S. RES. 333

At the request of Mr. HUTCHINSON, the names of the Senator from Alabama (Mr. SESSIONS), the Senator from Iowa (Mr. GRASSLEY), the Senator from Wyoming (Mr. THOMAS), and the Senator from Virginia (Mr. ALLEN) were added as cosponsors of S. Res. 333, a resolution expressing the sense of the Senate relating to a dispute between the Pacific Maritime Association and the International Longshore and Warehouse Union.

S. CON. RES. 142

At the request of Mr. SMITH of Oregon, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. Con. Res. 142, a concurrent resolution expressing support for the goals and ideas of a day of tribute to all firefighters who have died in the line of duty and recognizing the important mission of the Fallen Firefighters Foundation in assisting family members to overcome the loss of their fallen heroes.

S. CON. RES. 146

At the request of Mrs. LINCOLN, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. Con. Res. 146, a concurrent resolution supporting the goals and ideas of National Take Your Kids to Vote Day.

S. CON. RES. 149

At the request of Mr. LEVIN, his name was added as a cosponsor of S. Con. Res. 149, a concurrent resolution recognizing the teams and players of the Negro Baseball Leagues for their achievements, dedication, sacrifices, and contributions to baseball and the Nation.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. WYDEN (for himself and Mr. HATCH):

S. 3063. A bill to establish a Citizens Health Care Working Group to facilitate public debate about how to improve the health care system for Americans and to provide for a vote by Congress on the recommendations that are derived from this debate; to the Committee on Health, Education, Labor, and Pensions.

Mr. WYDEN. Mr. President, today I join with Senator ORRIN HATCH, one of the most caring and thoughtful public officials I have ever known, in offering a bipartisan roadmap to creating a health care system that works for all Americans. Our country has been trying to find such a path since President Harry Truman's proposal to cover all Americans was voted down in 1945. I believe the Wyden-Hatch proposal can succeed after 57 years of failure because our bipartisan plan begins with the public discussing and deciding their health care priorities, followed by a guarantee Congress will actually vote on the recommendations that result from this grassroots debate.

This approach has never been tried before. Now, when major health laws are written, politicians sit down and prescribe what benefits will be offered, and then try to come up with the money to pay for them. After the politicians write their plans, the special interest lobbies start attacking one feature or another through shrill television commercials. Pretty soon, the public gets understandably confused, the chance for building consensus is lost, and important health care needs go unmet.

The 280 million Americans whose survival depends on quality, affordable health care have never been given the chance to shape their health care future before the special interest lobbyists weigh in. The Wyden-Hatch bill changes that. Under our proposal, the public gets to jump-start health reform by stating their priorities at the outset, rather than being treated as an afterthought. We believe our legislation can serve as an illuminated route to a health care system where each American has the ability to obtain quality, affordable health care coverage. We placed three signposts on our roadmap to provide guidance to the American people and their elected officials as they make the tough choices inherent in tackling health care reform.

At the first signpost, the public is given an extensive opportunity, in their home communities and on line, to state their personal health care priorities and how they should be paid for. In addition, the public will be asked to look beyond their personal needs, to those of the community at large, and how those needs should be paid for.

Our legislation forthrightly asks the questions that must be answered to have meaningful health reform—questions such as: What kind of health care do you want most? How much are you willing to pay? How should costs be contained without sacrificing the quality of care? Should the Government or private businesses be required to pay a portion of your costs? How about those of your neighbors?

Our national Government has never directly asked the public these questions. After asking these questions, the Government ought to keep quiet for a bit and listen to the people because without some sense of the public's view, it is always going to be virtually impossible to create a health care system that works for everyone, with the consensus that is needed to get it done.

To ask the key questions and follow up on the suggestions given by the American people, the Wyden-Hatch legislation creates a Citizens' Health Care Working Group. The Working Group is made up of a representative cross-section of our people. It is not just another Washington, DC commission of so-called policy experts.

The Working Group directs the public participation portion of this proposal. For example, as a guide to help the public in formulating their views on the tough choices that lie ahead, the Wyden-Hatch legislation directs the Working Group to prepare and make widely available a ''Health Report to the American People.''

The legislation we have authored requires that this report be written in understandable language and describe the cost and availability of the major public and private health choices now available—and also contain enough information so the public can create alternatives. Here are the kinds of issues we want to address: ''If covering liver transplants under government health programs requires cutting other services, what services are you willing to cut, or would you rather not have liver transplants covered? If government coverage of long-term care for the elderly would require workers to begin contributing to the program at age 40, is it still worth it to you?''

These are moral choices about what health care the public has a right to expect. These are economic choices that affect the finances of our families. These are legal and social choices that will be difficult for our people to make. The Wyden-Hatch proposal is built around the proposition that these choices are too important to duck any longer.

After establishing a sense of how the public feels about these hard choices, the legislation directs that the Working Group move to the second signpost on our roadmap. There the Working Group is to take the ideas offered by the American people, and translate these views into recommendations for our elected officials to create a health care system that works for all. With the Working Group's involvement in the public participation requirement of this legislation, we believe they are the right people to take this historic step: to synthesize the opinions and information provided by the public and then present a faithful picture to Congress.

At the third signpost, the Congress takes the recommendations from the Working Group and utilizes the legislative process to develop one or more plans for the recommendations, with a guarantee to the public that the plans will be voted on in both Houses of Congress. We believe that the assurance that Congress will vote after the public's will is expressed provides an added measure of credibility for this legislation. Simply put, people will be able to see their voices, their participation, lead to actual votes on the floors of both Houses of Congress to create a health care system that works for all. With these steps I have described, our country can as never before discuss, decide and deliver on health care reforms.

I know there will be many questions about this proposal, and I'll try to answer them in the coming days. I'd like to briefly answer just one question I've already been asked: ''Why now? This is the end of the Congressional session; we are all concerned about the possibility of war with Iraq. Why are you putting this before Congress today?''

My answer is that the lack of decent health care for so many Americans,

and the skyrocketing costs of coverage for insured Americans, threaten countless lives and our economic security just as tenaciously as any foreign enemy our Nation has ever faced. Just as we are beginning a debate about how best to address the Nation's security interests, it is high time Congress resumed the debate about how to address the inequities and failures of the American health care system.

On health care, our families can't afford to wait any longer. Congress is completing another session without significant progress on major health care issues. A demographic tsunami of baby boomer retirees is coming soon. It is increasingly evident that piecemeal health reform—considering prescription drugs one day, patients' rights legislation the next, something else after that—isn't working.

I have no intention on giving up on any one of those important issues when it's possible to get Congress to consider them separately. I still believe the bipartisan prescription drug bill I authored with OLYMPIA SNOWE could bring the Senate together and help seniors get and afford prescription medicine now.

Yet is clear that because health care is like an ecosystem, with one part affecting all others, it is extremely difficult to make real progress on a single important issue without factoring in the way it will ripple through our entire health care system.

So as the Congress pushes ahead on prescriptions and other urgent needs, let us simultaneously reopen the debate about creating a health care system that works for all. That debate stopped in 1994, and needs to begin again. The Wyden-Hatch bill provides an opportunity to reopen this debate, and by introducing our bill now we believe it will be ready for full Congressional deliberation when the next Congress begins in January.

One way or another, it is urgent that Congress find a way to do better by the people's health care needs.

My constituents at home in Oregon make this case constantly. At town meetings, Chamber of Commerce lunches, labor halls, non-profit board meetings, after church coffee hours, and especially at my ''sidewalk office hours'' where I just set up a card table to listen, they ask, ''RON, when's Congress going to get going on health care and help us out?''

One Oregon business after another has been telling me their health premiums are going up by as much as 20 percent a year. The number of uninsured is going up, with many of these individuals working at small businesses whose owners desperately want to offer health coverage and can't figure out how to do it and keep their doors open. Many physicians have been leaving government health programs because of inadequate reimbursements. Thousands and thousands of pages of health care regulations now exist and the system is almost choking on all the bureaucracy.

We know that America's health care system is scientifically prodigious. Every day our dedicated and caring health care providers are performing miracles. Last year more than $1.4 trillion was spent on health care in America. Divide that sum by the number of Americans, and there would be enough for every family of four to receive more than $18,000 for health care. With all this money, and so much talent and creativity in America, shouldn't it be possible to create a health system that works for everyone?

Senator HATCH and I believe it is. We know it will be hard, but we believe it can be done if our roadmap is used.

For example, to achieve real reform our elected officials are going to have to reject the blame game. Republicans can no longer say the problem in health care is primarily the trial lawyers. Democrats can no longer say the problem in health care is primarily the insurance companies. All—let me repeat, all—of the powerful lobbies are going to have to accept some changes they have rejected in the past if America is to have a health care system that works for everyone. I believe that's what we'll hear from the public if they're given the chance to discuss and decide their health care priorities as the Wyden-Hatch legislation envisions.

Before I wrap up, I wish to offer a few thank yous.

The first thank you is to the people of Oregon. They have honored me with a chance to serve, and I get up every morning feeling like the luckiest guy around. It was not very long ago, as co-director of the Oregonian Gray Panthers, I was driving to senior citizens meetings in a beat-up station wagon, and I never thought I would have the privilege of being able to serve in this capacity.

Oregonians can see I have modeled much of this legislation after the debate that Oregon has had on health care. And we are proud that we are the first of the initiatives to ask the tough questions.

Oregonians began asking those difficult questions more than a decade ago in community meetings, for one reason: Gov. John Kitzhaber, an emergency room physician, insisted that we do it. He deserves great credit for his efforts, his courage, and his tenacity. When I told him I was going to push Congress to build on Oregon's public process, the Governor said: Go for it.

