citizens during thirty years of civil war. He undertook his inquiry after it became clear that the Guatemalan Clarification Commission would not seek to identify those responsible for even the worst atrocities. Bishop Gerardi's investigation, not surprisingly, attributed the overwhelming majority of human rights violations to the military and the death squads and paramilitary groups allied with them.

Mr. President, the United States bears more than a little responsibility for the slaughter in Guatemala that devastated that country in the years after the CIA-backed coup of 1954. Our government trained the Guatemalan armed forces, remained silent when they tortured and killed thousands of innocent people, withheld information about the atrocities, and justified our complicity as the necessary response to a guerrilla insurgency. In fact, during this period of political violence which is apparently not yet over, the principal victims were Guatemala's Mayan population of rural peasants who have been the target of discrimination and injustice for generations.

According to a statement by the Guatemalan Embassy, the Guatemalan Government ''condemns and repudiates'' this crime and has opened an investigation. Let us hope that this investigation can withstand the inevitable pressure from the forces who would intimidate anyone who seeks real justice in Guatemala. The Arzu Government deserves considerable credit for bringing the peace negotiations to a successful conclusion. But few weeks pass that I do not receive a report of a political crime in Guatemala, most of which go unsolved. Justice remains elusive for those who need it most.

How the Guatemalan government handles this investigation will either embolden or deter those who seek to undermine the peace accords, and, as the Ranking Member of the Foreign Operations Subcommittee I can say that as far as I am concerned it will also be important in determining our future assistance relationship with Guatemala.

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Williams, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Office laid before the Senate message from the President of the United States submitting one treaty and sundry nominations which were referred to Committee on Foreign Relations.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 3:40 p.m., a message from the House of Representatives, delivered by Ms. Goetz, one of its reading clerks, announced that pursuant to the provisions of 22 U.S.C. 276h, the Speaker appoints the following Members of the House to the Mexico-United States Interparliamentary Group: Mr. KOLBE, Chairman and Mr. GILMAN, Vice Chairman.

The message also announced that pursuant to the provision of 22 U.S.C. 276h, the Speaker appoints the following Member of the House to the Canada-United States Interparliamentary Group: Mr. HOUGHTON, Chairman.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Ms. COLLINS (for herself, Mr. CHAFEE, Mr. LEAHY, Mr. JEFFORDS, Mr. FEINGOLD, Mr. DURBIN, Mr. HARKIN, Ms. SNOWE, Mr. REED, Mr. SANTORUM, Mr. TORRICELLI, Mr. LEVIN, Mr. DASCHLE, and Mr. SPECTER):

S. 1993. A bill to amend title XVIII of the Social Security Act to adjust the formula used to determine costs limits for home health agencies under medicare program, and for other purposes; to the Committee on Finance.

By Mr. COATS (for himself, Mr. ABRAHAM, Mr. BROWNBACK, Mr. COVERDELL, and Mr. SANTORUM):

S. 1994. A bill to assist States in providing individuals a credit against State income taxes or a comparable benefit for contributions to charitable organizations working to prevent or reduce poverty and to protect and encourage donations to charitable organizations; to the Committee on Finance.

By Mr. ABRAHAM (for himself, Mr. BROWNBACK, Mr. COATS, Mr. COVERDELL, Mr. HUTCHINSON, and Mr. SANTORUM):

S. 1995. A bill to amend the Internal Revenue Code of 1986 to allow the designation of renewal communities, and for other purposes; to the Committee on Finance.

By Mr. SANTORUM (for himself, Mr. ABRAHAM, Mr. BROWNBACK, Mr. COATS, Mr. COVERDELL, and Mr. HUTCHINSON):

S. 1996. A bill to provide flexibility to certain local educational agencies that develop voluntary public and private parental choice programs under title VI of the Elementary and Secondary Education Act of 1965; to the Committee on Labor and Human Resources.

By Ms. MIKULSKI (for herself and Mr. FAIRCLOTH):

S. 1997. A bill to protect the right of a member of a health maintenance organization to receive continuing care at a facility selected by that member; to the Committee on Labor and Human Resources.

By Mr. HATCH (for himself, Mr. BENNETT, and Mr. BINGAMAN):

S. 1998. A bill to authorize an interpretive center and related visitor facilities within the Four Corners Monument Tribal Park, and for other purposes; to the Committee on Indian Affairs.

By Mrs. HUTCHISON (for herself, Mr. FAIRCLOTH, Mr. ASHCROFT, and Mr. MACK):

S. 1999. A bill to amend the Internal Revenue Code of 1986 to eliminate the marriage penalty by providing that the income tax rate bracket amounts, and the amount of the standard deduction, for joint returns shall be twice the amounts applicable to unmarried individuals; to the Committee on Finance.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. COLLINS (for herself, Mr. CHAFEE, Mr. LEAHY, Mr. JEFFORDS, Mr. FEINGOLD, Mr. DURBIN, Mr. HARKIN, Ms. SNOWE, Mr. REED, Mr. SANTORUM, Mr. TORRICELLI, Mr. LEVIN, Mr, DASCHLE, and Mr. SPECTER):

S. 1993. A bill to amend title XVIII of the Social Security Act to adjust the formula used to determine costs limits for home health agencies under medicare program, and for other purposes; to the Committee on Finance.

THE MEDICARE HOME HEALTH EQUITY ACT OF 1998

Ms. COLLINS. Mr. President, America's home health agencies provide invaluable services that have enabled a growing number of our most frail and vulnerable senior citizens to avoid hospitals and nursing homes and stay just where they want to be—in their own homes. Today, home health is the fastest growing component of Medicare spending, and the program grew at an astounding average annual rate of more than 25 percent from 1990 to 1997. As a consequence, the number of Medicare home health beneficiaries has more than doubled, and Medicare home health spending has soared from $2.7 billion in 1989 to $17.1 billion in 1996.

This rapid growth in home health spending understandably prompted Congress and the Health Care Financing Administration, as part of the Balanced Budget Act of 1997, to initiate changes that were intended to make the program more cost-effective and efficient and protect it from fraud and abuse. However, in trying to get a handle on costs, we in Congress and the administration have unintentionally created problems that may restrict some elderly citizens' access to vitally needed home health care.

Critics have long pointed out that Medicare's cost-based payment method for home health care has inherent incentives for home care agencies to provide more services, which has driven up costs. Therefore, the Balanced Budget Act called for the implementation of a prospective payment system for home care by October 1, 1999. Until then, home health agencies will be paid according to what is known as an Interim Payment System.

Under the new IPS, home health agencies will be paid the lesser of: their actual costs; a per-visit cost limit; or a new blended agency-specific per beneficiary annual limit based 75 percent on an agency's own costs per beneficiary and 25 percent on the average cost per beneficiary for agencies in the same region. These costs are to be calculated from cost reports for reporting periods ending in 1994.

I spent some time going over the formula because it is important to understand what the importance of that very

complicated formula is for many of our home health agencies.

At a recent hearing of the Senate Special Committee on Aging, on which I serve, we heard testimony from a number of witnesses who expressed concern that the new Interim Payment System inadvertently penalizes cost-efficient home health agencies by basing 75 percent of the agencies' per patient payment limits on their FY 1994 average cost per patient. This system effectively rewards agencies that provided the most visits and spent the most Medicare dollars in 1994, while it penalizes low-cost, more efficient providers. Let me repeat that point, Mr. President. The agencies, usually the nonprofits, that have provided services at the lowest cost, are penalized by the new payment system.

Home health agencies in the Northeast are among those that have been particularly hard-hit by the formula change. As the Wall Street Journal recently observed,

If New England had been just a little greedier, its home-health industry would be a lot better off now . . . Ironically, . . . [the region] is getting clobbered by the system because of its tradition of non-profit community service and efficiency.

Moreover, there is no logic to the variance in payment levels. As the same article goes on to point out, the average patient cap in Tennessee is expected to be $2,200 higher than Connecticut's, and the cap for Mississippi is expected to be $2,000 more than Maine's, without any evidence that patients in the Southern states are sicker or that nurses and other home health personnel in this region cost more. Mr. President, I ask unanimous consent that the entire text of this article be printed in the RECORD.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Ms. COLLINS. Mr. President, this system also gives a competitive advantage to high-cost agencies over their lower cost neighbors, since agencies in a particular region may have dramatically different reimbursement levels regardless of any differences among their patient populations. And finally, this system may force low-cost agencies to stop accepting patients with more serious health care needs.

That is exactly the opposite of what we should want. I simply do not think that this is what Congress intended. To rectify this problem, today I am pleased to introduce legislation along with Senators CHAFEE, JEFFORDS, LEAHY, FEINGOLD, SNOWE, DURBIN, HARKIN, REED and SANTORUM. The Medicare Home Health Equity Act will level the playing field and make certain that home health agencies that have been prudent in their use of Medicare resources are not unfairly penalized. The legislation will also ensure that home health agencies in the same region are reimbursed similarly for treating similar patients.

Instead of allowing the experience of high-cost agencies to serve as the basis for the new cost limits, the bill we are introducing today sets a new per beneficiary cost limit based on a blend of national and regional average costs per patient. This new formula will be based 75 percent on the national average cost per patient and 25 percent on the regional average cost per patient. Moreover, by eliminating the agency-specific data from the formula, the Medicare Home Health Equity Act will move us more quickly to the national and regional rates which will be the cornerstones of the future prospective payment system, and it will do so in a way that is budget neutral. This is a matter of common sense and fairness. It is also a matter of ensuring that there is a fair system for reimbursing these vitally needed home health agencies that are providing services that are so important to so many of our senior citizens. I urge all of my colleagues to join as cosponsors of the Medicare Home Health Equity Act, and I ask unanimous consent that the text of the bill as well as a section by section summary be printed in the RECORD.

The ACTING PRESIDENT pro tempore. Without objection, the items were ordered printed in the RECORD, as follows:

S. 1993

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 ''Medicare Home Health Equity Act of 1998''.

SEC. 2. REVISION OF HOME HEALTH INTERIM PAYMENT FORMULA.

(a) RESTORATION OF COST LIMITS.—Section 1861(v)(1)(L)(i)(IV) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(i)(IV)) (as added by section 4602 of the Balanced Budget Act of 1997) is amended—

(1) by striking ''105 percent'' and inserting ''112 percent''; and

(2) by striking ''median'' and inserting ''mean''.

