due to inadequate resources; one-tenth reported not eating for an entire day at least once in the last 6 months.

States are vocal about the problems created by current eligibility restrictions for immigrants. Sixteen of them provide food stamp replacement benefits with their own funds. Many others, according to the National Conference of State Legislatures, have appropriated additional resources for food banks and a variety of charitable programs serving the immigrant population.

The Food Stamp Program is the foundation of our country's nutrition safety net for vulnerable people. Until 1996, eligibility was based only on a family's financial need. Many, including President Bush, now voice the opinion that the food stamp immigrant policies legislated at that time were too harsh. I congratulate the President for his advocacy and the publicity that has surrounded that. It was a high-profile advocacy.

I ask that each of us in the Senate endorse the Bush administration's food stamp policy by voting for Senator DURBIN's amendment, which the Senator has pointed out encompasses exactly the same goals. It is our opportunity, in a bipartisan way, hopefully in a unanimous way, to improve the capacity of the Food Stamp Program to operate as a genuine nutrition safety net for our country.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Ms. CANTWELL). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

MORNING BUSINESS

Mr. REID. Madam President, I ask unanimous consent the Senate proceed to a period for morning business with Senators permitted to speak therein for up to 10 minutes each.

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

JEAN MARIE NEAL

Ms. STABENOW. Madam President, I rise to invite Members and staff to join me and my staff as we celebrate and thank this evening, in the Mansfield Room, Jean Marie Neal, who has been my chief of staff for the last year, my first year in the Senate. While I understand the rules of the Senate do not allow me to acknowledge her presence in the gallery, I do want to indicate that I believe it is important to recognize the service of this wonderful woman who has spent 21 years in the service of the Congress, the majority of that in the Senate, working for Senator Dick Bryan.

It is important to note that when we have someone who is dedicated to the Senate, to helping us achieve our goals, to be able to put forward those matters that allow us to represent our constituents and make our States and our country better places, that when that person decides to retire from their position and move on to other challenges, it is important that we recognize them and say thank you. That is what I want to make sure we are doing officially this evening in the RECORD of the Senate.

We have enjoyed in the last year the wonderful leadership of Jean Marie Neal in my office. As you know, I came from the House of Representatives and, while bringing some outstanding people with me, we had to put together a team of staff. It was under Jean Marie's leadership that we were able to find outstanding people who had been in service both in the Senate as well as in other places and who have come now to be a part of my office and my team.

As we come into our second year, we are building on a foundation and a gift that she gave me of putting together a wonderful team that is committed and intelligent and loyal and hard working. We in our office are going to miss her greatly, and we are very grateful for all of her hard work.

I know her previous employers, Senator Bryan and Congressman JOHN SPRATT, and all of those who have come in contact and have benefited from Jean Marie's intelligence and hard work and loyalty and ability to see and create a vision in terms of the office, as well as issues and advocacy for our States, are really happy for her.

Again, I invite anyone who is within earshot to come by until 7 o'clock this evening and join us to have an opportunity to celebrate Jean Marie's service to the Senate and to thank her for that and to wish her well as she moves on to, I am sure, many more successes.

AMERICA'S UNINSURED

Mr. SMITH of Oregon. Madam President, I come to the floor once again to talk about the uninsured in America. I think it is important that, as we sink our teeth into this year's budget, we remember the men, women, and children who live, work, and go to school every day without health insurance, knowing that any illness could threaten their livelihood and even their lives.

I have spent a great deal of time in recent months learning about the uninsured—who they are, why they have no health coverage, the effects on individuals and their families, and what can be done to resolve this crisis.

This year, the president's budget contains $89 billion to help the uninsured. This is no small number, to be sure, and it demonstrates the president's commitment to providing health coverage for all Americans; however, this proposal is only projected to provide coverage for up to six million of the forty million uninsured—leaving thirty-four million men, women, and children without health insurance. Therefore, I see the president's proposal as a starting point from which to make insurance both more accessible and more affordable for all working families.

Yesterday I pressed Office of Management and Budget Director Daniels to explain how the uninsured would fare under the president's new budget proposal. I also met with Centers for Medicare and Medicaid Services Administrator Tom Scully to urge him to assist in improving upon President Bush's proposal to provide health coverage to more low-income Americans.