Senator HATCH—and I note that Senator HATCH is in the Chamber this morning—could easily have said he wanted no part of this whole discussion. Senator HATCH has written several vital health care laws, from his S-CHIP legislation, to his community health centers bill, to the Hatch-Waxman legislation, to make sure there are pharmaceuticals available for the public, and that they are affordable. All of those pieces of legislation have made a huge contribution.

Senator HATCH has about the fullest plate in the Senate, with his Judiciary and Intelligence responsibilities, but he and Patricia Knight and Patricia DeLoatche have been thoughtful and patient as we went through draft after draft of this proposal in an effort to start the discussion now. I want Senator HATCH to know how grateful I am to him.

Dr. Paul Ellwood, who founded the Jackson Hole Health Group, has been working for more than three decades to create a health system that works for everybody. Now, when he could be enjoying retirement, riding horses in beautiful Wyoming, he is still bringing together health care policymakers, at 7 o'clock on a Sunday morning, in an effort to try to find a consensus on the kinds of common ground that Senator HATCH and I are pursuing.

Dr. Ellwood has been so helpful in the development of this proposal and his own new plan called Heroic Pathways, which encourages the use of information technologies and evidence-based medicine, which is a fancy way of saying health care that actually works. I am of the view that Dr. Ellwood's ideas have great potential. To Paul and Barbara Ellwood, I say this morning, we would not be here today without you.

In my office, Stephanie Kennan and Carole Grunberg kept us tethered to reality, and Ms. Daphne Edwards, a young lawyer in the legislative counsel's office, produced eight separate drafts of this legislation alone.

Finally, I went into public life because I have always believed if people could not get affordable, quality health care, they were not in a position to be able to do much of anything else. Since those Gray Panther days, I have believed that it is wrong for people in this country to die because they could not get health care or because it came too late.

America is now hemorrhaging dollars into a health care system that simply does not work at all for too many people. The longer people go on dying needlessly, and the longer prosperity and security allude our families, the less America looks like the America of our dreams. No one I know thinks it should be so easy to slip through the cracks in our health care system. No one I know believes America is supposed to be a place where people forfeit their well-being for doing honest work that just does not pay enough for good medical care.

The Wyden-Hatch legislation is a chance to move toward America as it is meant to be. People can voice their vision for health care in America. Their voices can count. Their vision can come to pass.

So today I ask the Senate to give our people this opportunity. The Wyden-Hatch bill provides a roadmap. The great people of this country, working with their public servants, can use it as a guide to a health care system that works for everyone.

Mr. President, I see that my colleague is on the floor this morning. I

wrap up by again expressing my appreciation to Senator HATCH. I have come to the conclusion that if you want to get anything important done, particularly in health care, it has to be bipartisan. Senator HATCH and I have been talking about this health care reform for an awfully long time. He has been extraordinarily patient—he and his staff—in working with me. I think we bring to the Senate today a chance, as we end this session—a session where there has not been the progress the people deserve on health care—a chance to move forward in a bipartisan way. I am just especially grateful to my colleague from the State of Utah, who is one of the most caring people I have known in public life, for all his help.

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. 3063

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 That Works for All Americans Act of 2002''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) In order to improve the health care system, the American public must engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage.

(2) More than a trillion dollars annually is spent on the health care system, yet—

(A) 41,000,000 Americans are uninsured;

(B) insured individuals do not always have access to essential, effective services to improve and maintain their health; and

(C) employers, who cover over 170,000,000 Americans, find providing coverage increasingly difficult because of rising costs and double digit premium increases.

(3) Despite increases in medical care spending that are greater than the rate of inflation, population growth, and Gross Domestic Product growth, there has not been a commensurate improvement in our health status as a nation.

(4) Health care costs for even just 1 member of a family can be catastrophic, resulting in medical bills potentially harming the economic stability of the entire family.

(5) Common life occurrences can jeopardize the ability of a family to retain private coverage or jeopardize access to public coverage.

(6) Innovations in health care access, coverage, and quality of care, including the use of technology, have often come from States, local communities, and private sector organizations, but more creative policies could tap this potential.

(7) Despite our Nation's wealth, the health care system does not provide coverage to all Americans who want it.

SEC. 3. PURPOSES.

The purposes of this Act are—

(1) to provide for a nationwide public debate about improving the health care system to provide every American with the ability to obtain quality, affordable health care coverage; and

(2) to provide for a vote by Congress on the recommendations that result from the debate.

SEC. 4. CITIZENS' HEALTH CARE WORKING GROUP.

(a) ESTABLISHMENT.—The Secretary, acting through the Agency for Healthcare Research and Quality, shall establish an entity to be known as the Citizens' Health Care Working Group (referred to in this Act as the ''Working Group'').

(b) APPOINTMENT.—Not later than 45 days after the date of enactment of this Act, the Speaker and Minority Leader of the House of Representatives and the Majority Leader and Minority Leader of the Senate (in this section referred to as the ''leadership'') shall each appoint individuals to serve as members of the Working Group in accordance with subsections (c), (d), and (e).

(c) MEMBERSHIP CRITERIA.—

(1) APPOINTED MEMBERS.—

(A) SEPARATE APPOINTMENTS.—The Speaker of the House of Representatives jointly with the Minority Leader of the House of Representatives, and the Majority Leader of the Senate jointly with the Minority Leader of the Senate, shall each appoint 1 member of the Working Group described in subparagraphs (A), (G), (J), (K), and (M) of paragraph (2).

(B) JOINT APPOINTMENTS.—Members of the Working Group described in subparagraphs (B), (C), (D), (E), (F), and (N) of paragraph (2) shall be appointed jointly by the leadership.

(C) COMBINED APPOINTMENTS.—Members of the Working Group described in subparagraphs (H) and (L) shall be appointed in the following manner:

(i) One member of the Working Group in each of such subparagraphs shall be appointed jointly by the leadership.

(ii) The remaining appointments of the members in each of such subparagraphs shall be divided equally such that the Speaker of the House of Representatives jointly with the Minority Leader of the House of Representatives, and the Majority Leader of the Senate jointly with the Minority Leader of the Senate each appoint an equal number of members.

(2) CATEGORIES OF APPOINTED MEMBERS.—Members of the Working Group shall be appointed as follows:

(A) 2 members shall be patients or family members of patients who, at least 1 year prior to the date of enactment of this Act, have had no health insurance.

(B) 1 member shall be a representative of children.

(C) 1 member shall be a representative of the mentally ill.

(D) 1 member shall be a representative of the disabled.

(E) 1 member shall be over the age of 65 and a beneficiary under the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(F) 1 member shall be a recipient of benefits under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(G) 2 members shall be State health officials.

(H) 3 members shall be employers, including—

(i) 1 large employer (an employer who employed 50 or more employees on business days during the preceding calendar year and who employed at least 50 employees on the first of the year);

(ii) 1 small employer (an employer who employed an average of at least 2 employees but less than 50 employees on business days in the preceding calendar year and who employs at least 2 employees on the first of the year); and

(iii) 1 multi-state employer.

(I) 1 member shall be a representative of labor.

(J) 2 members shall be health insurance issuers.

(K) 2 members shall be health care providers.

(L) 5 members shall be appointed as follows:

(i) 1 economist.

(ii) 1 academician.

(iii) 1 health policy researcher.

(iv) 1 individual with expertise in pharmacoeconomics.

(v) 1 health technology expert.

(M) 2 members shall be representatives of community leaders who have developed State or local community solutions to the problems addressed by the Working Group.

(N) 1 member shall be a representative of a medical school.

(3) SECRETARY.—The Secretary of Health and Human Services or the designee of the Secretary of Health and Human Services shall be a member of the Working Group.

(d) PROHIBITED APPOINTMENTS.—Members of the Working Group shall not include members of Congress or other elected government officials (Federal, State, or local) other than those individuals specified in subsection (c). To the extent possible, individuals appointed to the Working Group shall have used the health care system within the previous 2 years and shall not be paid employees or representatives of associations or advocacy organizations involved in the health care system.

(e) APPOINTMENT CRITERIA.—

(1) HOUSE OF REPRESENTATIVES.—The Speaker and Minority Leader of the House of Representatives shall make the appointments described in subsection (b) in consultation with the chairperson and ranking member of the following committees of the House of Representatives:

(A) The Committee on Ways and Means.

(B) The Committee on Energy and Commerce.

(C) The Committee on Education and the Workforce.

(2) SENATE.—The Majority Leader and Minority Leader of the Senate shall make the appointments described in subsection (b) in consultation with the chairperson and ranking member of the following committees of the Senate:

(A) The Committee on Finance.

(B) The Committee on Health, Education, Labor, and Pensions.

(f) PERIOD OF APPOINTMENT.—Members of the Working Group shall be appointed for a term of 2 years. Such term is renewable and any vacancies shall not affect the power and duties of the Working Group but shall be filled in the same manner as the original appointment.

(g) APPOINTMENT OF THE CHAIRPERSON.—Not later than 15 days after the date on which all members of the Working Group have been appointed under subsection (b), the leadership shall make a joint designation of the chairperson of the Working Group. If the leadership fails to make such designation within such time period, the Working Group Members shall, not later than 10 days after the end of such time period, designate a chairperson by majority vote.

(h) SUBCOMMITTEES.—The Working Group may establish subcommittees if doing so increases the efficiency of the Working Group in completing its tasks.