(b) CHANGE IN ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L)(v) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(v)) (as added by section 4602 of the Balanced Budget Act of 1997) is amended to read as follows:

''(v)(I) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the Secretary shall provide for an interim system of limits. Payment shall not exceed the costs determined under the preceding provisions of this subparagraph or, if lower, the product of—

''(aa) an agency-specific per beneficiary annual limitation calculated based 75 percent on the reasonable costs (including nonroutine medical supplies) of the standardized national average cost per patient in calendar year 1994, or best estimate thereof, (as published in the Health Care Financing Review Medicare and Medicaid 1997 Statistical Supplement) and based 25 percent on the reasonable costs (including nonroutine medical supplies) of the standardized regional average cost per patient for the agency's census division in calendar year 1995 (as so published), such national and regional costs updated by the home health market basket index and adjusted pursuant to clause (II); and

''(bb) the agency's unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation.

''(II) The labor-related portion of the updated national and regional costs described in subclause (I)(aa) shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located (as determined without regard to any reclassification of the area under section 1886(d)(8)(B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under section 1886(d)(10) for cost reporting periods beginning after October 1, 1995).''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1861(v)(1)(L)(vi) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(vi)) (as added by section 4602 of the Balanced Budget Act of 1997) is amended to read as follows:

''(vi) In any case in which the Secretary determines that beneficiaries use services furnished by more than 1 home health agency for purposes of circumventing the per beneficiary annual limitation in clause (v), the per beneficiary limitations shall be prorated among the agencies.''.

(2) Section 1861(v)(1)(L)(vii)(I) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(vii)(I)) (as added by section 4602 of the Balanced Budget Act of 1997) is amended by striking ''clause (v)(I)'' and inserting ''clause (v)(I)(aa)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply as if included in the enactment of the Balanced Budget Act of 1997.

SEC. 3. CBO ESTIMATE OF HOME HEALTH PAYMENT SAVINGS.

(a) ESTIMATE.—Not later than 60 days after the date of enactment of this Act, and annually thereafter until the prospective payment system for home health agencies established by section 1895 of the Social Security Act (42 U.S.C. 1395fff) is in effect, the Director of the Congressional Budget Office (referred to in this section as the ''Director'') shall estimate the amount of savings to the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.) resulting from the interim payment system for home health services established by the amendments to section 1861 of such Act (42 U.S.C. 1395x) made by section 4602 of the Balanced Budget Act of 1997.

(b) CERTIFICATION.—If the Director determines that the amount estimated under subsection (a) exceeds the amount of savings to the medicare program that the Director estimated immediately prior to the enactment of the Balanced Budget Act of 1997 by reason of such interim payment system, then the Director shall certify such excess to the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'').

(c) ADJUSTMENT.—

(1) IN GENERAL.—If the Director certifies an amount to the Secretary pursuant to subsection (b), the Secretary shall prescribe rules under which appropriate adjustments are made to the amount of payments to home health agencies otherwise made under subparagraph (L) of section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)) (as amended by section 4602 of the Balanced Budget Act of 1997) in the case of outliers—

(A) where events beyond the home health agency's control or extraordinary circumstances, including the case mix of such agency, create reasonable costs for a payment year which exceed the applicable payment limits; or

(B) in any case not described in subparagraph (A) where the Secretary deems such an adjustment appropriate.

(2) AMOUNT.—The total amount of adjustments made under paragraph (2) for a year may not exceed the amount certified to the Secretary pursuant to subsection (b) for such year. To the extent that such adjustments in

a year would otherwise exceed the amount certified to the Secretary pursuant to subsection (b) for such year, the Secretary shall reduce the payments to home health agencies in a pro rata manner so that the adjustments do not exceed such amount.

MEDICARE HOME HEALTH EQUITY ACT—SECTION-BY-SECTION SUMMARY

CURRENT LAW

The cost-based payment method that has historically been used for Medicare home health services has inherent incentives for home care agencies to provide a higher volume of services. Therefore, the Balanced Budget Act of 1997 (BBA) called for the implementation of a prospective payment system (PPS) for home care by October 1, 1999. In the interim (FYs 1998 and 1999), home health agencies will be paid according to an Interim Payment System (IPS) established by the BBA.

The IPS reimburses home health agencies using the lowest of three cost limits: 1) an agency's actual costs; 2) a per visit cost limit applied to each skilled nursing, physical therapy, or other type of home health visit provided; or 3) an agency-specific aggregate per patient cost limit that is based 75 percent on an agency's average cost per patient in 1994 and 25 percent on a regional average cost per patient in 1994.

The Interim Payment System penalizes cost-efficient home health agencies by basing 75 percent of the agencies' per patient payment limits on their FY 1994 average cost per patient. Giving such a heavy weight to the agency-specific costs per beneficiary effectively rewards agencies that provided the most visits and spent the most Medicare dollars in 1994, while it penalizes low-cost, more efficient providers. As a result, high-cost and inefficient agencies will continue to receive a disproportionate share of Medicare home health dollars.

THE MEDICARE HOME HEALTH EQUITY ACT

Formula change for setting per beneficiary cost limits

The Medicare Home Health Equity Act will level the playing field and make certain that those home health agencies that have been prudent in their use of Medicare resources are not unfairly penalized. Moreover, it will ensure that home health agencies in the same region are reimbursed similarly for treating similar patients. Instead of allowing the experience of high cost agencies to serve as the basis for the cost limits, the bill sets a new per beneficiary cost limit based on a blend of national and regional average costs per patient. This new formula would be based 75 percent on the national average cost per patient in calendar year 1994 ($3,987) and 25 percent on the regional average cost per patient in calendar year 1995.

Restoration of the per-visit cost limit to 112 percent of the national mean

The per visit cost limits essentially place a cap on the amount of costs that can be reimbursed by Medicare for each home health care visit provided. The BBA reduced these cost limits from 112 percent of the mean to 105 percent of the median. This was done to provide additional savings. However, most of the BBA savings (at least 80 percent) came from the per-beneficiary cost limits. According to Price-Waterhouse, changing the formula from an agency-specific to a national/regional average cost per patient blend achieves an additional $5.5 billion in savings. The Medicare Home Health Equity Act of 1998 uses these savings to restore the per-visit cost limit to 112 percent of the national mean.

Most analysts agree that the growth in Medicare home health expenditures is due to the high number of visits provided to patients, not by the cost per visit. In fact, the cost per visit has remained relatively stable in recent years, and CBO confirms that controlling use, not price, is the key to Medicare home health cost containment. It is appropriate to use the savings achieved by rewarding rather than penalizing cost-efficient agencies to re-establish the cost limits that enabled many of those agencies to provide more efficient care over the entire episode of care. The average cost per visit tends to be higher for lower-overall cost, non-profit HHAs which tend to provide care in fewer visits. By keeping visits to the number that are medically necessary, costs per visit may increase slightly, but overall costs per patient decrease.

Modifies Application of Proration of Per Beneficiary Limits Provision

The BBA contained a provision which requires proration of the per beneficiary annual limit where the patient is served by more than one home health agency. The Medicare Home Health Equity Act modifies this provision to clarify that proration only applies where it can be demonstrated that a home health agency is attempting to circumvent the limits by shifting care between agencies.

Establishes an Outlier Provision

The bill instructs the Secretary of HHS to prescribe rules under which adjustments can be made in payments to home health agencies that are ''outliers'' where events beyond their control or extraordinary circumstances, including their case mix, create ''reasonable costs'' that exceed what otherwise would be their payment limits. This is included so that there is some provision for higher payments for home health agencies that treat the sickest Medicare home care patients and does so in a way that is budget neutral.

[From the Wall Street Journal]

REGION'S HOME-CARE FIRMS FACE BEING PUNISHED FOR THEIR EFFICIENCY

(By Carol Gentry)

If New England had been just a little greedier, its home-health industry would be a lot better off now.

In a rush to cut Medicare spending, Congress has set up a home-health payment system that punishes low-cost agencies and states, while it rewards big spenders and regions where audits have found widespread fraud and abuse. Ironically, New England is getting clobbered by the system because of its tradition of non-profit community service and efficiency.

And patients are feeling the effects. In the past two weeks, about 30 complaints have come into the Boston office of the federal agency that must implement the change, the Health Care Financing Administration. The agency says the complaints are coming from patients who need frequent, long-term nursing visits, but say they are being turned away or cut off.

''I fear we're now looking at home health agencies dumping (expensive) patients,'' says Margaret Leoni-Lugo, chief of the HCFA quality-improvement branch for New England. Such discrimination violates state and federal regulations.

Ms. Leoni-Lugo says she sympathizes with the difficult situation confronting New England agencies, but cannot condone patient dumping. Today she is expected to hold a telephone conference with health-department officials in the six New England states, warning them to watch for evidence that agencies are cutting care too much.

''We want to keep the beneficiaries safe,'' says Ms. Leoni-Lugo.

THE NEW FORMULA

The new system rolls back payments to 1993–94 levels minus 2%, regardless of whether an agency's budget was low or grossly inflated during those years. Under the system, home-health agencies' Medicare payments will be affected not only by their own budget history, but also by their location. If a company is in a penny-pinching region, its payments will be lower than if it comes from an area of big spenders. The agencies that come out best under this formula are those that spent money willy-nilly five years ago and were surrounded by companies that did the same thing. The biggest winners will be states in the South.

Meanwhile, frugal agencies in regions with moderate costs—especially New England, the Midwest and the Mountain states—are reeling. Vermont, New Hampshire and Maine will be among the hardest-hit states in the nation. Massachusetts, Connecticut and Rhode Island fare only marginally better.

Advocates for the elderly and the region's home-health agencies say such a system gives a competitive advantage to the worst players in the industry. ''This is not in the best interest of taxpayers,'' says Susan Young, executive director of the Home Care Association of New Hampshire.

Adds Margaret Gilmour, president and chief executive officer of Home Health & Hospice Care, a home-care agency in Nashua, N.H.: ''This is going to be a tidal wave of disaster for elder care.''

Layoffs are already under way in New Hampshire, Ms. Young says, where the industry is among the leanest in the nation.

The congressional delegation from Massachusetts hopes to derail the new system before it can do massive damage. ''This defies common sense.'' says Rep. James P. McGovern, a Democrat from Worcester. ''This is a big, fat mistake.''

TAKING CARE OF THE HOMEBOUND

In late November, Rep. McGovern and 11 other members of the state's congressional delegation sent a letter of concern to HCFA. The group hopes to meet with top agency officials in Washington soon.

Home-health agencies send nurses, aides, and physical and speech therapists to the homes of patients who are so physically or mentally disabled that they cannot easily go or be taken to a medical clinic.

While most private insurers and health-maintenance organizations cover home health care, the main money pipeline is Medicare. All homebound elderly and disabled beneficiaries of the program are eligible for free unlimited visits, as long as the visits are part of a treatment plan that is authorized by a physician and is updated every two months.

There are several types of home-health agencies, including the community-based nonprofits, such as the Visiting Nurses Associations of America; the newer for-profit companies; and hospital-affiliated agencies. Medicare's costs have been higher for patients who go through one of the hospital or for-profit companies.