In my visits to community health centers across Oregon, it has become clear to me that the uninsured—working mothers, fathers, children, single adults, students—are not interested in budget battles that may prevent action on this important matter. What Americans need is access to high quality, affordable health insurance. There are a lot of good ideas out there to help the uninsured, but no single proposal is going to help or please everybody. We need to take the best these plans have to offer and come up with a comprehensive solution as soon as possible.

There has never been a better, or more important, time to act with respect to the uninsured. I understand the demands on our treasury are great as we fight the war on terrorism both at home and abroad; however, the demands on our health care system are also increasing. With a recession and rapidly rising health care costs, more and more Americans will find themselves without health insurance. This is no time to ignore them. I look forward to working with my colleagues and the Administration to find a way to make room for as many of them as we can in this year's budget, as we work toward a day when every American has access to high quality health care coverage.

MENTAL HEALTH

Mr. DURBIN. Madam President, I submit for the RECORD an article that ran in The Washington Post yesterday about the discrimination that individuals with a history of mental illness face in our current health insurance market. The story documents the dilemma of Michelle Witte who was denied health insurance coverage because she was successfully treated for depression during her adolescence. In fact, more than 50 million Americans each year suffer from mental illness. About 19 percent of the Nation's adults and 21 percent of the youths aged 9 to 17 have a mental disorder at some time during a one-year period.

Last Congress I introduced legislation to address the barriers faced by Michelle Witte and thousands like her who have been treated for a mental condition. I plan to reintroduce this legislation this spring, and I urge my colleagues to join me in this effort.

The Mental Health Patients' Rights Act limits the ability of health plans

to redline individuals with a preexisting mental health condition. I undertook this initiative when I learned that some of my constituents were being turned away from health plans in the private non-group market due solely to a past history of treatment for mental conditions. Unfortunately, under the current system of care in the United States, individuals who are undergoing treatment or have a history of treatment for mental illness may find it difficult to obtain private health insurance, especially if they must purchase it on their own and do not have an employer-sponsored group plan available to them. In part this is because while the Health Insurance Portability and Accountability Act, HIPAA, protects millions of Americans in the group health insurance market, it affords few protections for individuals who apply for private non-group insurance. While the majority of Americans under age 65 have employer-sponsored group coverage, a significant minority, approximately 12.6 million individuals, rely on private, individual health insurance.

The Mental Health Patients' Rights Act closes this loophole by limiting any preexisting condition exclusion relating to a mental health condition to not more than 12 months and reducing this exclusion period by the total amount of previous continuous coverage. It prohibits any health insurer that offers health coverage in the individual insurance market from imposing a preexisting condition exclusion relating to a mental health condition unless a diagnosis, medical advice or treatment was recommended or received within the 6 months prior to the enrollment date. And it prohibits health plans in the individual market from charging higher premiums to individuals based solely on the determination that the individual has had a preexisting mental health condition. These provisions apply to all health plans in the individual market, regardless of whether a state has enacted an alternative mechanism, such as a risk pool, to cover individuals with preexisting health conditions.

The Mental Health Patients' Rights Act complements ongoing efforts to enhance parity between mental health services and other health benefits. This is because parity alone will not help individuals who do not have access to any affordable health insurance due to preexisting mental illness discrimination. The Patients' Rights Act does not mandate that insurers provide mental health services if they are not already offering such coverage. It simply prohibits plans in the private non-group market from redlining individuals who apply for general health insurance based solely on a past history of treatment for a mental condition.

I have also asked the General Accounting Office to examine the types of mental health conditions for which individual health insurers typically underwrite; the degree to which there is an actuarial basis for these carrier practices; the prevalence of medical underwriting for mental health conditions that results in denying coverage or raising premiums; and the extent of state laws that prevent or constrain insurers from denying coverage or raising premiums due to a history of mental health conditions, including consumer protections such as appeals procedures and access to information. This report is due out next month.

It simply does not make sense that a person is rendered uninsurable for all health needs simply because he or she seeks treatment for mental illness. I invite my colleagues to enlist in this important initiative to ensure that such individuals are not discriminated against when applying for health insurance coverage.