(i) DUTIES.—

(1) HEARINGS.—Not later than 90 days after the date of appointment of the chairperson under subsection (g), the Working Group shall hold hearings to examine—

(A) the capacity of the public and private health care systems to expand coverage options;

(B) the cost of health care and the effectiveness of care provided at all stages of disease, but in particular the cost of services at the end of life;

(C) innovative State strategies used to expand health care coverage and lower health care costs;

(D) local community solutions to accessing health care coverage;

(E) efforts to enroll individuals currently eligible for public or private health care coverage;

(F) the role of evidence-based medical practices that can be documented as restoring, maintaining, or improving a patient's health, and the use of technology in supporting providers in improving quality of care and lowering costs; and

(G) strategies to assist purchasers of health care, including consumers, to become more aware of the impact of costs, and to lower the costs of health care.

(2) ADDITIONAL HEARINGS.—The Working Group may hold additional hearings on subjects other than those listed in paragraph (1) so long as such hearings are determined to be necessary by the Working Group in carrying out the purposes of this Act. Such additional hearings do not have to be completed within the time period specified in paragraph (1) but shall not delay the other activities of the Working Group under this section.

(3) THE HEALTH REPORT TO THE AMERICAN PEOPLE.—Not later than 90 days after the hearings described in paragraphs (1) and (2) are completed, the Working Group shall prepare and make available to health care consumers through the Internet and other appropriate public channels, a report to be entitled, ''The Health Report to the American People''. Such report shall be understandable to the general public and include—

(A) a summary of—

(i) health care and related services that may be used by individuals throughout their life span;

(ii) the cost of health care services and their medical effectiveness in providing better quality of care for different age groups;

(iii) the source of coverage and payment, including reimbursement, for health care services;

(iv) the reasons people are uninsured or underinsured and the cost to taxpayers, purchasers of health services, and communities when Americans are uninsured or underinsured;

(v) the impact on health care outcomes and costs when individuals are treated in later stages of disease;

(vi) health care cost containment strategies; and

(vii) information on health care needs that need to be addressed;

(B) examples of community strategies to provide health care coverage or access;

(C) information on geographic-specific issues relating to health care;

(D) information concerning the cost of care in different settings, including institutional-based care and home and community-based care;

(E) a summary of ways to finance health care coverage; and

(F) the role of technology in providing future health care including ways to support the information needs of patients and providers.

(4) COMMUNITY MEETINGS.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Working Group shall initiate health care community meetings throughout the United States (in this section referred to as ''community meetings''). Such community meetings may be geographically or regionally based and shall be completed within 180 days after the initiation of the first meeting.

(B) NUMBER OF MEETINGS.—The Working Group shall hold a sufficient number of community meetings in order to receive information that reflects—

(i) the geographic differences throughout the United States;

(ii) diverse populations; and

(iii) a balance among urban and rural populations.

(C) MEETING REQUIREMENTS.—

(i) FACILITATOR.—A State health officer may be the facilitator at the community meetings.

(ii) ATTENDANCE.—At least 1 member of the Working Group shall attend and serve as chair of each community meeting. Other members may participate through interactive technology.

(iii) TOPICS.—The community meetings shall, at a minimum, address the following issues:

(I) The optimum way to balance costs and benefits so that affordable health coverage is available to as many people as possible.

(II) The identification of services that provide cost-effective, essential health care services to maintain and improve health and which should be included in health care coverage.

(III) The cost of providing increased benefits.

(IV) The mechanisms to finance health care coverage, including defining the appropriate financial role for individuals, businesses, and government.

(iv) INTERACTIVE TECHNOLOGY.—The Working Group may encourage public participation in community meetings through interactive technology and other means as determined appropriate by the Working Group.

(D) INTERIM REQUIREMENTS.—Not later than 180 days after the date of completion of the community meetings, the Working Group shall prepare and make available to the public through the Internet and other appropriate public channels, an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings. There shall be a 90-day public comment period on such recommendations.

(j) RECOMMENDATIONS.—Not later than 120 days after the expiration of the public comment period described in subsection (h)(3)(D), the Working Group shall submit to Congress and the President a final set of recommendations, including any proposed legislative language to implement such recommendations.

(k) ADMINISTRATION.—

(1) EXECUTIVE DIRECTOR.—There shall be an Executive Director of the Working Group who shall be appointed by the chairperson of the Working Group in consultation with the members of the Working Group.

(2) COMPENSATION.—While serving on the business of the Working Group (including travel time), a member of the Working Group shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Working Group. For purposes of pay and employment benefits, rights, and privileges, all personnel of the Working Group shall be treated as if they were employees of the Senate.

(3) INFORMATION FROM FEDERAL AGENCIES.—The Working Group may secure directly from any Federal department or agency such information as the Working Group considers necessary to carry out this Act. Upon request of the Working Group, the head of such department or agency shall furnish such information.

(4) POSTAL SERVICES.—The Working Group may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(l) DETAIL.—Not more than 10 Federal Government employees employed by the Department of Labor and 10 Federal Government employees employed by the Department of Health and Human Services may be detailed to the Working Group under this section without further reimbursement. Any detail of an employee shall be without interruption or loss of civil service status or privilege.

(m) TEMPORARY AND INTERMITTENT SERVICES.—The chairperson of the Working Group may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(n) ANNUAL REPORT.—Not later that 1 year after the date of enactment of this Act, and annually thereafter during the existence of the Working Group, the Working Group shall report to Congress and make public a detailed description of the expenditures of the Working Group used to carry out its duties under this section.

(o) SUNSET OF WORKING GROUP.—The Working Group shall terminate when the report described in subsection (j) is submitted to Congress.

SEC. 5. CONGRESSIONAL ACTION.

(a) DRAFTING.—If the Working Group does not provide legislative language in the report under section 4(j) then the committees described in paragraphs (1) and (2) of section 4(e) may draft legislative language based on the recommendations of the Working Group.

(b) BILL INTRODUCTION.—

(1) IN GENERAL.—Any legislative language described in subsection (a) may be introduced as a bill by request in the following manner:

(A) HOUSE OF REPRESENTATIVES.—In the House of Representatives, by the Majority Leader and the Minority Leader not later than 10 days after receipt of the legislative language.

(B) SENATE.—In the Senate, by the Majority Leader and the Minority Leader not later than 10 days after receipt of the legislative language.

(2) ALTERNATIVE BY ADMINISTRATION.—The President may submit legislative language based on the recommendations of the Working Group and such legislative language may be introduced in the manner described in paragraph (1).

(c) COMMITTEE CONSIDERATION.—

(1) IN GENERAL.—Any legislative language submitted pursuant to paragraph (1) or (2) of subsection (b) (in this section referred to as ''implementing legislation'') shall be referred to the appropriate committees of the House of Representatives and the Senate.

(2) REPORTING.—

(A) COMMITTEE ACTION.—If, not later than 150 days after the date on which the implementing legislation is referred to a committee under paragraph (1), the committee has reported the implementing legislation or has reported an original bill whose subject is related to reforming the health care system, or to providing access to affordable health care coverage for Americans, the regular rules of the applicable House of Congress shall apply to such legislation.

(B) DISCHARGE FROM COMMITTEES

(i) SENATE.—

(I) IN GENERAL.—If the implementing legislation or an original bill described in subparagraph (A) has not been reported by a

committee of the Senate within 180 days after the date on which such legislation was referred to committee under paragraph (1), it shall be in order for any Senator to move to discharge the committee from further consideration of such implementing legislation.

(II) SEQUENTIAL REFERRALS.—Should a sequential referral of the implementing legislation be made, the additional committee has 30 days for consideration of implementing legislation before the discharge motion described in subclause (I) would be in order.

(III) PROCEDURE.—The motion described in subclause (I) shall not be in order after the implementing legislation has been placed on the calendar. While the motion described in subclause (I) is pending, no other motions related to the motion described in subclause (I) shall be in order. Debate on a motion to discharge shall be limited to not more than 10 hours, equally divided and controlled by the majority leader and the minority leader, or their designees. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed or disagreed to.

(IV) EXCEPTION.—If implementing language is submitted on a date later than May 1 of the second session of a Congress, the committee shall have 90 days to consider the implementing legislation before a motion to discharge under this clause would be in order.

(ii) HOUSE OF REPRESENTATIVES.—If the implementing legislation or an original bill described in subparagraph (A) has not been reported out of a committee of the House of Representatives within 180 days after the date on which such legislation was referred to committee under paragraph (1), then on any day on which the call of the calendar for motions to discharge committees is in order, any member of the House of Representatives may move that the committee be discharged from consideration of the implementing legislation, and this motion shall be considered under the same terms and conditions, and if adopted the House of Representatives shall follow the procedure described in subsection (d)(1).

(d) FLOOR CONSIDERATION.—

(1) MOTION TO PROCEED.—If a motion to discharge made pursuant to subsection (c)(2)(B)(i) or (c)(2)(B)(ii) is adopted, then, not earlier than 5 legislative days after the date on which the motion to discharge is adopted, a motion may be made to proceed to the bill.

(2) FAILURE OF MOTION.—If the motion to discharge made pursuant to subsection (c)(2)(B)(i) or (c)(2)(B)(ii) fails, such motion may be made not more than 2 additional times, but in no case more frequently than within 30 days of the previous motion. Debate on each of such motions shall be limited to 5 hours, equally divided.

(3) APPLICABLE RULES.—Once the Senate is debating the implementing legislation the regular rules of the Senate shall apply.

SEC. 6. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to carry out this Act, other than section 4(i)(3), $3,000,000 for each of fiscal years 2003, 2004, 2005.

(b) HEALTH REPORT TO THE AMERICAN PEOPLE.—There are authorized to be appropriated for the preparation and dissemination of the Health Report to the American People described in section 4(i)(3), such sums as may be necessary for the fiscal year in which the report is required to be submitted.

The ACTING PRESIDENT pro tempore. The Senator from Utah.