Hospital-affiliated agencies tend to have higher per-visit costs than independent ones because they can legally transfer some of the hospital's overhead to the home-health books and have Medicare pay for it. For-profit agencies tend to generate higher Medicare payments by billing for a greater number of visits per patient.

Patients recuperating from surgery or a short-term illness may need only a few visits, but home-health agencies are a lifeline for patients with long-term conditions—multiple sclerosis. Alzheimer's disease, heart failure, severe diabetes—who are trying to stay out of nursing homes.

The new system sets an annual limit on the amount that Medicare will spend on any given patient. While that cap is different for every agency, it averages out to 75 visits a year in Massachusetts. Patient advocates say this gives agencies an incentive to take only those clients who are going to get better or die in a short time.

To make matters worse, agencies must reduce expenses without knowing just how deep the cuts will be. The details of the payments formula won't be determined until April 1, but will be retroactive to Oct. 1.

SEEKING FORMULA CHANGE

In the letter to HCFA, the Massachusetts delegation asked administrators to alter the new formula to ''lessen the blow'' to low-cost, efficient home-health agencies. The letter says it is unfair to tag payments to a 1994 average per-patient cost of $4,328 in Massachusetts, when Tennessee was getting $6,508 and Louisiana $6,700.

Rep. McGovern says he hopes to repeal the payment-system provision when Congress convenes later this month, but he knows that may not be easy. Many of the leaders of Congress are from the South, where payment rates are projected to be double those in much of New England.

Massachusetts has a lot at stake. In 1995, the last year for which Medicare has complete data, the program spent more than $1 billion in New England to provide home health to 246,000 beneficiaries. Of that money, Massachusetts absorbed more than half for 119,000 homebound patients. More than 14% of the state's Medicare beneficiaries were served by home care, while the rate was about 10% nationwide.

Under the new payment system, members of the Massachusetts delegation say, their state stands to lose $95 million and at least 1.5 million patient visits in the first year.

Why will the system affect Massachusetts so much? The state's home-health agencies deliver care at a more moderate cost per visit than most other states, federal data show, but also perform more visits per patient, on average. Pat Kelleher. executive director of the Home Health Care Association of Massachusetts, says one reason is that the state has deliberately pushed home care to save state tax money. Federally paid Medicare home-health visits keep patients out of nursing homes, which draw most of their revenue from the state Medicaid program.

ROUGH TIME AHEAD FOR VERMONT

If the other New England states affected, Vermont, the only state that legally requires home-health companies to be non-profit, especially faces troubled times. After consistently providing home care at the lowest cost per patient in the nation. Vermont's 13 agencies stand to lose more than $2 million this year and estimate they will have to reduce service by 10%.

The Vermont Assembly of Home Health Agencies estimates the average per person payments in the state this year will be $2,600 a year, less than half what they payout is expected to be in, say, Alabama.

''The system was supposed to limit the high rollers'' says the association's director, Peter Cobb but instead ''Congress rewarded excess.''

The rule changes stem from the passage last August of the Balanced Budget Act, which cuts $115 billion from Medicare by 2002. The home-care portion of the act slices $16.2 billion from the budget.

Home care seemed a logical place to look for cuts, since it's the fastest-growing segment of the health industry. Between 1990 and 1995, while the number of Medicare beneficiaries rose 10%, the number of home-health visits grew 255% and spending went up 316%.

Some of that increase accompanied the rise of managed-care companies that try to keep patients out of the hospital to save money and, if they must go, keep the visits as brief as possible. However, much of the inflation in home care was a predictable response to a payment system that offered no incentive to be frugal.

PROBE FINDS WASTE, FRAUD

Massive fraud, waste and ineptitude in Medicare billings were reported last summer by the Office of the Inspector General of the U.S. Department of Health and Human Services following a two-year investigation called Operation Restore Trust. The study covered five states that account for 40% of Medicare payments: California, New York, Florida, Texas and Illinois.

The report said one-fourth of home-health agencies in those states received nearly half the Medicare dollars spent on home-health care. According to the report, the ''problem'' agencies tended to be for-profit, closely held corporations with owners that were involved in a tangle of interlocking, self-referring businesses. Texas was cited as the biggest home-health spender of the states studied. (An HCFA audit conducted in Massachusetts and Connecticut last year found a few overpayments, but no cases of fraud.)

It just so happened that the revelations of Operation Restore Trust occurred at the same time that Congress was looking for ways to cut Medicare spending.

Congress wanted to change the home-health payment system so that it would reward efficiency, by switching to a flat rate by diagnosis. This ''prospective payment system'' would be similar to the one that Medicare uses to pay hospitals.

But HCFA said it needed more time to develop the complex formula to set prospective payment in motion. So Congress created an interim system that will run until Oct. 1, 1999. It freezes spending at the rates there were in place in 1993–94—before Operation Restore Trust began.

VARYING PAYMENTS

Now payments vary illogically. The average patient cap in Tennessee is expected to be $2,200 higher than that in Connecticut, and the cap for Mississippi $2,000 more than Maine, without any evidence that patients in the Southern states are sicker or that nurses cost more there.

But those who think the Southern states are pleased at getting a patient cap double that of New England are mistaken. Officials at the Texas Association for Home Care say they need bigger payment rates because they have a high rate of poor elderly who have never had proper health care, and the state Medicaid program hasn't taken care of them because it's stingy.

''Congress has cut into the bone,'' says Sara Speights, director of government and public relations for the Texas group.

Inequities exist even within the same region. Ms. Gilmour of the Nashua, N.H., home-care agency says a competitor in northern Massachusetts could end up with a payment cap twice as high as her own as a result of her staff's efforts to keep costs down. Because patients are free to choose either agency, she worries they will gravitate to the one that has a bigger budget.

Joan Hull, chief executive of the nearby competitor, the Home Health Visiting Nurses Association of Haverhill, Mass., says her agency is a product of a merger between agencies that had different payment rates, so she doesn't know whether the Medicare cap will be $3,400 or $4,600 per patient. Unfortunately for her agency, services it has delivered since the beginning of its fiscal year in October will be on the new payment rate, but the agency won't know what the rate is until April.

''It's crazy, isn't it?'' Ms. Hull says with a laugh.

YANKEE THRIFT

Home health agencies in the New England states have delivered care for less money than the national average, both in Medicare payments per visit and per patient. (Data shown here are from 1995.)

	No. of patients (in thousands)	Avg. payment per visit	Pct. above or below national avg.	Avg. payment per patient	Pct. above or below national avg.
Connecticut	57	$60	−30	$4,770	6.6
Massachusetts	119	50	−19.0	4,730	−5.7
Rhode Island	19	64	3.0	4,037	−9.7
Maine	22	53	−15.0	3,717	−16.9
New Hampshire	17	50	−19.0	3.057	−31.7
Vermont	12	45	−28.0	3,030	−32.3
New England	246	53	−15.0	4,400	−1.6
U.S.	3,430	62	.....	4,473	.....

Sources: Health Care Financing Administration and The Wall Street Journal

BIG SPENDERS

While Medicare costs for home health services have gone up nationwide, Sunbelt states led the spending spree. The new payment system rewards states where payments were far above average, as shown below (Data are for 1995.)

	No. of visits per patient	Avg. payment per patient	Pct. above national avg.
Louisiana	144	$7,867	75.9
Oklahoma	127	7,358	64.5
Texas	117	7,217	61.3
Tennessee	121	6,886	53.9
Utah	106	6,283	40.5
Mississippi	128	6,205	38.7
THE SOUTH	95	5,488	22.7
U.S.	72	4,473	.....

Sources: Health Care Financing Administration and The Wall Street Journal

Mr. FEINGOLD. Mr. President, I rise today to join my colleagues, Senators COLLINS, CHAFEE, JEFFORDS, LEAHY, REID and others in introducing the Home Health Medical Equity Act of 1998. I especially want to compliment the Senator from Maine, who has taken the lead on this issue. It is a matter of enormous concern in her State and also in mine. I think it is worth taking a moment just to acknowledge how useful the Senate Aging Committee is, to be able to highlight an issue like this. I wonder whether this issue would have gotten the attention it deserves had it not been for that forum, where we were able to have an excellent hearing and hear from Senators all over the country whose States are very negatively affected by the rules that were put into place. I congratulate the Senator from Maine for taking the initiative out of that hearing to introduce legislation.

This legislation is a crucial step in ensuring that the Medicare Home Health Care program's Interim Payment System does not penalize regions of the country that have been providing home health services efficiently.

Mr. President, I have been working to promote the availability of home care and other long-term care options for my entire public life because I believe strongly in the importance of enabling people to stay in their own homes. For seniors who are homebound and have skilled nursing needs, having access to home health services through

the Medicare program is the difference between staying in their own home and being moved into a nursing facility. Home care offers feelings of security, dignity and hope. Where there is a choice, we should do our best to allow patients to choose home health care.

Mr. President, I recognize that there are situations when one's ability to conduct the activities of daily living are so limited, and the medical needs are so great, that the patient would be better served, in some cases, in a skilled nursing facility. I also want to recognize that my State of Wisconsin has a very, very good network of caring and high-quality nursing homes. Without a doubt, there is a need for these services. But, Mr. President, as I travel throughout Wisconsin's 72 counties every year, what seniors tell me again and again is that, to the extent possible, and as long as it is medically appropriate for them to do so, they would like to remain in their own homes. I think seniors need and deserve that choice.

Mr. President, seniors clearly prefer to remain in their own homes rather than be moved to a nursing home. Their medical needs can often be met through home health services. Despite these facts, the implementation of the Medicare Home Health Interim Payment System as passed in last year's budget could create serious access problems for seniors in States like Wisconsin and Maine when they seek the home health benefit. The cuts to the Medicare Home Health program imposed by the Interim Payment System are so severe that home health agencies will have no choice but to reduce dramatically the amount of services provided. Some home care agencies may get out of the home care business altogether. But, Mr. President, the real impact of the Interim Payment System will not be simply to reduce payments to home care providers and force some out of business, what it will really do and what really concerns me is it will drastically reduce the options that homebound seniors now have today with respect to whether they will remain in their home in the community or whether they will be forced into a nursing home situation that is not necessarily the best place for them.

As of right now, Mr. President, the Interim Payment System for Medicare home health care is a system that pays agencies the lowest of the following three measures: (1) actual costs; (2) a per visit limit of 105% of the national median; or (3) a per beneficiary annual limit, derived from a blend of 75% an agency's costs and 25% regional costs. Now, these measures are pretty technical and I will not go into any more of the specifics about them. But suffice it to say that the net effect of the Interim Payment System will be to penalize severely agencies who have been operating efficiently all these years. Since the Interim Payment System will pay the agency the lowest of the three measures that I mentioned, agencies in areas where costs have been kept lower will be disproportionately and unfairly affected.

