, and we lavish them on our altars, our civil shrines, and the final resting places of our honored dead. In 1986, in recognition of the high esteem roses are held, President Ronald Reagan and the Congress of the United States proclaimed the rose as the National Floral Emblem of the United States of America.

This proclamation was as a result of the handiwork and dedication of the American Rose Society. The American Rose Society is the premier organization dedicated exclusively to the cultivation of roses. Since 1892, the American Rose Society has strived to enhance the enjoyment and promotion of roses to gardeners of all skill levels. In 2001, the American Rose Society, in conjunction with the 37 member countries that make up the World Federation of Rose Societies, the National Council of State Garden Clubs, and the American Nursery and Landscape Association began waging a campaign to honor our national floral emblem, the Rose.

In an effort to increase support for public rose gardens in the United States; recognize the beauty and inspiration roses add to the environment and landscapes of cities, and communities around the country; to introduce the therapeutic benefits of roses to people of all ages and background; to provide educational programs designed to stimulate and teach about the joys of gardening, especially rose gardening; and to teach the great history and diversity the genus offers, the American Rose Society, whose national headquarters is located in Shreveport, Louisiana, is requesting a joint congressional resolution proclaiming the year 2002 as the Year of the Rose.

The American people have long held a special place in their hearts for roses. Let us continue to cherish them, honor the love and devotion they represent and to bestow them upon all we love just as God has bestowed them on us.

I ask unanimous that the text of this resolution be printed in the RECORD.

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

S.J. RES. 8

Whereas the study of fossils has shown that the rose has been a native wild flower in the United States for over 35,000,000 years;

Whereas the rose is grown today in every State;

Whereas the rose has long represented love, friendship, beauty, peace, and the devotion of the American people to their country;

Whereas the rose has been cultivated and grown in gardens for over 5,000 years and is referred to in both the Old and New Testaments;

Whereas the rose has for many years been the favorite flower of the American people, has captivated the affection of humankind, and has been revered and renowned in art, music, and literature;

Whereas our first President was also our first rose breeder, 1 of his varieties being named after his mother and still being grown today; and

Whereas in 1986 the rose was designated and adopted as the national floral emblem of the United States: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That Congress—

(1) designates the year of 2002 as the ''Year of the Rose''; and

(2) requests the President to issue a proclamation calling on the people of the United States to observe the year with appropriate ceremonies and activities.

By Mrs. BOXER (for herself, Mr. REID, Ms. SNOWE, Mr. JEFFORDS, Ms. COLLINS, Mr. SPECTER, and Mr. CHAFEE):

S.J. Res. 9. A joint resolution providing for congressional disapproval of the rule submitted by the United States Agency for International Development relating to the restoration of the Mexico City Policy; to the Committee on Foreign Relations.

Mrs. BOXER. Mr. President, on February 15, the United States Agency for International Development issued Contract Information Bulletin 01–03 regarding the ''Restoration of the Mexico City Policy.''

This bulletin reinstates the international gag rule, which prohibits international family planning organizations that receive federal funding from using their own privately-raised funds to counsel women about abortion, provide abortion services, and lobby on reproductive rights.

Today, I am introducing, along with Senators REID, SNOWE, JEFFORDS, COLLINS, SPECTER, and CHAFEE, a joint resolution of disapproval under the Congressional Review Act.

As my colleagues know, the CRA establishes a procedure for the expedited consideration of a resolution disapproving an agency rule.

I can think of no other case where expedited procedures are more appropriate. Women's lives are at stake.

Approximately 78,000 women throughout the world die each year as a result of unsafe abortions. At least one-fourth of all unsafe abortions in the world are to girls aged 15–19. By 2015, contraceptive needs in developing countries will grow by more than 40 percent.

As a result of the gag rule, the organizations that are reducing unsafe abortions and providing contraceptives will be forced either to limit their services or to simply close their doors to women across the world. And this will cause women and families increased misery and death.

Make no mistake, the international gag rule will restrict family planning, not abortions. In fact, no United States funds can be used for abortion services. That is already law, and has been since 1973. This gag rule does, however, restrict foreign organizations in ways that would be unconstitutional here at home and that is why we seek to reverse it in an expedited fashion under the CRA.

Mr. President, I ask unanimous consent that a copy of the joint resolution be printed in the RECORD.

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

S.J. RES. 9

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That Congress disapproves the rule submitted by the United States Agency for International Development relating to the restoration of the Mexico City Policy (contained in Contract Information Bulletin 01–03, dated February 15, 2001), and such rule shall have no force or effect.

Mr. REID. Mr. President, I am pleased to join Senator BOXER in introducing a joint resolution of congressional disapproval relating to the restoration of the Mexico City Policy.