Mr. HATCH. Mr. President, I thank my colleague for his kind remarks, especially his kind remarks with regard to me. I share a mutual affection for him because, as a leader in the House on health care, he did so many good things. We are so happy to have him in the Senate where he has continued his work on health care. I am very grateful to him.

Mr. President, I rise to associate myself with the remarks of my good friend and colleague, the Senator from Oregon, Mr. WYDEN.

Last week, we were all dismayed to learn the Census Bureau figures indicate the number of uninsured in our country has risen from 39.8 million in 2000 to 41.2 million in 2001.

Of even greater concern is the fact that most of the newly uninsured previously had employer-based coverage.

Obviously, this is a trend in the wrong direction despite years of efforts here in Washington to improve our country's health care delivery system.

Clearly, we must take another approach.

In a nutshell, the legislation that Senator WYDEN and I are introducing today will stimulate fruitful discussion and debate on how we can really effect improvements to our nation's health care system—improvements that can be accepted at all levels, from communities on up to the Federal government.

We have worked on this bill for several months and are proud to have reached bipartisan consensus.

Bipartisanship, it seems, is a rare occurrence these days. But, in our opinion, the only way to resolve our country's health crisis is to put politics aside and work together toward common goals.

The Health Care That Works for All Americans Act of 2002 reflects our common goals on how to resolve this country's health care woes.

We accomplish these important goals by fostering candid discussions—in every corner of our country—through which the public can have an earnest discussion about our current health care system.

These discussions will lead to recommendations on how to improve health care coverage which will help guide the Congress as it moves forward in this area.

It is our hope that, in the end, this legislation will provide Americans with the proper tools to access high quality, affordable health care coverage.

Basically, our legislation envisions three steps: public meetings; recommendations to Congress; and congressional action.

We see this an as interactive process, which will help all of us be more informed consumers and which can produce real changes for the public.

At this point, I would like to take this opportunity to discuss each of these steps in more detail.

The first step of this bill is to stimulate community gatherings at which individuals from all walks of life can provide their viewpoints on which health benefits they believe should be covered.

Obviously, a necessary component of that discussion will be how the benefits can be paid for, and by whom. Strange as it may seem, our government has never actually asked the American people what they want from our health care system. These community meetings would pose questions to individuals such as, ''What type of health coverage do you want how much are you willing to pay?''

In addition, debate would focus on the financial responsibilities of the government, businesses, and individual citizens.

I believe these issues must be discussed at the beginning of a new debate on health coverage, because the public's response is essential to building a nationwide consensus for creating a new health care system. It is critical to receive feedback from those who use the health care system on a daily, weekly or even annual basis.

Our plan is to hear from everyone who has had first-hand experience with the health care system. We want to hear what people like and dislike about the current system and their proposals for change. And, we also hope to hear from those who do not use health services and the reasons why they have not sought health care coverage.

We hope to stimulate a provocative discussion based on key questions. Is health care too expensive? Too complicated? Or is it just not available to certain segments of our society?

The Wyden-Hatch legislation creates a Citizens' Health Care Working Group which would be charged with posing these tough questions and overseeing this crucial debate on how to improve upon our current health care system.

The Citizens' Health Care Working Group will be comprised of individuals who have a deep interest in health care: patients; providers, community leaders; and key state and federal officials.

The Working Group will coordinate nationwide community meetings and facilitate the public in expressing their views on the complex and often difficult choices concerning health care coverage.

To achieve this objective, our bill directs the Working Group to produce a ''Health Care Report to the American People.'' This report will be used as a guidebook designed to describe the cost and availability of health choices available to Americans across the country—taking into account geographic differences.

Since this issue has been visited over and over again without noticeable results, we believe that it is time to have an honest dialogue about sensitive health care issues with the public so that individual citizens will have a better idea of what choices members of Congress and key health officials are facing when health care issues are being debated.

We envision asking citizens about a whole range of services and procedures, a ''bottom-up'' review of the health

care system, if you will. We hope these community discussions will look at current coverage issues, such as whether Medicaid should provide better coverage for transplants, recognizing that these are very expensive, labor-intensive procedures that may use scarce resources that might have been used elsewhere.

Another area we hope might be explored is how to improve coverage of long-term care services, and how this should be paid.

These choices—economic, moral, legal and social—will be difficult ones, but the purpose of our legislation is this—to start discussing these vital issues with those on whom there will be the greatest impact—the American people. We cannot afford to put off these discussions any longer.

In the past, health reform debates have not included the voice of the people who actually need to live with these decisions. The Wyden-Hatch legislation will ensure that those Americans who depend on quality, affordable health care are at the forefront of the discussion before the special interests weigh in with their objectives.

Mr. President, I ask my colleagues, given the failures of the past, isn't it time that we approach this problem by listening to citizens' viewpoints on health care coverage?

The second step of this legislation is to direct the Working Group to take the ideas offered by the public and translate these comments into recommendations for our elected officials, specifically Members of Congress and the President.

The Working Group will have substantial awareness of our citizens' preferences because of their involvement in the public meetings across the country. After the meetings are completed, the Working Group will highlight the issues raised by the public and provide them to members of Congress and the President for evaluation.

The third step of this legislation involves drafting these recommendations into legislation which will eventually be voted upon by both the House and the Senate.

Never before has Congress voted on a health care proposal built on a foundation created by the public making difficult heath care choices.

If enacted, the Wyden-Hatch bill will provide for just such a vote.

Senator WYDEN and I both know there will be many questions about this proposal, but, in my opinion, the most important question is ''Why now?''

The answer is simple—the American people cannot afford to wait any longer. The number of uninsured Americans, which had been declining for the past couple of years, is now increasing.

In addition, the costs of gridlock are simply too great—on human, social, economic and moral grounds. Congress is on the verge of completing another session without significant progress on major health care reforms.

Once again, we have not passed prescription drug coverage for Medicare beneficiaries. Once again, we have not addressed the issue of the uninsured. Once again, we have not approved legislation that includes patient protections.

And the reason for this inaction is partisan politics—no one is willing to compromise so we end up doing nothing and the American public suffers. In my opinion, something must be done to address these important issues, sooner rather than later.

One issue that must be addressed is the overwhelming cost of health care. Every time I go home to Utah, I hear complaints from my constituents about escalating health care premiums and the price of prescription drugs. People are having a difficult time paying for their health insurance premiums, their physicians' visits and their medicines. We were all disturbed last year to hear about a recent Towers Perrin survey indicating that the cost of health benefit plans at large companies is expected to rise an average of 15 percent—15 percent!—in 2003.

Some businesses, especially smaller employers, are worried that they will no longer be able to provide health insurance coverage to their employees. Utah physicians complain to me about the inadequate Medicare reimbursement rates and are threatening to leave the state.

In fact, many of the federal health programs have complicated and overbearing regulations that are confusing to participating providers. For example, is it necessary to have a book of Medicaid regulations thicker than the Black's Law Dictionary?

While our health care system provides the highest quality services in the world and is the most technologically advanced, America's health system has fundamental flaws. The purpose of this legislation is to build on the positive components of our current system and improve the flaws.

We believe that the best way to improve the current system is to listen to public input and implement their ideas and suggestions.

We must get past playing the blame game. All of the powerful special interests are going to have to accept some reforms they have rejected in the past if America is to have a health care system that works for all.

I believe this is what we will hear from the American people if they are given the chance to drive the debate on health reform as envisioned by this legislation. Unfortunately, there never has been a system to gather that public input until now.

Mr. President, I am proud to be the lead Republican sponsor of the Health Care that Works for All Americans Act of 2002. I urge my colleagues to work with us so this legislation will be enacted into law in a timely manner. The American people cannot afford to wait any longer.

I praise my colleague again for his leadership in so many areas, but especially the area of health care. He is sincere. He is dedicated. He is smart. He works hard on these issues. I am proud to work with him on this issue, and hope we can be successful in passing this bill and getting this very worthwhile effort started.

By Mr. NELSON of Florida:

S. 3064. A bill to prohibit the use of patient databases for marketing without the express consent of the patient; to the Committee on Health, Education, Labor, and Pensions.

Mr. NELSON of Florida. Mr. President, privacy concerns continues to grow not only in Florida, but throughout the Nation. This past August, the Administration finalized rules which will allow pharmacies and other health care entities to profit from their confidential patient databases by entering marketing agreements with giant health corporations.

Under the new rules, a pharmacy can search its database for patients using a specific prescription drug and then turn around and send an unsolicited advertisement on behalf of a drug maker peddling a more expensive alternative drug, even if it's less effective. And to make matters worse, the consumer can't ask the company to stop.

Instead of banning this anti-consumer practice, the Administration issued non-binding guidelines asking third parties not to provide financial incentives to doctors or pharmacies in exchange for suggesting certain drugs to patients. While the guidelines are well meaning, this terrible practice won't stop if the government doesn't do more than offer suggestions. We need to pass a law to prohibit this behavior.

Today, I'm introducing a bill that allows consumers to decide if they want to receive health advertisements generated as a result of their personal health characteristics. Under my legislation, pharmacies, insurance companies and other health entities would be prohibited from using private, personally identifiable health information to provide marketing services to any entity without providing notice to the consumer about its disclosure practices and obtaining the consumer's express written consent.

The legislation makes an exception for treatment communications unless the covered entity receives direct or indirect remuneration from a third party for making the communication. The free flow of information is important when sought by the consumer, but treatment communications tarnished by the marketing dollars of third parties create an inherent conflict of interest by encouraging patients, who don't know their pharmacist has been paid, to purchase high-cost alternative drugs that are not necessarily more effective than those prescribed by their doctor. Unnecessary spending driven by this practice, not only hurts individual consumers, but also the American taxpayer as Medicare and Medicaid costs skyrocket.