Mr. President, according to the Health Care Financing Administration, just in Wisconsin alone, there are currently 181 home health care agencies that participate in Medicare. Of these, two-thirds of them are operated as nonprofit entities. These nonprofit home health care providers are often county health departments and visiting nurse organizations; these are not entities out to make a fast buck on the backs of homebound seniors. According to administrators of Valley Visiting Nurse Association in Neenah, WI, the average, per patient Medicare home care cost in Wisconsin is $2,586, compared to $5,000 in other parts of the country. Let me repeat that, the statistics, because it is really quite striking. The average, per patient Medicare home care cost in Wisconsin is only $2,586, compared to often over $5,000 or more in other places in the country. These nonprofit providers in Wisconsin are already as lean as they can be. I am fairly convinced they don't have any ''fat'' to cut from their programs. The Visiting Nurse Association Home Health of Wausau showed me some figures demonstrating that, over the past 5 years, their services have averaged 30 percent below limits imposed by the Health Care Financing Administration, with 36 percent fewer visits per beneficiary than the national average.

Mr. President, the effect of the deep reductions imposed by the Interim Payment System will be, quite simply, a devastating blow to these types of agencies, and, in turn, will seriously impact the availability of home health care services to many people in Wisconsin. This devastating blow is dealt not because Wisconsin has been providing too many services too expensively. It is just to the contrary. States like Wisconsin and others are being penalized more precisely because they have always operated efficiently. Moreover, on a national level, with a reduced per-patient limit, home health agencies have a disincentive to take more seriously ill patients onto their rolls.

Mr. President, the legislation my colleagues and I introduce today will change the Interim Payment System to bring about greater payment equity for Medicare home health providers in different parts of the country. The bill, as the Senator from Maine outlined, would create a new formula for the per-patient limit that reflects a higher percentage of national data rather than relying solely on regional and local data. The change in payment calculation would enable high-efficiency, low-cost home health agencies to continue providing services efficiently and cost-effectively. But, Mr. President, the most important impact of the Medicare Home Health Equity Act will be to make sure that seniors who are homebound and have skilled nursing needs will retain for as long as possible the right to decide to stay in their own homes.

Mr. President, I thank the Chair and yield the floor.

Ms. COLLINS. Mr. President, I thank the Senator from Wisconsin for his cosponsorship of this important legislation and for his leadership in this issue.

Mr. CHAFEE. Mr. President, I am pleased to sponsor the Medicare Home Health Equity Act of 1998 with my distinguished colleague from Maine. I want to applaud Senator COLLINS' efforts to correct a provision in the Balanced Budget Act (BBA) of 1997 which has had the effect of penalizing those home health agencies that have taken the lead in becoming more cost-efficient over the last several years.

The Medicare Home Health Equity Act of 1998 will help avert the potentially devastating effect of the Interim Payment System (IPS), established by the Balanced Budget Act, on many home health agencies in Rhode Island, and throughout the country.

The IPS for Medicare home health services that was established by the BBA bases its reimbursement in large part on agency-specific costs during fiscal year 1994. Consequently, home health agencies that had already been implementing cost-efficient practices at that time, like many agencies in Rhode Island were doing, are now finding their reimbursements greatly reduced.

Home health agencies in my home state have told me that this decreased reimbursement, in addition to being unfair, might lead to reductions in critical health services that currently enable elderly patients to maintain their dignity and quality of life. These agencies also have pointed out that this interim payment system may well result in a loss of jobs in the home health industry.

I am greatly troubled by the thought that the IPS now in effect may well put into financial jeopardy those Rhode Island home health agencies that have been working diligently to heed our appeal to deliver cost-efficient services. The impact of this payment system on one of Rhode Island's most vulnerable populations, the infirm elderly, is unpredictable and potentially devastating.

The Medicare Home Health Equity Act of 1998 bases Medicare reimbursement for home health services primarily on national costs during the baseline year rather than agency-specific costs. Consequently, the most efficient home health agencies will not be placed at financial disadvantage. This is a matter of economic necessity—we will never be able to maintain the financial security of the Medicare program unless we encourage everyone involved in the system to help make it work.

This bill is budget-neutral and will not increase overall Medicare expenditures. The legislation is a big step forward in our goal of a cost-efficient and reliable health care system for our older citizens.

Mr. President, I encourage my colleagues to join me in supporting the

Medicare Home Health Equity Act of 1998.

Mr. JEFFORDS. Mr. President, Vermont's home health agencies are a model of efficiency for the nation. For the past seven consecutive years, the average Medicare expenditure for home health care in Vermont has been the lowest in the nation. This efficiency was achieved by exclusive reliance on 13 nonprofit agencies which provide care without sacrificing quality, and which adhere strictly to Medicare requirements and guidelines. Today, I am cosponsoring The Medicare Home Health Equity Act of 1998, with my good friend Senator COLLINS, in order to preserve this high-quality, low-cost home health system from possible insolvency.

At this moment, Vermont is facing an unprecedented crisis in its home health care system. This is not a crisis of their own making, and the home health agencies had little, if any, advance warning that disaster was imminent. The crisis that befalls Vermont's home health care agencies, and many others throughout the country, arose from the decision made by Congress, as a part of the Balanced Budget Act of 1997 (BBA), to adopt a Medicare prospective payment system for home health care.

There is compelling rationale and general agreement for moving Medicare to a prospective payment system (PPS) in the home health care sector. Under a national, prospective payment system, low-cost agencies will fare well, as they have already learned how to manage their resources wisely. However, the interim system created by the BBA for the transition to a PPS is fundamentally flawed and rewards high-cost agencies. Under the Interim Payment System, reimbursement limits for home health care are heavily weighted toward an agency's historical costs. This means that until a prospective payment system can be designed and implemented, the lowest cost agencies will face the most significant caps on their Medicare payments.

Where a prospective payment system aims to level the playing field for agencies that care for similarly situated patients, the interim system preserves and reinforces significant disparities across agencies. Although high-cost agencies will face reductions in payments under the interim system, these will be the agencies in the best position to make those cuts. Low-cost agencies with budgets that are already lean have no place to turn. It would be a national tragedy if those low-cost agencies cannot survive the transition to a prospective system.

I commend the efforts of my good friend Senator COLLINS for bringing this bill forward. it was a difficult task to craft a remedy that allows committed and responsible home health agencies to survive and also maintain budget neutrality. The Medicare Home Health Equity Act of 1998 would alter the interim payment formula by basing payment caps on a blend of national and regional averages. In this way, we can move toward a more uniform level of reimbursement and allow home health care agencies in the same locale to operate under the same constraints. Furthermore, this legislation can be implemented quickly. This is important, because the regulations defining the interim payment system were not published until January of this year—nearly four months after the payment system was in force.

The situation is serious. We must provide relief to home health agencies and peace of mind to the clients who are under their care. Last August, I voted in support of the Balanced Budget Act of 1997. I was proud of the changes we made to preserve Medicare benefits for the present and for future generations. Today, I urge my colleagues to enact The Medicare Home Health Equity Act of 1998 and correct the unintended consequences of the BBA's interim payment system reimbursement limits on low-cost home health agencies.

Mr. HARKIN. Mr. President, I am pleased to join today with my distinguished colleague, Senator SUSAN COLLINS, in the introduction of the ''Medicare Home Health Equity Act of 1998.'' This bill tries to fix what we believe to be an unintended injustice in the Balanced Budget Act of 1997.

As many of you know, home health agencies have historically been reimbursed on the basis of costs. The Health Care Financing Administration paid each agency to cover the cost of providing care. This arrangement has been widely criticized because of offers no incentive for agencies to control their costs.

In order to correct this, we in Congress agreed that Medicare should move to a prospective payment system to control costs and ensure quality and access to care. The Balanced Budget Act establishes this system for home health, effective as of October 1, 1999. In the mean time, an interim payment system has been put in place. These changes were needed in order to rein in the incredible growth—some due to inappropriate payments—in the industry in the last seven years. In 1990, Medicare spent $3.7 billion on home health care. In 1996, $16.7 billion was spent. In addition, the average number of visits per beneficiary soared from 26 in 1990 to 76 in 1996.

I believe the change to the prospective payment system had to be done. However, the interim payment system will reward high-cost, inefficient home health provides at the expense of those home health agencies that have historically kept their costs low. I don't believe this was the intent of Congress, and that is why I am cosponsoring Senator COLLINS' bill to correct this injustice.

As co-chair of the Senate Rural Health Caucus, I've been working for a long time to change the big city, urban bias in Medicare's reimbursement payments. It penalizes more conservative cost-effective approaches to health care, and that hurts rural areas like Iowa. We went a long way towards fixing that bias in Balanced Budget Act by equalizing Medicare's reimbursement payments for managed care services.

But unbeknownst to me and, I believe, most of my colleagues, while we provided rural equity in one area, we took it away in another. It is just common sense that we should reward those who provide quality care in a cost-effective, efficient manner. We did this when we changed the Medicare managed care rates. It doesn't seem right that in the same Act, we created an interim payment system for home health services that rewards the high cost, wasteful agencies and leaves those that have successfully kept their costs low struggling to survive.

The system's reliance on a provider's historical costs in determining their reimbursement amounts has produced an uneven playing field. Many of the newer agencies, who got started during a period of high growth, now have a competitive advantage. They will now be reimbursed at a higher rate than their lower cost competitors.

Senator COLLINS' bill does the right thing—it rewards those agencies who have done the most to save Medicare money. These include many visiting nurse associations, non-profit free standing agencies and most non-profit hospital based programs.

The Home Health Equity Act will revise the current system of reimbursement based on 75 percent of agency cost blended with 25 percent of national costs. The legislation would create a 75 percent national rate blended with 25 percent regional rate to level payments to providers in a given geographic area. In addition, this bill continues the cost savings that the interim payment system was intended to achieve. Price Waterhouse has analyzed the bill and found it to be budget neutral.

If we don't fix the interim payment system, I am afraid we risk a reduction in access to and quality of health care for Iowa seniors. Iowa home health care agencies have historically provided efficient, quality service and they ought to be rewarded, not punished for this. Most importantly, rural patients and their families deserve continued access to the best possible care.

Mr. DASCHLE. Mr. President, today I join my colleagues in introducing the Medicare Home Health Equity Act of 1998.

The Balanced Budget Act (BBA) included numerous changes to Medicare that were necessary to extend the solvency of the trust fund and increase the program's integrity. It was extremely important legislation that I strongly supported, but there was no way to know the impact of every provision it included.

One provision of the BBA in particular, the interim payment system for

home health care, locks in place inequities between regions of the country, efficient and inefficient providers, and new and older agencies. I am concerned about the impact of that provision on my state of South Dakota.