We are taking this step because the global gag rule—which denies funding to any organization that uses its own funds to provide or promote abortion services overseas—is an ill-conceived, anti-woman, and anti-American policy.

The President's rationale for reimposing the gag rule was that he wanted to make abortions more rare. Yet the last time the Mexico City Policy was in effect, there was no reduction in the number of abortions, only reduced access to quality health care services, more unintended pregnancies and more abortions. Research shows that the only way to reduce the need for abortion is to improve family planning efforts that will decrease the number of unintended pregnancies. Access to contraception reduces the probability of having an abortion by 85 percent.

It the only reason to repeal the Mexico City Policy was to decrease the need for abortions then that would be enough. But our support of international family planning programs literally means the difference between life or death for women in developing countries. At least one woman dies every minute of every day from causes related to pregnancy and child birth in developing nations. This means that almost 600,000 women die every year from causes related to pregnancy. Family planning efforts that prevent unintended pregnancies save the lives of thousands of women and infants each year.

In addition to reducing maternal and infant mortality rates, family planning helps prevent the spread of sexually transmitted diseases. This effort is particularly critical considering that the World Health Organization has estimated that 5.9 million individuals, the majority of whom live in developing nations, become infected with HIV almost every year.

Let me be clear: We are not asking to use one single taxpayer dollar to perform or promote abortion overseas. The law has explicitly prohibited such activities since 1973. Instead, the Mexico City Policy would restrict foreign organizations in a way that would be unconstitutional in the United States. The Mexico City Policy violates a fundamental tenet of our democracy—freedom of speech. Exporting a policy that is unconstitutional at home is the ultimate act of hypocrisy. Surely this is not the message we want to send to struggling democracies who are looking to the United States for guidance.

When President Bush reinstated the Mexico City Policy, he turned the clock back on women around the world by almost two decades. Today, Senator BOXER and I are looking toward the future and taking the first step to repeal this antiquated, anti-woman policy.

AMENDMENTS SUBMITTED & PROPOSED

SA 115. Mr. DOMENICI (for himself Mr. DEWINE, Mr. DURBIN, Mr. ENSIGN, Mrs. FEINSTEIN, Ms. COLLINS and Mr. MCCONNELL) proposed an amendment to the bill S. 27, to amend the Federal Election Campaign Act of 1971 to provide bipartisan campaign reform.

SA 116. Mr. THOMPSON submitted an amendment intended to be proposed by him to the bill S. 27, supra; which was ordered to lie on the table.

SA 117. Mr. BENNETT proposed an amendment to the bill S. 27, supra.

SA 118. Mr. SMITH, of Oregon proposed an amendment to the bill S. 27, supra.

SA 119. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 27, supra; which was ordered to lie on the table.

SA 120. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 27, supra; which was ordered to lie on the table.

SA 121. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 27, supra; which was ordered to lie on the table.

SA 122. Mr. TORRICELLI (for himself, Mr. DURBIN, Mr. CORZINE and Mr. DORGAN) proposed an amendment to the bill S. 27, supra.

TEXT OF AMENDMENTS

SA 115. Mr. DOMENICI (for himself, Mr. DEWINE, Mr. DURBIN, Mr. ENSIGN, Mrs. FEINSTEIN, Ms. COLLINS, and Mr. MCCONNELL) proposed an amendment to the bill S. 27, to amend the Federal Election Campaign Act of 1971 to provide bipartisan campaign reform; as follows:

On page 37, between lines 14 and 15, insert the following:

SEC. 305. MODIFICATION OF INDIVIDUAL CONTRIBUTION LIMITS IN RESPONSE TO EXPENDITURES FROM PERSONAL FUNDS.

(a) INCREASED LIMITS FOR INDIVIDUALS.—

(1) IN GENERAL.—Section 315 of the Federal Election Campaign Act of 1971 (2 U.S.C. 441a) is amended—

(A) in subsection (a)(1), by striking ''No person'' and inserting ''Except as provided in subsection (i), no person''; and

(B) by adding at the end the following:

''(i) INCREASED LIMIT TO ALLOW RESPONSE TO EXPENDITURES FROM PERSONAL FUNDS.—

''(1) INCREASE.—

''(A) IN GENERAL.—Subject to paragraph (2), if the opposition personal funds amount with respect to a candidate for election to the office of Senator exceeds the threshold amount, the limit under subsection (a)(1)(A) (in this subsection referred to as the 'applicable limit') with respect to that candidate shall be the increased limit.

''(B) THRESHOLD AMOUNT.—

''(i) STATE-BY-STATE COMPETITIVE AND FAIR CAMPAIGN FORMULA.—In this subsection, the threshold amount with respect to an election cycle of a candidate described in subparagraph (A) is an amount equal to the sum of—

''(I) $150,000; and

''(II) $0.04 multiplied by the voting age population.