My goal is to restore control to the consumer, so that they can make a decision to receive, or not receive, these advertisements once they have been informed that their personal information will be used for that purpose and once they understand that the covered entity is being paid to make a particular recommendation.

I look forward to working with all interested parties to resolve this problem in a timely manner for consumers and 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. 3064

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 Records Confidentiality Act of 2002''.

SEC. 2. DEFINITIONS.

In this Act:

(1) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term ''individually identifiable health information'' means information that is a subset of health information, including demographic information collected from an individual, that—

(A) is created or received from a health care provider, health plan, employer, or health care clearinghouse;

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; and

(C)(i) identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(2) MARKETING.—The term ''marketing'' means to make a communication about a product or service to encourage recipients of the communication to purchase or use the product or service, but does not include communications made as part of the treatment of a patient for the purpose of furthering treatment unless the covered entity receives direct or indirect remuneration from a third party for making the communication.

SEC. 3. PROTECTION OF PRIVATE HEALTH INFORMATION.

Except in accordance with section 4, a health care provider, pharmacy, health researcher, health plan, health oversight agency, public health authority, employer, health or life insurer, or school or university shall not—

(1) disclose individually identifiable health information to an entity for marketing the products or services of such entity; or

(2) use individually identifiable health information in its possession to provide marketing services to any entity.

SEC. 4. NOTICE AND CONSENT REQUIREMENTS.

A health care provider, pharmacy, health researcher, health plan, health oversight agency, public health authority, employer, health or life insurer, or school or university may provide marketing services to a pharmaceutical company if such health care entity—

(1) provides clear and conspicuous notice to the individual involved concerning its disclosure practices for all individually identifiable health information collected or created with regard to the individual; and

(2) obtains the consent of the individual involved to use the information and that consent is manifested by an affirmative act in a written communication which only references and applies to the specific marketing purpose for which the information is to be used.

By Mr. INOUYE:

S. 3066. A bill to improve programs relating to Indian tribes; to the Committee on Indian Affairs.

Mr. INOUYE. Mr. President, I ask unanimous consent that the text of the bill and a section-by-section analysis be printed in the RECORD.

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

S. 3066

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Indian Technical Corrections Act''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. DEFINITION OF SECRETARY.

In this Act, the term ''Secretary'' means the Secretary of the Interior.

TITLE I—PROGRAMS RELATING TO INDIAN TRIBES

SEC. 101. LEASES OF RESTRICTED LAND.

Subsection (a) of the first section of the Act of August 9, 1955 (25 U.S.C. 415(a)) is amended by adding at the end the following: ''Notwithstanding any other provision of law, no approval by the Secretary shall be required for any new lease, or for renewal of any existing lease, of land under this subsection if the lease, including all periods covered by any renewal, is for an aggregate term of less than 7 years.''.

SEC. 102. LEASE OF TRIBALLY-OWNED LAND BY ASSINIBOINE AND SIOUX TRIBES OF THE FORT PECK RESERVATION.

The first section of the Act of August 9, 1955 (25 U.S.C. 415) is amended by adding at the end the following:

''(g) LEASE OF TRIBALLY-OWNED LAND BY ASSINIBOINE AND SIOUX TRIBES OF THE FORT PECK RESERVATION.—

''(1) IN GENERAL.—Notwithstanding subsection (a) and any regulations under part 162 of title 25, Code of Federal Regulations, subject to paragraph (2), the Assiniboine and Sioux Tribes of the Fort Peck Reservation may lease to the Northern Border Pipeline Company tribally-owned land on the Fort Peck Indian Reservation for 1 or more interstate gas pipelines.

''(2) CONDITIONS.—A lease entered into under paragraph (1)—

''(A) shall commence during fiscal year 2011 for an initial term of 25 years;

''(B) may be renewed for an additional term of 25 years; and

''(C) shall specify in the terms of the lease an annual rental rate—

''(i) which rate shall be increased by 3 percent for each 5-year period; and

''(ii) the adjustment of which in accordance with clause (i) shall be considered to satisfy any review requirement under part 162 of title 25, Code of Federal Regulations.''.

SEC. 103. NAVAJO-HOPI RELOCATION IMPACT STUDY.

(a) IN GENERAL.—Section 34 of Public Law 93–531 (commonly known as the ''Navajo-Hopi Land Settlement Act of 1974'') (25 U.S.C. 640d et seq.) (as added by section 203 of the Indian Programs Reauthorization and Technical Amendments Act of 2002) is amended to read as follows:

''SEC. 34. NAVAJO-HOPI RELOCATION IMPACT STUDY.

''(a) IN GENERAL.—Not later than 120 days after the date of enactment of this section, the Office of Navajo and Hopi Indian Relocation shall enter into a contract with an independent contractor under which the independent contractor shall complete, not later than 18 months after the date of enactment of this section, a study to determine whether—

''(1) the purposes of this Act have been achieved; and

''(2) recommended activities should be carried out to mitigate the consequences of the implementation of this Act.

''(b) SCOPE.—The study conducted under subsection (a) shall include an analysis of—

''(1) the long-term effects of the relocation programs under this Act on the Hopi Tribe and the Navajo Nation;

''(2) the ongoing needs of the Hopi and Navajo populations relocated under this Act;

''(3) the ongoing needs of the other communities affected by relocations under this Act (including communities affected by section 10(f) and communities on Hopi partitioned land and Navajo partitioned land);

''(4) the effects of termination of the relocation programs under this Act, including the effects of—

''(A) closure of the Office of Navajo and Hopi Indian Relocation; and

''(B) transfer of responsibilities of that Office to other Federal agencies, the Hopi Tribe, and the Navajo Nation in accordance with applicable provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.); and

''(5) other appropriate factors, as determined by the Office of Navajo and Hopi Indian Relocation.

''(c) RESTRICTION ON STUDY.—The study conducted under subsection (a) shall neither address, nor make any recommendations relating to, the relocation requirements for Navajos and Hopis under this Act, including any proposals for the return of Navajos or Hopis.

''(d) REPORT.—Not later than 2 years after the date of enactment of this section, the Office of Navajo and Hopi Relocation shall submit to Congress, the Hopi Tribe, and the Navajo Nation a report that describes the results of the study conducted under subsection (a).

''(e) FUNDING.—Of amounts made available to the Office of Navajo and Hopi Indian Relocation, not more than $1,000,000 shall be made available to carry out this section.''.

(b) EFFECTIVE DATE.—The amendment made by this section takes effect on the later of—

(1) the date of enactment of this Act; or

(2) the date of enactment of the Indian Programs Reauthorization and Technical Amendments Act of 2002.

SEC. 104. INDIAN HEALTH DEMONSTRATION PROJECT.

Section 10 of the Ponca Restoration Act (25 U.S.C. 983h) is amended by adding at the end the following:

''(e) DEMONSTRATION PROJECT.—The Director of the Indian Health Service shall direct the Aberdeen Area Office of the Indian Health Service to carry out, in coordination with the Tribe, a demonstration project to determine—

''(1) the ability of an urban, restored facility of the Tribe to provide health services to members residing in Douglas County and Sarpy County, Nebraska, and Pottawattamie County, Iowa;

''(2) the viability of using third-party billing to enable a facility described in paragraph (1) to become self-sustaining; and

''(3) the effectiveness of using a computer-registered patient management system in the counties specified in paragraph (1).''.

SEC. 105. FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECT GRANTS.

Section 708(f)(2) of the Indian Health Care Improvement Act (25 U.S.C. 1665g(f)(2)) (as amended by section 103(g)(1)(C) of the Indian Programs Reauthorization and Technical Amendments Act of 2002) is amended by inserting before the period at the end the following: ''(including to carry out demonstration projects that involve 1 or more Indian tribes, tribal organizations, or urban Indian organizations working with organizations such as the National Organization on Fetal Alcohol Syndrome to carry out subparagraphs (A) and (F) of subsection (a)(2))''.

SEC. 106. ILLEGAL NARCOTICS TRAFFIC ON THE TOHONO O'ODHAM AND ST. REGIS RESERVATIONS.

(a) IN GENERAL.—Section 4216(a)(3) of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2442(a)(3)) (as amended by section 104(e)(1) of the Indian Programs Reauthorization and Technical Amendments Act of 2002) is amended by striking paragraph (3) and inserting the following:

''(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated—

''(A) to carry out paragraph (1)(A), $1,000,000 for each of fiscal years 2002 through 2006; and

''(B) to carry out provisions of this subsection other than paragraph (1)(A), such sums as are necessary for each of fiscal years 2002 through 2006.''.

(b) EFFECTIVE DATE.—The amendment made by this section takes effect on the later of—

(1) the date of enactment of this Act; or

(2) the date of enactment of the Indian Programs Reauthorization and Technical Amendments Act of 2002.

SEC. 107. REHABILITATION OF CELILO INDIAN VILLAGE.

Section 401(b)(3) of Public Law 100–581 (102 Stat. 2944) is amended by inserting ''Celilo Village and other'' before ''existing sites''.

SEC. 108. RURAL HEALTH CARE FACILITY, FORT BERTHOLD INDIAN RESERVATION, NORTH DAKOTA.

The Three Affiliated Tribes and Standing Rock Sioux Tribe Equitable Compensation Act is amended—

(1) in section 3504 (106 Stat. 4732), by adding at the end the following:

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.''; and

(2) by striking section 3511 (106 Stat. 4739) and inserting the following:

''SEC. 3511. RURAL HEALTH CARE FACILITY, FORT BERTHOLD INDIAN RESERVATION, NORTH DAKOTA.

''There is authorized to be appropriated to the Secretary of Health and Human Services for the construction of a rural health care facility on the Fort Berthold Indian Reservation of the Three Affiliated Tribes, North Dakota, $20,000,000.''.