In South Dakota, the interim payment system has raised significant concern. The interim payment system bases each agency's per patient cost limit largely on its per beneficiary cost in 1994. My concern is that South Dakota's cost per beneficiary and number of visits per patient were well below the national average in 1994. Many of the home health agencies in the state have expanded the geographic area they serve since 1994 and have added services that formerly were not available in the more rural parts of the state. Some of these agencies are the sole providers in our most rural counties.

I have heard from Hand County Home Health Agency which primarily serves women, age 85 and older, with little family nearby and with difficult health conditions. Since 1994, the Hand County Home Health Agency has kept its costs down, but has added new services such as physical therapy and has expanded the geographic area to serve areas that no other provider covers. The agency has told me that they have to consider discontinuing the new services they cover or decreasing the geographic area they serve. Neither of these options seems acceptable to me.

The interim payment system also creates problems between new and older agencies. In the same geographic area, where there is a new provider and an old agency, the new provider's limit will be based on the national median reimbursement. This results in significant discrepancies in reimbursement and ultimately the services that agencies can afford to deliver within the same area and market.

Ultimately the impact of this payment system falls on beneficiaries, and this must be foremost in our minds. Senator COLLINS' bill would go a long way to addressing the access, quality, and equity issues that have been raised by the interim payment system in South Dakota. I am pleased to join her in beginning the dialogue on this issue that I hope will lead to construction changes for home health care patients in South Dakota and across the nation.

By Mr. COATS (for himself, Mr. ABRAHAM, Mr. BROWNBACK, Mr. COVERDELL, and Mr. SANTORUM):

S. 1994. A bill to assist States in providing individuals a credit against State income taxes or a comparable benefit for contributions to charitable organizations working to prevent or reduce poverty and to protect and encourage donations to charitable organizations; to the Committee on Finance.

By Mr. ABRAHAM (for himself, Mr. BROWNBACK, Mr. COATS, Mr. COVERDELL, Mr. HUTCHINSON, Mr. SANTORUM, and Mr. LIEBERMAN):

S. 1995. A bill to amend the Internal Revenue Code of 1986 to allow the designation of renewal communities, and for other purposes; to the Committee on Finance.

By Mr. SANTORUM (for himself, Mr. ABRAHAM, Mr. BROWNBACK, Mr. COATS, Mr. COVERDELL, and Mr. HUTCHINSON):

S. 1996. A bill to provide flexibility to certain local educational agencies that develop voluntary public and private parental choice programs under title VI of the Elementary and Secondary Education Act of 1965; to the Committee on Labor and Human Resources.

RENEWAL ALLIANCE LEGISLATION

Mr. COATS. Mr. President, I am here today to announce, along with several Members—in fact, a coalition of 30 Republican Members from both the House and the Senate called the Renewal Alliance, which has been in business now for a considerable amount of time—more than a year—will be jointly introducing new initiatives to help restore hard-pressed urban neighborhoods of our country to reach out to families and communities and neighbors that are dealing with some of the most difficult and intractable social problems that affect our society.

This package, called REAL Life—renewal, empowerment, achievement, and learning for life—contains what we believe are essential elements to help bring improvements and restore hope to impoverished communities and to bring self-sufficiency to low-income individuals and families. REAL Life seeks to address the critical deficits facing neighborhoods and communities, families, those communities and neighborhoods who lie behind the gleaming skyscrapers, the neighborhoods where some of the most difficult problems in our society—homelessness, drug abuse, teen pregnancy, poverty, and violence—are found in some of the most complex and intractable forms in the neighborhoods, however, where groups of individuals and private community organizations and leaders are already at work defeating the poverty and dysfunction that have defied our well-intentioned and lavishly funded Federal efforts.

Before I begin to make specific comments about the legislation that we will be introducing, let me take a moment to read from a letter given to me by Light of Life Ministries, a rescue mission operating in Pittsburgh, PA. I think this letter communicates in a very compelling and clear way both the problems that we face today in our low-income areas and particularly in our cities—although these are no respecters of income or persons, but it seems that the problems are particularly acute in some of our urban areas—but also addresses some of the solutions that even today are within our grasp.

This letter is from a fellow named Benjamin Primis, a young man who, after a promising start in life, fell on hard times. He was a graphic artist working in the television industry, and he began using drugs and became addicted to crack cocaine. Soon he was homeless and desperate.

Benjamin writes:

> I found myself homeless in Pittsburgh. It seemed as though the world had turned its back on me. . . . When there was nowhere else to run, the Light of Life Ministry in Pittsburgh opened their doors of unconditional love. . . . Instantly I was comforted with three hot meals a day, clean linens, drug and alcohol therapy. . . . They fed me when I was hungry. They clothed me when I had nothing else to wear. [Most importantly,] they cared for me when I didn't care for myself.

Benjamin Primis's story is one of thousands, maybe tens of thousands, of stories of hope and restoration and healing that bring us together here on this floor, the Senate floor, this morning. Ben Primis was failed by both the dogmas and initiatives of Republicans and Democrats, conservatives and liberals. A booming economy did not prevent his fall into poverty. And the Government safety net proved to be an illusion. Instead, Ben was rescued by one of the thousands of neighborhood-based, privately run, often faith-based religious charities that operate in poor neighborhoods across our country.

Let me give another example, Mr. President. For years, officials in the District of Columbia and Members of Congress have wrestled with the problem of violence in this city that has plagued this city. A lot of programs have been tried, and the police department has been strengthened and reorganized and redeployed on several occasions to almost no effect. It seemed that none of the often very expensive initiatives had any fruition.

Last year, a group of African American men called the Alliance of Concerned Men began brokering peace treaties among the gangs that inhabit, and frequently dominate, some of the city's public housing complexes. Benning Terrace in southeast Washington, known to the D.C. police department as perhaps the most dangerous area of the city, has not had a single murder since the Alliance's peace treaty went into effect early last year. This movement is now spreading across the city.

These are community healers who are saving lives where all other Government efforts have failed. I have met with these individuals. I have listened to their stories and some of the most remarkable stories of transformation of individual lives and reconciliation that anyone could ever encounter.

The Light of Life Mission in Pittsburgh, the Alliance of Concerned Men in Washington, DC, Gospel Rescue Mission of Washington, these are the kinds of organizations that the Renewal Alliance REAL Life initiative wants to place at the center of our Nation's welfare and social policies.

REAL Life is not a handout, it is an opportunity agenda for America's poor,

and it is concentrated on those who live on America's meanest streets. It does acknowledge a role for Government programs, but it makes that role one of a junior partner—not a CEO, not a director, but a junior partner, a junior partner with those organizations that, without Government help, without Government rules and regulations, are reaching out and actually bringing hope and bringing restoration to some of the most desperate situations that our country encounters. This whole array of community-based organizations, faith-based organizations, social institutions, help restore individual lives and rebuilds neighborhoods.

Finally, REAL Life is a vision that starts with a belief that real and lasting social reform begins among the families, the churches, the schools, the businesses, that are the heart and the soul of local communities.

We have three central components in REAL Life. We have a community renewal component, which I will talk a little bit more in a moment, which incorporates a State-based voluntary charity tax credit, charity donations protection, liability reform. We have an economic empowerment component, which incorporates a number of empowerment initiatives that have been discussed and talked about over the years. These will be discussed by other members of the Renewal Alliance. We have educational opportunity for low-income families. This real-life initiative by the Renewal Alliance has narrowed its scope to three essential components as a means of demonstrating the effectiveness of these initiatives.

Before I yield to other members of the Renewal Alliance—and I note that Senator ABRAHAM, a key member of our Alliance, is here and ready to speak—let me briefly discuss the community renewal portion of the package we are introducing today.

The REAL Life Community Renewal Act begins with the belief that social capital, the invisible elements of trust, cooperation, and mutual support that undergird communities life, have been severely damaged by 30 years of misguided Government programs. The traditional networks of community action and caring anchored in churches, schools, and volunteer programs have been displaced by Government programs. Too much money and too little wisdom have combined to wreak havoc in urban neighborhoods. We seek to repair that damage done by the Great Society by shifting authority and resources out of Government and into the private, religious, and voluntary groups that know the deepest needs of local neighborhoods. We achieve this through State-based charity tax credit.

We tap a wide range of existing Federal welfare block grants as a funding source for these charity tax credits. The credit is entirely voluntary. It builds up on efforts in the States to find innovative approaches for the delivery of welfare services. Already, Arizona and Pennsylvania and Indiana have either incorporated or are in the process of incorporating charity tax credits as a way to provide incentives for contributions to these organizations.

As I said, we also contain provisions which will strengthen charities through enhanced liability protections and also to prevent IRS actions against these organizations to allow them to better do their mission. Others here this morning will speak in greater detail about the economic empowerment and educational opportunities sessions of our proposal.

The bottom line is this: After 30 years of experiments with top-down Federal poverty strategies and an enormous expenditure of money, the returns are in. The Great Society approach, the Government-knows-all approach, the Government-can solve-all-your-problems approach, has failed. It has been a failure that has been widespread across this country. Many of the initiatives were well motivated, but the results are in. It is time now for us to look at a new approach, a new approach that makes local leadership, community-based institutions, and neighborhood center reform efforts the heart of our welfare strategy.

I trust that my colleagues will join us in this effort to bring real life to those in greatest need in our society. I could spend the day discussing and talking about initiatives that have taken place in communities across this country where individuals, inspired by nothing more than a dream or a vision, often severely and desperately underfunded, have opened their arms and opened their hearts and opened their doors to provide real support and real help for real people in need. They have done so in a remarkable way.

The Center for the Homeless in South Bend, IN, has combined the efforts of 300 churches spanning the spectrum of denominations and religions. They have utilized the services of the University of Notre Dame, the hospital community of St. Joseph County, and help from volunteers from all walks of life, and put together a model homeless shelter which has a six-part, 2-year strategy of taking homeless individuals and turning them into homeowners, restoring their lives, and, in the process, restoring neighborhoods and restoring communities. It is one of the most remarkably efficient and effective efforts that I have witnessed.

But the story is repeated all across the State of Indiana in initiative after initiative. The Matthew 25 clinic in Fort Wayne, IN, a combination of doctors, dentists, and nurses, on a volunteer basis, is reaching out and established a clinic, providing medical care and help to low-income individuals who are not insured and don't have opportunities for medical treatment in the normal course of things. They have made a remarkable difference in our community. It is not a Federal program; it has nothing to do with a Federal program; there are no Federal funds. It is voluntary efforts by the community of medical personnel in our city. Whether it is a maternity home, a home for girls, a spouse abuse shelter, any of a number of programs, they are duplicated and replicated in virtually every city in America. Yet, they are struggling, struggling because, as I said, after 30 years of Federal initiatives, their efforts have been almost overwhelmed by the well-intended, well-meaning, extraordinarily expensive, and incredibly low-result efforts of the Federal Government. It is this problem that we are trying to address.