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

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

[From the Washington Post, Feb. 5, 2002]

SECOND OPINION: THE PERILS OF DOING RIGHT

(By Abigail Trafford)

Michelle Witte did everything right. She graduated from the University of Maryland last June with a degree in English. She got a job she loves with a Washington communications firm that is too small to qualify for a group health plan. But her employer will pay for an an individual policy, so she applied to CareFirst BlueCross BlueShield. In answer to questions on the form, she stated that she has chronic asthma and had been prescribed antidepressant medication for a short period when she was in high school.

The health plan rejected her.

''Upon review of the Individual Health Evaluation Questionnaire, you have documented that you have been or are currently being treated for depressive disorder,'' stated the letter from the health plan. ''Based upon our medical underwriting criteria, we are unable to approve this coverage for you.''

''I just think it's shocking,'' said Witte, 23. CareFirst has refused to comment on the case. But in its official reply to her application, the plan expressed no concern over her ongoing problem of asthma. It was one episode of successfully treated depression in adolescence that turned Witte into a health plan pariah. ''It didn't occur to me that it could be such a liability,'' she said.

This is how discrimination works against people with mental diseases. For all the rhetoric about removing the stigma of mental illness and treating disorders of the brain the same way as disorders of the body, the bias persists. A physical disease like asthma is okay; a mental disorder like depression is not.

If anything, Witte ought to be a prized health plan client. She has demonstrated that she knows how to take care of herself. Six years ago, when she was in high school, she developed anorexia, an eating disorder. Her parents promptly took her to a psychiatrist at Children's National Medical Center who diagnosed depression and prescribed a six-month course of the antidepressant Zoloft. Witte responded well. She overcame her eating problems. She has had no problems with depression since that time.

How many teenage girls try to keep their destructive eating habits secret? How many go for years without proper treatment? They can end up needing hospitalization and may suffer long-term complications. In the end, that is much more expensive to a health plan than covering outpatient psychotherapy and medications for six months.

In short, Witte and her parents—her father works for the federal government, her mother for a health maintenance organization—did everything right in getting prompt treatment. ''It was a success story,'' said Witte. ''I'm a proponent of drugs when they're used properly. They can really help.''

Why should she be penalized for being a success story?

It's legal for health insurers to consider a person's health status when they offer individual policies. Otherwise some people might not buy insurance until they were diagnosed with a major medical problem and needed coverage to get care.

But this is obviously not the case with Witte, a healthy young woman who runs regularly and likes to take day-long hikes. As a health insurance reject, she is eligible for programs designed for high-risk individuals, but the costs of coverage are generally higher and the benefits more limited compared to a regular plan. That's a steep price to pay for having had a six-month prescription for Zoloft.

In many parts of the country, the infrastructure of mental health services is unraveling. Headlines have rightly focused on the collapse of public programs for people who need government-funded treatment.

But a much larger population with mental disorders remains in the private sector. They are holding jobs and raising families. They rely on private insurance and private therapists for treatment. Support for them is eroding, too, as insurance agencies stint on payment for mental health services, managed care plans place limits on benefits, and the burden of co-payments and other out-of-pocket expenses continues to increase.

Even people with good jobs and supposedly good health coverage are hurting. One man who works for the federal government has been treated for major depression since his first episode at age 38. He has seen the same psychiatrist, who monitors his medications and provides psychotherapy, every week for 15 years.

This year his insurance plan has eliminated the more generous high-option policy that covered 50 visits to the doctor. His current plan, with a premium that is a few dollars cheaper every month, covers only 25 sessions. His psychiatrist charges $165 an hour; the plan now covers about half the hourly fee, and only half the time. Bottom line: His doctor bills come to $8,250 a year. His plan pays $1,800; he pays the rest.

''It's not fair,'' he said, ''it has to cost us so much money when there's supposed to be parity'' in coverage of mental and physical illnesses. ''Parity keeps slipping away.''

The president last week came out in favor of patients' rights. That ought to include the millions of Americans with mental illness.

LOCAL LAW ENFORCEMENT ACT OF 2001

Mr. SMITH of Oregon. Madam President, I rise today to speak about hate crimes legislation I introduced with Senator KENNEDY in March of last year. The Local Law Enforcement Act of 2001 would add new categories to current hate crimes legislation sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred April 17, 1993 in Portland, ME. Two men assaulted a father and son they mistook for a gay couple. The assailants, James G. Miezin, 23, of Parma, and Thomas J. Lengieza, 22, were charged with harassment and assault.