SEC. 109. HEALTH CARE FUNDING ALLOCATION, EAGLE BUTTE SERVICE UNIT.

Section 117 of the Indian Health Care Improvement Act (25 U.S.C. 1616j) is amended by adding at the end the following:

''(g) CHEYENNE RIVER SIOUX TRIBE BONUS PAYMENT.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, to promote more efficient use of the health care funding allocation for fiscal year 2003, the Eagle Butte Service Unit of the Indian Health Service, at the request of the Cheyenne River Sioux Tribe, may carry out a program under which a health professional may be paid—

''(A) a base salary in an amount up to the highest grade and step available to a physician, pharmacist, or other health professional, as the case may be; and

''(B) a recruitment or retention bonus of up to 25 percent of the base salary rate of the health professional.

''(2) MONITORING AND REPORTING.—If the Service implements the program under paragraph (1), the Service shall—

''(A) monitor the program closely; and

''(B) not later than September 30, 2003, submit to the Committee on Indian Affairs of the Senate and the Committee on Resources and the Committee on Energy and Commerce of the House of Representatives a report that includes an evaluation of the program.''.

SEC. 110. OKLAHOMA NATIVE AMERICAN CULTURAL CENTER AND MUSEUM.

Section 1 of the Act entitled ''An Act to authorize the construction of a Native American Cultural Center and Museum in Oklahoma City, Oklahoma'' is amended—

(1) by striking subsection (c)(3) and inserting the following:

''(3) DIRECTOR.—The term 'Director' means the Director of the Institute of Museum and Library Services.''; and

(2) by striking ''Secretary'' each place it appears and inserting ''Director''.

SEC. 111. CERTIFICATION OF RENTAL PROCEEDS.

Notwithstanding any other provision of law, any actual rental proceeds from the lease of land acquired under section 1 of Public Law 91–229 (25 U.S.C. 488) certified by the Secretary of the Interior shall be deemed—

(1) to constitute the rental value of that land; and

(2) to satisfy the requirement for appraisal of that land.

SEC. 112. WAIVER OF REPAYMENT OF EXPERT ASSISTANCE LOANS TO THE OGLALA SIOUX TRIBE.

Notwithstanding any other provision of law—

(1) the balances of all outstanding expert assistance loans made to the Oglala Sioux Tribe under Public Law 88–168 (77 Stat. 301), and relating to Oglala Sioux Tribe v. United States (Docket No. 117 of the United States Court of Federal Claims), including all principal and interest, are canceled; and

(2) the Secretary of the Interior shall take such action as is necessary to—

(A) document the cancellation under paragraph (1); and

(B) release the Oglala Sioux Tribe from any liability associated with any loan described in paragraph (1).

SEC. 113. WAIVER OF REPAYMENT OF EXPERT ASSISTANCE LOANS TO THE SEMINOLE TRIBE OF OKLAHOMA.

Notwithstanding any other provision of law—

(1) the balances of all outstanding expert assistance loans made to the Seminole Tribe of Oklahoma under Public Law 88–168 (77 Stat. 301), and relating to Seminole Tribe of Oklahoma v. United States (Docket No. 247 of the United States Court of Federal Claims), including all principal and interest, are canceled; and

(2) the Secretary of the Interior shall take such action as is necessary to—

(A) document the cancellation under paragraph (1); and

(B) release the Seminole Tribe of Oklahoma from any liability associated with any loan described in paragraph (1).

SEC. 114. FACILITATION OF CONSTRUCTION OF PIPELINE TO PROVIDE WATER FOR EMERGENCY FIRE SUPPRESSION AND OTHER PURPOSES.

(a) IN GENERAL.—Notwithstanding any other provision of law, subject to valid existing rights under Federal and State law, the land described in subsection (b), fee title to which is held by the Barona Band of Mission Indians of California (referred to in this section as the ''Band'')—

(1) is declared to be held in trust by the United States for the benefit of the Band; and

(2) shall be considered to be a portion of the reservation of the Band.

(b) LAND.—The land referred to in subsection (a) is land comprising approximately 85 acres in San Diego County, California, and described more particularly as follows: San Bernardino Base and Meridian; T. 14 S., R. 1 E.; sec. 21: W½SE¼, 68 acres; NW¼NW¼, 17 acres.

(c) GAMING.—The land taken into trust by subsection (a) shall neither be considered to have been taken into trust for gaming, nor be used for gaming (as that term is used in the Indian Gaming Regulatory Act (25 U.S.C. 2701 et seq.).

SEC. 115. CONVEYANCE OF NATIVE ALASKAN OBJECTS.

Notwithstanding any provision of law affecting the disposal of Federal property, on the request of the Chugach Alaska Corporation or Sealaska Corporation, the Secretary of Agriculture shall convey to whichever of

those corporations that has received title to a cemetery site or historical place on National Forest System land conveyed under section 14(h)(1) of the Alaska Native Claims Settlement Act (43 U.S.C. 1613(h)(1)) all artifacts, physical remains, and copies of any available field records that—

(1)(A) are in the possession of the Secretary of Agriculture; and

(B) have been collected from the cemetery site or historical place; but

(2) are not required to be conveyed in accordance with the Native American Graves Protection Act and Repatriation Act (25 U.S.C. 3001 et seq.) or any other applicable law.

SEC. 116. SHAKOPEE FEE LAND.

(a) IN GENERAL.—Notwithstanding any other provision of law, without further authorization by the United States, the Shakopee Mdewakanton Sioux Community in the State of Minnesota (referred to in this section as the ''Community'') may lease, sell, convey, warrant, or otherwise transfer all or any part of the interest of the Community in or to any real property that is not held in trust by the United States for the benefit of the Community.

(b) TRUST LAND NOT AFFECTED.—Nothing in this section—

(1) authorizes the Community to lease, sell, convey, warrant, or otherwise transfer all or part of an interest in any real property that is held in trust by the United States for the benefit of the Community; or

(2) affects the operation of any law governing leasing, selling, conveying, warranting, or otherwise transferring any interest in that trust land.

SEC. 117. AGREEMENT WITH DRY PRAIRIE RURAL WATER ASSOCIATION, INCORPORATED.

(a) IN GENERAL.—Any agreement between the Tribe and Dry Prairie Rural Water Association, Incorporated (or any non-Federal successor entity) for the use of water to meet the needs of the Dry Prairie system that is entered into under section 5 of the Fort Peck Reservation Rural Water System Act of 2000 (114 Stat. 1454)—

(1) is approved by Congress; and

(2) shall be approved and executed by the Secretary.

TITLE II—COLLABORATION BETWEEN TRIBAL GOVERNMENTS AND FOREST SERVICE

SEC. 201. SHORT TITLE.

This title may be cited as the ''Tribal Governments and Forest Service Collaboration Act of 2002''.

SEC. 202. FINDINGS.

Congress finds that—

(1) Indian tribes, members of Indian tribes, and Alaska Natives hold 100,600,000 acres of land (56,600,000 acres in the lower 48 States and 44,000,000 acres in Alaska), equaling 4.2 percent of the land area of the United States;

(2) land held in trust for Indian tribes shares thousands of miles of common boundary with National Forest System land;

(3) Indian tribes have reserved rights and interests that affect the management of hundreds of thousands of acres of National Forest System land;

(4) National Forest System land contains hundreds of thousands of acres in which Indian tribes have cultural, religious, and traditional interests, including interests recognized in—

(A) the Native American Graves Protection and Repatriation Act (25 U.S.C. 3001 et seq.); and

(B) the Act of August 11, 1978 (42 U.S.C. 1996 et seq.) (commonly referred to as the ''American Indian Religious Freedom Act'');

(5) tribal land and National Forest System land share natural resource attributes in many common ecosystems, including biodiversity of plant and animal fauna, timber, fish, wildlife, range, soils, recreation attributes, airsheds, and watersheds;

(6) effective ecosystem management—

(A) integrates ecological principles and economic and social factors; and

(B) safeguards ecological sustainability, biodiversity, and productivity;

(7) Federal land management activities on National Forest System land are affecting ecosystems that encompass National Forest System land and tribal land;

(8) collaborative planning and management between Indian tribes and the Forest Service needs to be strengthened;

(9) management practices on National Forest System land can—

(A) adversely affect tribal trust, cultural, religious, and traditional resources on National Forest System land; and

(B) place tribal land and resources at risk;

(10) Indian tribal land managers and National Forest System land managers have shared interests in maintaining the health of the forests and in coordinating and sustaining the timber supply from National Forest System land and tribal trust land in order to jointly contribute to the economic stability of local, timber-dependent communities;

(11) cross-boundary management collaboration is needed to address forest health emergencies that currently exist on Federal and tribal forest land because of substantial areas of dead and dying trees resulting from drought, insects, fire, windstorm, or other causes;

(12) tribal communities possess unique traditional knowledge and technical expertise that can provide valuable insight and guidance in the management of land and resources contained within the National Forest System;

(13) the Forest Service lacks comprehensive authorities to work with tribal neighbors on collaborative or other issues;

(14)(A) in recognition of that goal, in October 1999, the Chief Operating Officer of the Forest Service commissioned a National Tribal Relations Program Task Force to develop recommendations to improve working relationships with Indian tribes; and

(B) the Task Force issued a final report in August 2000, including administrative and legislative recommendations on which this title is based;

(15) Indian tribes and National Forests would benefit from improved coordination and integration in application of wildland fire resources, including Native American fire crews; and

(16) the Forest and Rangeland Renewable Resources Research Act of 1978 (16 U.S.C. 1600 et seq.) does not contain specific authority for the Secretary to enter into cooperative research and development agreements with tribal governments.