This doesn't have to be a partisan issue. This is something Republicans and Democrats can come together on. I believe liberals, who have been well-motivated and well-intended, have seen the dismal results of their efforts and are looking for an alternative. And those conservatives who say, ''Let this sort itself out; after all, it is an issue of personal responsibility and there is nothing Government should be involved in,'' I think are ignoring the fact that some of these institutions that are so essential to helping in this process need support and need to be rebuilt.

This is not a new, massive Federal program, this is simply some startup initiatives to point the way and, hopefully, to encourage the support and development of these non-Government institutions.

My colleague from Michigan is on the floor, Senator ABRAHAM, who has been instrumental in helping to develop the REAL Life initiative. I am pleased to yield time to him to explain another component of this particular package.

The PRESIDING OFFICER. The distinguished Senator from Michigan is recognized.

Mr. ABRAHAM. Mr. President, I would like to begin by thanking Senator COATS for the leadership he has provided. Even before there was such a thing as the Renewal Alliance, Senator COATS was, in a variety of contexts, bringing forth the arguments in the case that he has begun to present here today. I think the existence of his efforts and the various projects he has worked on was really the basis upon which a lot of us thought it made sense to begin working on a joint venture, the Renewal Alliance agenda that we are presenting today.

I would like to discuss a piece of legislation that has to do with an important part of the Renewal Alliance agenda. This is a bill which provides economic empowerment in economically distressed areas. It is part of an effort by a number of us who wish to bring about the revitalization of economically and socially distressed areas in our country, especially in our cities.

Traditional responses to persistent poverty have not been particularly effective. Frankly, even in the best of economic times, we find that certain parts of our communities still don't see significant change and feel that they are left behind—and indeed they are,

economically. On the other hand, at the other end of the spectrum there has been the Government solution approach that we have seen over the last several decades, more than $5 trillion in Government programs. Yet, we have seen very little change in the level of poverty in the country. The fact is that the debate that has occurred over the past 30 years between, on the one hand, the argument that all we need is a strong economy and, on the other hand, all we need are more Government programs, leaves us still short of the mark.

So what the Renewal Alliance has attempted to do is look beyond those traditional responses, believing that across America people have an abundance of desire to help the less fortunate to rebuild our cities and stop moral decay; also believing that too often the Federal Government impedes or fails to promote the community renewal that we need.

We must encourage families, churches, small businesses, and community organizations to take on the hard work of social renewal. How? By reducing Government barriers that are making it difficult for economically distressed areas to improve the quality and conditions of life there and, at the same time, providing incentives so that the culture and the private sector can assist the Government in achieving this objective. Yes, we do need a social safety net for the truly deserving, but that will never give people the opportunity to get out the economically distressed conditions they find themselves in. We must go further.

So what I would like to talk about specifically now is the economic empowerment component of the Renewal Alliance agenda. What we need are new approaches to our urban problems and problems of any community in the country that suffers from economic disadvantage because, as I say, despite the War on Poverty, our cities still face an array of problems.

Illegitimacy in our inner cities is at a record high level, in some areas exceeding 80 percent.

Harvard's Lee Rainwater estimates that by 2000, 40 percent of all American births will occur out of wedlock. And our cities are losing population, as well.

Since the mid-1960s, our largest 25 cities have lost approximately 4 million residents. Too often, the people left behind are the poor.

Half the people in our distressed inner cities lived below the poverty line in 1993.

To address this tragic situation, we propose the ''REAL Life Economic Empowerment Act.'' This legislation would target America's 100 poorest communities and offer pro-growth incentives to create jobs and spur entrepreneurship where it is needed most.

In order to become a renewal community, a community must meet several criteria. First, it must need the assistance. That means people in the area must be experiencing abnormally high rates of poverty and unemployment.

Second, State and local governments must enter into a written contract with neighborhood organizations to reduce taxes and fees, increase the efficiency of local services, formulate and implement crime reduction strategies, and make it easier for charities to operate.

Third, the community must agree not to enforce a number of restrictions on entry into business or occupations, including unnecessary licensing and zoning requirements.

In exchange, the community would receive a number of benefits from the Federal level. Our legislation would zero out capital gains taxes within these empowerment areas, it would increase business expensing, it would give a 20 percent wage credit to businesses hiring qualified workers who were still employed after 6 months, and it would provide tax incentives for entrepreneurs who clean up environmentally contaminated ''brownfield'' sites.

Unlike the administration's current ''empowerment zones,'' our incentives recognize that it is the private sector, not the Federal Government, that must be part of any effort to revitalize our communities.

Mr. President, there will be no boards established to dole out Government patronage, and our legislation will not include the onerous conditions and bureaucratic requirements of current programs. What is more, States and localities will be joining the Federal Government in reducing the burden of Government so that local small businesses can start and grow in distressed areas.

We know that it is these small businesses, from barber shops to local grocery stores, that often serve as the glue holding communities together. Not only do these small businesses provide jobs, they also provide places where people can meet one another to exchange news and keep in touch with local events and other job opportunities. It is crucial that we seed our distressed areas with businesses like these so that residents can pull their communities together and work toward a better life.

Mr. President, in short, what we hope to do with our legislation is to provide the incentives so that small entrepreneurial enterprises can develop in areas where there is currently significant economic distress. Therefore, the jobs being created will be created where the people are who don't have jobs. Right now, the biggest impediment to creating jobs is to create conditions in which entrepreneurship can exist. That means cleaning up contaminated brownfield sites, it means providing access to capital so small businesses can begin and flourish, it means making sure that Government regulations and rules aren't so burdensome and onerous that even the best-intentioned small business person can't even open their enterprise. The only way that is going to happen is if we have State, local, and Federal teams working together in the fashion that our legislation suggests.

The suggestion that this can work is, I think, abundantly clear if one looks to just existing examples of this going on in the country today. In our State of Michigan, under Governor John Engler, we have launched several extraordinarily interesting initiatives along these lines—one called the Renaissance Zone Concept, which essentially does the same thing we are proposing in this legislation; it just doesn't have the Federal component. Obviously, the State could not include us in the mix. But what the State has done is to say that, within a certain number of zones in the State, in economically distressed areas—and they range from inner-cities to rural areas, Mr. President—we will dramatically reduce the burdens of taxes and regulations in order to try to stimulate economic development. And we are doing that with tremendous results.

Another approach that is somewhat similar is being done in an effort to get people off of the welfare rolls and onto the job rolls. In fact, we have a country in Michigan which, because of this kind of State and local cooperative effort, the county of over 200,000 people has virtually nobody left on the welfare rolls because of the innovative approach that is being taken.

It is time to learn from these ''laboratories,'' these experiences at the State level. We believe this legislation moves us in that direction. So as we proceed forward with this Renewal Alliance agenda, I intend to work very hard on that component of it to find us economic empowerment. We want to give the Members of the Senate a chance to decide whether or not the business-as-usual approach is the way we want to enter the 21st century, or whether we want to augment what we do in Federal programs, as well as private sector initiatives, by providing, through the legislation we will offer, an opportunity to reduce the impediments to starting new business opportunities in our economically distressed areas, as well as providing incentives to create more of those businesses that obviously provide more people with a chance to get on the first rung of the economic ladder.

Mr. President, let me conclude, because other members of the Alliance are here. I thank Senator COATS for his leadership on this. I look forward to working with all of our colleagues as we try to move this agenda forward this year.

Mr. COATS. Mr. President, I thank the Senator from Michigan for his invaluable contributions to this effort. I now turn to another key member of our Renewal Alliance, someone who has offered additional invaluable contributions, for further explanation of the package we are introducing, Senator SANTORUM of Pennsylvania.

The PRESIDING OFFICER. The distinguished Senator from Pennsylvania is recognized.

Mr. SANTORUM. I thank the distinguished Presiding Officer for his recognition.

Mr. President, let me thank Senator COATS for his tremendous leadership on what is, really, a new paradigm. Those listening to the debate on the Senate floor and the discussion of the Renewal Alliance agenda—renewal, empowerment, achievement learning for life—may be hearing some things for the first time, as to a different approach.

One of the things that I know Senator COATS talked about and, in a sense, schooled many of us in here on this side of the aisle and on the other side of the aisle, I might add, is the importance of understanding the problems of this country, the real intractable problems, the ones that we sort of don't believe that there are any quick fixes to and are not going to be fixed in Washington. In fact, many of us would argue that many were exacerbated by attempts by Washington to fix those problems.

As a result of Senator COATS' urgings, the more I have gotten out into the neighborhoods in the last few years—poor neighborhoods, in particular, in Pennsylvania—to see what works and what doesn't: What are people doing at the local level that is making a difference in people's lives, that is taking absolute hopelessness and despair and turning it into productivity and optimism?

What I see is that, almost without exception, they are not Government programs and, almost without exception, they don't take Government dollars because, in so doing, it would corrupt what works for them because the Government would have some way of dictating to them how this program must work or what hoops they must jump through. And they have designed a program that meets the needs of the people in that community, designed by people in that community who have, in many, if not most, cases experienced the same kind of hopelessness and despair before they arrived where they are today—in a state of now helping those come out of the problems they have.

So what I have learned from my discussions with those very people is that we need to look here in Washington as to how we can help them, help them do the mission—and it is a mission, it is not a job. I don't know of anybody I have met in these communities who is making any money, who is getting a good night's sleep at night, who is profiting in any real financial way from, or any tangible way from, their work, but profiting enormously in the intangibles that are, frankly, the most satisfying.

It is a true labor of love for people in these communities, whether they are in the economic development area, or in the community development area, or in dealing with homelessness, or abused women, or doing a charter school, or running a small parochial school. Whatever the case may be, these are people who are convicted, who care deeply—not about education, not about homelessness, not about drug abuse; they care about that person sitting across the table from them. It is not a macroissue. It is a one-to-one, person-to-person challenge to save someone's life. They do it because they care. They do it because they love that person. That is the magic that no Government program can provide.

What DAN COATS, SPENCER ABRAHAM, and SAM BROWNBACK—those of us who are members of the alliance having looked into the eyes of those who care, not those who appropriate money here in Washington who say we care, but those who are there across the table shedding the tears, holding the hands, embracing those in real pain, those people who care—how can we help them? How can we help the world ministries, the real healing agents of our society to solve those intractable problems that, believe it or not, they solve, and do so so well? How did we help them do it better? How can we help them turn more lives around and replicate the great accomplishments they have made to so many neighborhoods? There isn't a neighborhood in America where there is not at least one person or one organization—whether it is a school or whether it is a rehab center or whether it is a homeless shelter or a soup kitchen—that isn't touching and changing people.

We have come forward with this agenda that is not, as the speaker said before, a Washington-based solution to the problem. But it is, in fact, a way that Washington can, one, get out of the way; two, maybe help with some of the things in a legal sense to get out of the way; three, give financial resources to those organizations that need those resources to either help the community or help the economy; and, next, give resources to the hands of parents and children so they can have the opportunity to hope through an education that gives them the tools to be able to be successful in our society.

But I am going to focus my couple of minutes more to talk in the area of education. I cannot tell you the number of employers I talked to just within the southeastern Pennsylvania area the other day, Philadelphia. Employer after employer, factory or industry, they told me how they desperately need skilled people. They desperately need people who are even semiskilled who can be trained. There are such shortages in the workplace today. Then I asked—the unemployment rate in the city of Philadelphia, the center city, or in Chester, or in Levittown, or places like that is very high, and there is available work? They say, ''Yes, there is. We have job fares. We ask people to apply, and they don't.'' I said, ''Why don't they?'' They said, ''Well, by and large, they don't have the education. They can't, in many cases, fill out applications, or they just simply don't have the education necessary to even meet what is a minimal skilled job.''

The jobs are there. But we just do not have people who are educated enough to take advantage of those opportunities. That is, in fact, a shame, and, as a result of a variety of factors, a breakdown in the family, the breakdown in the community, and, yes, the breakdown of the educational structure.

There are lots of things we can do to solve the first two problems that have been talked about. I am going to talk about the third, which is the breakdown of the education structure. I am not going to profess to you I have the answer—the silver bullet to make public education work in America's poor neighborhoods. I do not have a silver bullet. I can sit up here and suggest a variety of things that may or may not work to solve that intractable problem in educating poor students in poor schools. I do not have that answer off the top of my head. What I do have is a solution that will give children and families the opportunity to send their child to school where they can get a good education tomorrow. We have to step back and say, ''Well, is that good enough?'' Some may say, ''Senator, you are not solving the big problem tomorrow in public education in the poor neighborhoods of our country.'' I will answer, You are right. I am not. I am not going to solve that problem tomorrow. But what I am going to start to do today is to give that young person who may have a dream, or that mother or father who sees the spark in that young child's eye and believes that spark can lead them to somewhere in life if given the educational tools. I am going to give them the chance to get that child a chance. That is all we can do right now—to give them a scholarship, to send them to a school where they will have the opportunity to see that spark catch fire, to feed them what they need to take on the world.

Our program, called Educational Opportunities for Low-Income Families, is to provide scholarships through existing block grants that go to the States right now. We would allow that block grant to be used for scholarships to go to low-income children and 185 percent of poverty and below in the poorest neighborhoods in our country so that it will give low-income kids in poor neighborhoods the opportunity to have a scholarship that pays up to 60 percent of the cost of their tuition and would give them the opportunity to go to school and learn. I think it is a great opportunity for us to help one child at a time. I believe that in the long run helping one child at a time and giving that choice will, in fact, cause dramatic reforms in the whole educational system in those communities.

I have been given the high sign here. I will follow my chairman's lead. Again, I thank Senator COATS for his tremendous leadership on this.

Mr. COATS. Mr. President, it is very difficult to ask the Senator from Pennsylvania to wrap up his remarks because he, obviously, has such a deep-felt and heartfelt passion for these issues. I appreciate his work with us. We are under some time constraint.

I now turn the floor over to the Senator from Kansas, Senator BROWNBACK, who has also been a very key instrumental member of the development of this package.

The PRESIDING OFFICER. The distinguished Senator from Kansas is recognized.

Mr. BROWNBACK. Thank you very much. Mr. President, I am delighted to be able to work with the distinguished Senator from Kansas, who is presiding today, and also the distinguished Senator from Indiana, who has put forth this new alliance. It is a cadre of members who are putting forth these points that we think have not been sufficiently debated nor brought forward in the overall debate in America about what we should do about the crying issues of poverty that has so hit and harmed our Nation in so many places, both urban and rural.

More than 30 years after the United States first declared the War on Poverty, most signs point to failure. The United States has spent hundreds of billions of dollars—by some accounts we have spent nearly $4 trillion—to fight poverty only to find poverty in America has grown more widespread, more entrenched, and more pathological. The solution is not to expand more Government but rather to go a different way, and to say, ''Look, we have tried that route. We have spent nearly $4 trillion trying that route. We have tried every program you possibly can with that route. Maybe there is another way that we should be going.''

This is what the Renewal Alliance, this program, is about—about rewarding self-help and not Government help. It is about encouraging charity rather than encouraging Government. It is about encouraging volunteerism rather than putting more people on the taxpayer rolls to solve problems that we have failed to be able to solve. Family breakdown, crime, poor education performance, and a lack of opportunity in the inner cities, and many other areas, including many rural areas, are now national problems. But many of the solutions are to be found on a local level and not in Washington, through personal contacts that people can make between individuals and the dedicated involvement of families, churches, schools, and neighborhood associations. These small groups, not big Government, but rather small groups, often referred to as the ''little platoons'' in a civil society, can often accomplish what no Government program could dream of or ever been able to do. They have the soft hearts and the willing hands to be able to reach out and touch people directly in a community where they are in there with the families working with them.

Last December, I had the chance to visit several of these small, private charities in my home State of Kansas. To me, they are living proof of the amazing effectiveness of small, local charities that lead with heart, that lead with love.

Mr. President, in this very body, in this very room, as you enter into the main doorway coming in here, there is a sign above the door mantle which reads ''In God We Trust.'' As I visited these small charities in Kansas, I was reminded at that time and was thinking about how many people say that versus how many people do that. These are charities, which ''In God We Trust'' they live every day.

I visited Good Samaritan Clinic in Wichita, which serves around 300 patients a month from Wichita's poorest neighborhood. This tiny clinic operates on less than a shoestring budget. With the exception of a fax machine and one piece of furniture, everything in the clinic is donated. The clinic's staff, a dedicated and accomplished group of doctors, are mostly volunteers. They are reaching out and touching people, and helping and healing people with their skills and with their hearts.

I visited the Topeka Rescue Mission and the Union Rescue Mission of Wichita, both of which serve thousands of people each year.

These missions are not merely assigning people to bunks, but they challenge them personally and spiritually, and they are challenged to change their hearts and their souls along with helping them out in their lives.

I visited the Crisis Pregnancy Outreach Program in Topeka and a maternity home in Wichita and saw firsthand the love and personal attention devoted to each woman who passes through those doors.

Contrast that with the large Government solution that we have tried for the past 30 years that gets millions of people flowing through the door but constantly keeps them flowing back out the door and never really changes things in a person's life, continues to hand them something but doesn't put arms around them and hug them, doesn't put arms around them and give them heart and soul and say, ''Here is my phone number; call anytime.''

It is not that we don't have a lot of good and dedicated servants; we do, but they are limited in what they can do. This is a mission for them. They must not see the number of people who are walking through; they must see a soul at a time. They must see another and another, to reach out and touch and help them. We need to encourage these groups and not discourage them.

As the past 35 years of our history has shown, the Federal Government is limited in its capacity to solve the problems of poverty and pathology, But it can eliminate perverse incentives that reward irresponsibility and fuel the flight of capital from the inner cities, and it can encourage entrepreneurialism, charitable giving and investment in the inner cities and its inhabitants, investment in the inhabitants of those areas and rural areas as well. It can do these things and it should. And through the renewal alliance REAL Life legislation, it will.

That is why I am delighted to be associated with the Senator from Indiana in this package that we have put forward. It is a different way. It is a way that people every day are proving can and is working, and we need to encourage it and lift it up and move it forward. I am delighted to be a part of this legislation.

Mr. COATS. Mr. President, I thank the Senator from Kansas for his invaluable support and effort in helping craft this legislation.

Mr. President, I know the time allocated to us is just about up.

I send to the desk three pieces of legislation, one that I am introducing, another that Senator ABRAHAM is introducing, and a third that Senator SANTORUM is introducing, all of which encompass the three major components of the renewal alliance package. I would ask for its immediate referral.

Mr. President, I also ask unanimous consent if it is possible—a qualified unanimous consent request—to have these numbered sequentially since these three pieces of legislation are part of a package. If it is possible, we would like to have them numbered consecutively.

The PRESIDING OFFICER. Is there an objection? The Chair hears none, and the bills will be so numbered. They will be received and appropriately referred.

Mr. COATS. Mr. President, I believe that wraps up our time. I think the Senator from Iowa is in the Chamber prepared to speak within a moment or two. Let me ask unanimous consent for 2 additional minutes to wrap up.

The PRESIDING OFFICER. The Senator has 2 additional remaining on his time.

Mr. COATS. That is propitious then. The Senator will take all 2 of those minutes. I thank the Chair.

Mr. President, in summary, let me state that what we are attempting to accomplish here is a third alternative. We believe that the well-intentioned, well-motivated programs of the past, at great cost to the taxpayers, have failed to successfully address some of the most difficult social problems facing our Nation, and particularly problems facing low-income urban communities where in many situations nothing but crime and drugs are the prevalent activities of those organizations. By the same token, the argument that no Federal policy is the best policy to address these problems is something that we as a group cannot accept.

We think this third alternative, providing REAL Life meaningful solutions to the areas of community renewal, economic empowerment and educational opportunities for low-income families offers real hope. It does so not through Government organizations,

Government structures or even significant Government funding. It does so by encouraging those community volunteer, nonprofit, often faith-based organizations that already exist and should exist in greater numbers to take a much greater role in addressing these problems. We want to make the Federal Government not the dominant partner but a junior partner, an entity that can assist through the provision of Tax Code changes, primarily tax credits and other incentives, to encourage individuals and other organizations to contribute to these nonprofit groups to allow them to do a better job. They have demonstrated success at an efficiency rate and at a cost-effectiveness that far exceeds those current programs in place.

Are we calling for a dismantling of the safety net? No, we are not. We are calling for a better use of dollars, a better commitment, stronger commitment to organizations which have demonstrated real success in providing hope to individuals, transformation and renewal of communities.

Mr. President, I believe the time is probably expired, and with that I yield the floor and encourage my colleagues to take a look at the REAL Life Renewal Alliance initiative which we are happy to provide and discuss with our colleagues.

By Ms. MIKULSKI (for herself and Mr. FAIRCLOTH):

S. 1997. A bill to protect the right of a member of a health maintenance organization to receive continuing care at a facility selected by that member; to the Committee on Labor and Human Resources.

THE ''SENIORS' ACCESS TO CONTINUING CARE ACT OF 1998''

Ms. MIKULSKI. Mr. President, I rise today to introduce the ''Seniors' Access to Continuing Care Act of 1998'', a bill to protect seniors' access to treatment in the setting of their choice and to ensure that seniors who reside in continuing care communities, and nursing and other facilities have the right to return to that facility after a hospitalization.