SEC. 203. FOREST LEGACY PROGRAM.

(a) PARTICIPATION BY INDIAN TRIBES.—Section 7 of the Cooperative Forestry Assistance Act of 1978 (16 U.S.C. 2103c) is amended—

(1) in the first sentence of subsection (a), by inserting '', and Indian tribes,'' after ''government'';

(2) in subsection (b), by inserting ''and programs of Indian tribes'' after ''regional programs'';

(3) in the second sentence of subsection (f), by striking ''other appropriate State or regional natural resource management agency'' and inserting ''other appropriate natural resource management agency of a State, region, or Indian tribe'';

(4) in subsection (h)(2), by inserting ''or Indian tribe'' before the period at the end; and

(5) in the first sentence of subsection (j)(2), by inserting ''Indian tribes,'' after ''governmental units,''.

(b) OPTIONAL STATE AND TRIBAL GRANT PROGRAM.—

''(1) IN GENERAL.—Section 7 of the Cooperative Forestry Assistance Act of 1978 (16 U.S.C. 2103c) is amended by striking subsection (l) and inserting the following:

''(l) OPTIONAL STATE AND TRIBAL GRANTS.—

''(1) DEFINITION OF INDIAN TRIBE.—In this subsection, the term 'Indian tribe' has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

''(2) GRANTS.—At the request of a participating State or participating Indian tribe, the Secretary shall provide a grant to the State or Indian tribe to carry out the Forest Legacy Program.

''(3) ADMINISTRATION.—If a State or Indian tribe elects to receive a grant under this subsection—

''(A) the Secretary shall use a portion of the funds made available under subsection (m), as determined by the Secretary, to provide the grant to the State or Indian tribe; and

''(B) the State or Indian tribe shall use the grant to carry out the Forest Legacy Program.''.

(2) CONFORMING AMENDMENTS.—Section 7 of the Cooperative Forestry Assistance Act of 1978 (16 U.S.C. 2103c) is amended—

(A) in subsection (i), by striking ''subsection (b)'' and inserting ''this section'';

(B) in subsection (j)(1), by striking the first sentence and inserting the following: ''Fair market value shall be paid for any property interest acquired under this section.''; and

(C) in subsection (k)(2), by striking ''United States or its'' and inserting ''United States, a State, Indian tribe, or other entity, or their''.

SEC. 204. FORESTRY AND RESOURCE MANAGEMENT ASSISTANCE TO INDIAN TRIBES.

(a) AUTHORITY TO PROVIDE ASSISTANCE.—The Secretary of Agriculture may provide financial, technical, educational, and related assistance to an Indian tribe (as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)) for—

(1) tribal consultation and coordination with the Forest Service on issues relating to—

(A) access by members of the Indian tribe to National Forest System land for traditional, religious, and cultural purposes;

(B) coordinated or cooperative management of resources shared by the Forest Service and the Indian tribe; and

(C) provision of tribal traditional, cultural, or other expertise or knowledge;

(2) projects and activities for conservation education and awareness with respect to forest land and grassland under the jurisdiction of the Indian tribe; and

(3) technical assistance for forest resources planning, management, and conservation on land under the jurisdiction of the Indian tribe.

(b) IMPLEMENTATION.—

(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Secretary of Agriculture shall promulgate regulations to implement subsection (a), including rules for determining the distribution of assistance under that subsection.

(2) CONSULTATION.—In carrying out paragraph (1), the Secretary shall engage in full, open, and substantive consultation with Indian tribes and representatives of Indian tribes.

(c) COORDINATION WITH THE SECRETARY OF THE INTERIOR.—The Secretary of Agriculture shall coordinate with the Secretary of the

Interior during the establishment, implementation, and administration of subsection (a) to ensure that programs under that subsection—

(1) do not conflict with tribal programs provided under the authority of the Department of the Interior; and

(2) meet the goals of the Indian tribes.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

TITLE III—PUEBLO OF SANTA CLARA AND SAN ILDEFONSO, NEW MEXICO

SEC. 301. DEFINITIONS.

In this title:

(1) AGREEMENT.—The term ''Agreement'' means the agreement entitled ''Agreement to Affirm Boundary Between Pueblo of Santa Clara and Pueblo of San Ildefonso Aboriginal Lands Within Garcia Canyon Tract'', entered into by the Governors on December 20, 2000.

(2) BOUNDARY LINE.—The term ''boundary line'' means the boundary line established under section 304(a).

(3) GOVERNORS.—The term ''Governors'' means—

(A) the Governor of the Pueblo of Santa Clara, New Mexico; and

(B) the Governor of the Pueblo of San Ildefonso, New Mexico.

(4) INDIAN TRIBE.—The term ''Indian tribe'' has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

(5) PUEBLOS.—The term ''Pueblos'' means—

(A) the Pueblo of Santa Clara, New Mexico; and

(B) the Pueblo of San Ildefonso, New Mexico.

(6) TRUST LAND.—The term ''trust land'' means the land held by the United States in trust under section 302(a) or 303(a).

SEC. 302. TRUST FOR THE PUEBLO OF SANTA CLARA, NEW MEXICO.

(a) IN GENERAL.—All right, title, and interest of the United States in and to the land described in subsection (b), including improvements on, appurtenances to, and mineral rights (including rights to oil and gas) to the land, shall be held by the United States in trust for the Pueblo of Santa Clara, New Mexico.

(b) DESCRIPTION OF LAND.—The land referred to in subsection (a) consists of approximately 2,484 acres of Bureau of Land Management land located in Rio Arriba County, New Mexico, and more particularly described as—

(1) the portion of T. 20 N., R. 7 E., sec. 22, New Mexico Principal Meridian, that is located north of the boundary line;

(2) the southern half of T. 20 N., R. 7 E., sec. 23, New Mexico Principal Meridian;

(3) the southern half of T. 20 N., R. 7 E., sec. 24, New Mexico Principal Meridian;

(4) T. 20 N., R. 7 E., sec. 25, excluding the 5–acre tract in the southeast quarter owned by the Pueblo of San Ildefonso;

(5) the portion of T. 20 N., R. 7 E., sec. 26, New Mexico Principal Meridian, that is located north and east of the boundary line;

(6) the portion of T. 20 N., R. 7 E., sec. 27, New Mexico Principal Meridian, that is located north of the boundary line;

(7) the portion of T. 20 N., R. 8 E., sec. 19, New Mexico Principal Meridian, that is not included in the Santa Clara Pueblo Grant or the Santa Clara Indian Reservation; and

(8) the portion of T. 20 N., R. 8 E., sec. 30, that is not included in the Santa Clara Pueblo Grant or the San Ildefonso Grant.

SEC. 303. TRUST FOR THE PUEBLO OF SAN ILDEFONSO, NEW MEXICO.

(a) IN GENERAL.—All right, title, and interest of the United States in and to the land described in subsection (b), including improvements on, appurtenances to, and mineral rights (including rights to oil and gas) to the land, shall be held by the United States in trust for the Pueblo of San Ildefonso, New Mexico.

(b) DESCRIPTION OF LAND.—The land referred to in subsection (a) consists of approximately 2,000 acres of Bureau of Land Management land located in Rio Arriba County and Santa Fe County in the State of New Mexico, and more particularly described as—

(1) the portion of T. 20 N., R. 7 E., sec. 22, New Mexico Principal Meridian, that is located south of the boundary line;

(2) the portion of T. 20 N., R. 7 E., sec. 26, New Mexico Principal Meridian, that is located south and west of the boundary line;

(3) the portion of T. 20 N., R. 7 E., sec. 27, New Mexico Principal Meridian, that is located south of the boundary line;

(4) T. 20 N., R. 7 E., sec. 34, New Mexico Principal Meridian; and

(5) the portion of T. 20 N., R. 7 E., sec. 35, New Mexico Principal Meridian, that is not included in the San Ildefonso Pueblo Grant.

SEC. 304. SURVEY AND LEGAL DESCRIPTIONS.

(a) SURVEY.—Not later than 180 days after the date of enactment of this Act, the Office of Cadastral Survey of the Bureau of Land Management shall, in accordance with the Agreement, complete a survey of the boundary line established under the Agreement for the purpose of establishing, in accordance with sections 302(b) and 303(b), the boundaries of the trust land.

(b) LEGAL DESCRIPTIONS.—

(1) PUBLICATION.—On approval by the Governors of the survey completed under subsection (a), the Secretary shall publish in the Federal Register—

(A) a legal description of the boundary line; and

(B) legal descriptions of the trust land.

(2) TECHNICAL CORRECTIONS.—Before the date on which the legal descriptions are published under paragraph (1)(B), the Secretary may correct any technical errors in the descriptions of the trust land provided in sections 302(b) and 303(b) to ensure that the descriptions are consistent with the terms of the Agreement.

(3) EFFECT.—Beginning on the date on which the legal descriptions are published under paragraph (1)(B), the legal descriptions shall be the official legal descriptions of the trust land.

SEC. 305. ADMINISTRATION OF TRUST LAND.

(a) IN GENERAL.—Effective beginning on the date of enactment of this Act—

(1) the land held in trust under section 302(a) shall be declared to be a part of the Santa Clara Indian Reservation; and

(2) the land held in trust under section 303(a) shall be declared to be a part of the San Ildefonso Indian Reservation.

(b) APPLICABLE LAW.—

(1) IN GENERAL.—The trust land shall be administered in accordance with any law (including regulations) or court order generally applicable to property held in trust by the United States for Indian tribes.

(2) PUEBLO LANDS ACT.—The following shall be subject to section 17 of the Act of June 7, 1924 (commonly known as the ''Pueblo Lands Act'') (25 U.S.C. 331 note):

(A) The trust land.

(B) Any land owned as of the date of enactment of this Act or acquired after the date of enactment of this Act by the Pueblo of Santa Clara in the Santa Clara Pueblo Grant.

(C) Any land owned as of the date of enactment of this Act or acquired after the date of enactment of this Act by the Pueblo of San Ildefonso in the San Ildefonso Pueblo Grant.

(c) USE OF TRUST LAND.—

(1) IN GENERAL.—Subject to the criteria developed under paragraph (2), the trust land may be used only for—

(A) traditional and customary uses; or

(B) stewardship conservation for the benefit of the Pueblo for which the trust land is held in trust.

(2) CRITERIA.—The Secretary shall work with the Pueblos to develop appropriate criteria for using the trust land in a manner that preserves the trust land for traditional and customary uses or stewardship conservation.

(3) LIMITATION.—Beginning on the date of enactment of this Act, the trust land shall not be used for any new commercial developments.

SEC. 306. EFFECT.

Nothing in this title—

(1) affects any valid right-of-way, lease, permit, mining claim, grazing permit, water right, or other right or interest of a person or entity (other than the United States) that is—

(A) in or to the trust land; and

(B) in existence before the date of enactment of this Act;

(2) enlarges, impairs, or otherwise affects a right or claim of the Pueblos to any land or interest in land that is—

(A) based on Aboriginal or Indian title; and

(B) in existence before the date of enactment of this Act;

(3) constitutes an express or implied reservation of water or water right with respect to the trust land; or

(4) affects any water right of the Pueblos in existence before the date of enactment of this Act.

SECTION BY SECTION ANALYSIS OF S. 3059—ASSINIBOINE AND SIOUX TRIBES OF THE FORT PECK RESERVATION JUDGMENT FUND DISTRIBUTION ACT OF 2002

Section 1. Short Title. The Act may be cited as the ''Assiniboine and Sioux Tribes of the Fort Peck Reservation Judgment Fund Distribution Act of 2002.''

Section 2. Findings and Purpose. Section 2 provides congressional findings including that in 1987, the Assiniboine and Sioux Tribes of the Fort Peck Reservation and five individual Fort Peck tribal members filed a complaint in the United States Claims Court in Assiniboine and Sioux Tribes of the Fort Peck Reservation v. the United States of America, Docket No. 773–87–L to recover interest earned on trust funds while those funds were held in special deposit and IMPL-agency accounts; in this case, the Court held that the United States was liable for any income derived from investment of the trust funds of the Tribe and individual members of the Tribe; the plaintiffs entered into a settlement with the United States for payment of the claims; the terms of the settlement were approved by the Court and judgment in the amount of $4,522,551.81 was entered;

Section 3. Definitions. Terms defined in this section include ''Distribution Amount,'' ''Judgment Amount,'' ''Principal Indebtedness,'' and ''Tribe.''

Section 4. Distribution of Judgment Funds. Section 4 describes how the distribution amount awarded to the Tribe shall be made available for tribal health, education, housing and social services programs of the Tribe and the amount of funds allocated among these uses shall be specified in an annual budget developed by the Tribe and approved by the Secretary of the Interior.

Section 5. Applicable Law. Section 5 provides that all funds distributed under this act, except those distributed under Section 4 are subject to sections 7 and 8 of the Indian Tribal Judgment Funds Use or Distribution Act.

Section 6. Agreement with Dry Prairie Rural Water Association, Incorporated. Section 6 provides that any agreement between the Tribe and the Dry Prairie Rural Water Association for the use of water that is entered into under section 5 of the Fort Peck Reservation Rural Water System Act of 2000 is approved by Congress and shall be approved and executed by the Secretary.

By Mr. THOMPSON:

S. 3067. A bill to amend title 44, United States Code, to make Government information security reform permanent, and for other purposes; to the Committee on Governmental Affairs.

Mr. THOMPSON. Mr. President, I rise today to introduce a bill which will make permanent a law which was intended to protect the security of Federal computers and information systems. Over the years, numerous Governmental Affairs Committee hearings and General Accounting Office reports uncovered and identified systemic failures of government information systems which highlighted our Nation's vulnerability to computer attacks, from international and domestic terrorists to crime rings to everyday hackers. As a result, Congress enacted the Government Information Security Reform Act as part of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001, Public Law 106–398. Since its passage in the 106th Congress, the law has required Federal agencies to develop and implement security policies and provided the Office of Management and Budget authority to demand from agencies better plans for improving computer security. Unfortunately, this relatively new law is set to expire next month.

The information security legislation upon which the law is based, which I sponsored along with Senator LIEBERMAN, was reported by the Governmental Affairs Committee and passed by the Senate with no sunset provision. A two-year sunset was added in conference providing that the law expire on November 29, 2002.

The bill I am introducing today would repeal the sunset and restore the language to what originally was approved by the Governmental Affairs Committee and the Senate last Congress. Further, given that the law is commonly referred to as the ''Government Information Security Reform Act,'' the bill also would codify that short title.

We must ensure that Federal agencies continue to protect their assets and prevent hackers and cyberterrorists from wreaking havoc with citizens' sensitive information, such as taxpayer data, veterans' medical records, and social security portfolios. We must not let this law expire.

By Mr. SPECTER:

S. 3068. A bill to amend the Agricultural Adjustment Act to require the Secretary of Agriculture to use the price of feed grains and other cash expenses as factors to determine the basic formula price for milk under milk marketing orders; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. SPECTER. Mr. President, I had sought recognition initially to discuss two other subjects. While the issue of Iraq is very much on the minds of the American people and the focus of attention worldwide, there are other important considerations which are pending and are of interest to Pennsylvanians and what is happening with the economy.

We really cannot let our attention focus solely on Iraq.

There are many matters which involve important economic issues and great numbers of jobs. That is a subject that is very much on my mind with respect to the Pennsylvania dairy farmers. I propose to introduce legislation this afternoon on that subject.

Agriculture is the largest industry in Pennsylvania, and dairy is its single largest component. Pennsylvania is the fourth largest dairy producer in the Nation. We have approximately 10,300 dairy farms which produce $1.710 billion worth of milk each year.

Regrettably, over the past decades, Pennsylvania has lost an average of 300 to 500 dairy farmers per year. In the years 1993 to 1998, Pennsylvania lost more than 11 percent of its dairy farmers. That is because Pennsylvania farmers have had to deal with drought and other natural disasters, high feed and transportation costs, and other variables that challenge their ability to sustain their farms, but mostly because the cost of production exceeds what has been the average price for class 3 dairy products. It varies tremendously. It was $15.90 in September of last year. It went down to $9.92 in September of this year. The cost has been tremendous.

Meanwhile, the average cost of production of milk in Pennsylvania per hundredweight is calculated by the Pennsylvania Department of Agriculture. The average was $14.32 in the year 2001. The price for milk in January of 2002 was $11.87 per hundredweight, going down to $10.82 per hundredweight in May, and $9.54 per hundredweight in August of this year. The cost of production exceeds what the Pennsylvania dairy farmers are able to obtain for their milk.

I serve on the Agriculture Subcommittee of Appropriations. On May 14 of last year at an extensive hearing in Philadelphia, we heard from economists, we heard from farmers, and an analysis for merchants and an analysis of what was happening on dairy farming.

It is a complex matter. While the price of milk goes down for dairy farmers, the cost of milk goes up to the consumer. I know at the shop where I buy a half-gallon of milk, it was $1.89, and it jumped to $2.19 for a half-gallon of milk at the precise time when the payments made to the dairy farmers were going down. It seems to me there really has to be an additional factor in the calculation of these prices by the U.S. Department of Agriculture.

It is for that reason that I am proposing legislation today which would amend section 8(c)(5) of the Agriculture Adjustment Act with amendments by the Agriculture Marketing Agreement Act of 1937 to add the following:

Subsection M, using as factors to determine the basic formula price for milk under an order issued pursuant to this section (i) the price of feed grains, including the cost of concentrates, by-products, liquid, whey, hay, silage, pasture, and other forage; and (ii) other cash expenses, including the cost of hauling, artificial insemination, veterinary services and medicine, bedding and litter, marketing, custom services and supplies, fuel, lubrication, electricity, machinery and building repairs, labor, association fees, and assessments.

During the course of the July and August break, I traveled extensively on open house town meetings throughout Pennsylvania. I heard recurrent complaints from the dairy farmers about being unable to maintain the dairy farms. It is a very important matter that the small dairy farmers be able to continue to produce milk, which is a very important item in our daily diets. I don't think I need to expand upon that point.

But the dairy farmers are facing enormous problems. We had hoped there would be a dairy compact. There had been one for the New England States. Legislation has been introduced—S. 1157—which is now pending before the Judiciary Committee. And the dairy compact would be of material assistance to farmers generally but certainly farmers in Pennsylvania.

We had many Senators supporting the dairy compact concept but have had contentious battles on the Senate floor. And while the proposed legislation on the dairy compact was pending, I do propose the legislation to which I refer, and I send that amendment to the desk.

SUBMITTED RESOLUTIONS

SENATE RESOLUTIONS 335—RELATIVE TO THE DEATH OF JO-ANNE COE

Mr. DASCHLE (for himself and Mr. LOTT) submitted the following resolution; which was considered and agreed to:

S. RES. 335

Whereas Jo-Anne Coe served as an employee of the Senate of the United States and ably and faithfully upheld the high standards and traditions of the staff of the Senate from January 3, 1969 until January 31, 1989 for a period that included ten Congresses;

Whereas Jo-Anne Coe was the first woman in history to be elected as the Secretary of the Senate in 1985;

Whereas Jo-Anne Coe served as Secretary of the Senate, Administrative Director of the