As our population ages, more and more elderly will become residents of various long term care facilities. These include independent living, assisted living and nursing facilities, as well as continuing care retirement communities, which provide the entire continuum of care. In Maryland alone, there are over 12,000 residents in 32 continuing care retirement communities and 24,000 residents in over 200 licenced nursing facilities.

I have visited many of these facilities and have heard from both residents and operators. They have told me about a serious and unexpected problem encountered with returning to their facility after a hospitalization. Many individuals have little choice when entering a nursing facility. They do so because it is medically necessary, because they need a high level of care that they can no longer receive in their homes or in a more independent setting, such as assisted living. But residents are still able to form relationships with other residents and staff and consider the facility their ''home''.

More and more individuals and couples are choosing to enter continuing care communities because of the community environment they provide. CCRC's provide independent living, assisted living and nursing care, usually on the same campus—the Continuum of Care. Residents find safety, security and peace of mind. They often prepay for the continuum of care. Couples can stay together, and if one spouse needs additional care, it can be provided right there, where the other spouse can remain close by.

But hospitalization presents other challenges. Hospitalization is traumatic for anyone, but particularly for our vulnerable seniors. We know that having comfortable surroundings and familiar faces can aid dramatically in the recovery process. So, we should do everything we can to make sure that recovery process is not hindered.

Today, more and more seniors are joining managed care plans. This trend is likely to accelerate given the expansion of managed care choices under the 1997 Balanced Budget Act. As more and more decisions are made based on financial considerations, choice often gets lost. Currently, a resident of a continuing care retirement community or a nursing facility who goes to the hospital has no guarantee that he or she will be allowed by the MCO to return to the CCRC or nursing facility for post acute follow up care.

The MCO can dictate that the resident go to a different facility that is in the MCO network for that follow up care, even if the home facility is qualified and able to provide the needed care.

Let me give you a few examples:

In the fall of 1996, a resident of Applewood Estates in Freehold, New Jersey was admitted to the hospital. Upon discharge, her HMO would not permit her to return to Applewood and sent her to another facility in Jackson. The following year, the same thing happened, but after strong protest, the HMO finally relented and permitted her to return to Applewood. She should not have had to protest, and many seniors are unable to assert themselves.

A Florida couple in their mid-80's were separated by a distance of 20 miles after the wife was discharged from a hospital to an HMO-participating nursing home located on the opposite side of the county. This was a hardship for the husband who had difficulty driving and for the wife who longed to return to her home, a CCRC. The CCRC had room in its skilled nursing facility on campus. Despite pleas from all those involved, the HMO would not allow the wife to recuperate in a familiar setting, close to her husband and friends. She later died at the HMO nursing facility, without the benefit of frequent visits by her husband and friends.

An elderly couple in Riverside, California encountered the same problem when the husband was discharged from the hospital and retained against her will at the HMO skilled nursing facility instead of the couple's community. At 25 miles apart, it was impossible for his wife and friends to visit at a time when he needed the tenderness and compassion of loved ones.

Another Florida woman, a resident of a CCRC fractured her hip. Her HMO wanted her to move into a nursing home for treatment. She refused to abandon her home and received the treatment at the CCRC. Her HMO refused to pay for the treatment, so she had to pay out of her pocket.

Collington Episcopal Life Care Community, in my home state of Maryland, reports ongoing problems with its frail elderly having to obtain psychiatric services, including medication monitoring, off campus, even though the services are available at Collington—how disruptive to good patient care!

On a brighter note, an Ohio woman's husband was in a nursing facility. When she was hospitalized, and then discharged, she was able to be admitted to the same nursing facility because of the Ohio law that protected that right.

Seniors coming out of the hospital should not be passed around like a baton. Their care should be decided based on what is clinically appropriate, not what is financially mandated. Why is that important? What are the consequences?

Residents consider their retirement community or long term care facility as their home. And being away from home for any reason can be very difficult. The trauma of being in unfamiliar surroundings can increase recovery time. The staff of the resident's ''home'' facility often knows best about the person's chronic care and service needs. Being away from ''home'' separates the resident from his or her emotional support system.

Refusal to allow a resident to return to his or her home takes away the person's choice. All of this leads to greater recovery time and unnecessary trauma for the patient.

And should a woman's husband have to hitch a ride or catch a cab in order to see his recovering spouse if the facility where they live can provide the care? No. Retirement communities and other long term care facilities are not just health care facilities. They provide an entire living environment for their residents, in other words, a home. We need to protect the choice of our seniors to return to their ''home'' after a hospitalization. And that is what my bill does.

It protects residents of CCRC's and nursing facilities by: enabling them to return to their facility after a hospitalization; and requiring the resident's insurer or managed care organization (MCO) to cover the cost of the care, even if the insurer does not have a contract with the resident's facility.

In order for the resident to return to the facility and have the services covered by the insurer or MCO: 1. The service to be provided must be a service that the insurer covers; 2. The resident must have resided at the facility before hospitalization, have a right to return, and choose to return; 3. The facility must have the capacity to provide the necessary service and meet applicable licensing and certification requirements of the state; 4. The facility must be willing to accept substantially similar payment as a facility under contract with the insurer or MCO.

My bill also requires an insurer or MCO to pay for a service to one of its beneficiaries, without a prior hospital stay, if the service is necessary to prevent a hospitalization of the beneficiary and the service is provided as an additional benefit. Lastly, the bill requires an insurer or MCO to provide coverage to a beneficiary for services provided at a facility in which the beneficiary's spouse already resides, even if the facility is not under contract with the MCO, provided the other requirements are met.

In conclusion, Mr. President, I am committed to providing a safety net for our seniors—this bill is part of that safety net. Seniors deserve quality, affordable health care and they deserve choice. This bill offers those residing in retirement communities and long term care facilities assurance to have their choices respected, to have where they reside recognized as their ''home'', and to be permitted to return to that ''home'' after a hospitalization. It ensures that spouses can be together as long as possible. And it ensures access to care in order to prevent a hospitalization. I urge my colleagues to join me in passing this important measure to protect the rights of seniors and their access to continuing care.

By Mr. HATCH (for himself, Mr. BENNETT, and Mr. BINGAMAN):

S. 1998. A bill to authorize an interpretive center and related visitor facilities within the Four Corners Monument Tribal Park, and for other purposes; to the Committee on Indian Affairs.

THE FOUR CORNERS INTERPRETIVE CENTER ACT

Mr. HATCH. Mr. President, I rise today to introduce legislation that would authorize an interpretive center and visitor facilities at the Four Corners National Monument. As my colleagues know, Four Corners is the only place in our country where four state boundaries meet. Over a quarter of a million people visit this monument every year.

The Four Corners area is also unique for reasons other than the political boundaries of four states. Once inhabited by the earliest Americans, the Anaxazi, this area is rich in historical, archaeological,and cultural significance as well as natural beauty.

Currently, however, there is nothing at Four Corners that would help visitors to fully appreciate and learn about the area. And, at a national monument that has 250,000 visitors a year, one would expect certain basic facilities to exist—restrooms, for example. But, there is no electricity, running water, telephone, or permanent structure at Four Corners.

The bill I am introducing today is simple: We propose a Federal matching grant to build an interpretive center and visitor facilities within the boundaries of Four Corners Monument Tribal Park.

We are not suggesting a museum the size of the Guggenheim. But, exhibits on the history, geography, culture, and ecology of the region would significantly enhance the area and Americans' appreciation of this unique part of their country and their heritage. And, I daresay that some very basic guest amenities would enhance their enjoyment of it.

There is, as you can imagine, a great deal of excitement and enthusiasm for this project from many fronts. Currently, the Monument is operated as one of the units of the Navajo Nation Parks and Recreation Department. And, since there has been so much debate about ''monuments'' recently, I should clarify that the Four Corners ''Monument'' is merely a slightly elevated concrete slab at the juncture of our four states.

The Navajo Nation owns the land in the Arizona, New Mexico, and Utah quarters and the Ute Mountain Ute Tribe owns the quarter in Colorado. Although the Navajo Nation and the Ute Mountain Ute Tribe are fully supportive of the project and have entered into an agreement with one another in order to facilitate planning and development at the Four Corners Monument, neither Tribe has the necessary resources to improve the facilities and create an interpretive center at the Monument.

The bill, however, does not contemplate federal government giveaway. The bill requires matching funds from nonfederal sources and for the two tribes to work collaboratively toward the development of a financial management plan. It is intended that the Interpretive Center become fully self-sufficient within five years.

The bill requires that proposals meeting the stated criteria be submitted to the Secretary of the Interior. These criteria include, among other things, compliance with the existing agreements between the Navajo and Ute Mountain Ute Tribes, a sound financing plan, and the commitment of nonfederal matching funds. The federal contribution would not exceed $2.25 million over a 5 year period.

Over the past several years, the Navajo Nation has met with many of the local residents of the area and has found overwhelming support to improve the quality of the services provided at the Four Corners Monument. The local area suffers an unemployment rate of over 50 percent and any development which would create employment opportunities and would encourage visitors to stay longer in the area would be welcomed.

Another important participant in the development of this proposal is the Four Corners Heritage Council. This Council, which was established in 1992 by the governors of the four states, is a coalition of private, tribal, federal, state, and local government interests committed to finding ways to make the economy of the Four Corners region sustainable into the future. The mission of the Heritage Council is to guide the region toward a balance of the sometimes competing interests of economic development, resource preservation, and maintenance of traditional life ways.

Back in 1949, nearly 50 years ago, the governors of the states of Arizona, Colorado, New Mexico, and Utah assembled at the Four Corners in a historic meeting. Each governor sat in their respective state and had what is probably the most unusual picnic lunch in history. They pledged to meet often at the Four Corners Monument to reaffirm their commitment to working together. Clearly, the governors understood that they shared stewardship of a unique piece of western real estate.

Mr. President, the heritage of this area belongs to all Americans. The small investment requested in this legislation will help bring it to life.

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

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

S. 1998

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 ''Four Corners Interpretive Center Act''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds that—

(1) the Four Corners Monument is nationally significant as the only geographic location in the United States where 4 State boundaries meet;

(2) the States with boundaries that meet at the Four Corners area are Arizona, Colorado, New Mexico, and Utah;

(3) between 1868 and 1875 the boundary lines that created the Four Corners were drawn, and in 1899 a monument was erected at the site;

(4) a United States postal stamp will be issued in 1999 to commemorate the centennial of the original boundary marker;

(5) the Four Corners area is distinct in character and possesses important historical, cultural, and prehistoric values and resources within the surrounding cultural landscape;

(6) although there are no permanent facilities or utilities at the Four Corners Monument Tribal Park, each year the park attracts approximately 250,000 visitors;

(7) the area of the Four Corners Monument Tribal Park falls entirely within the Navajo Nation or Ute Mountain Ute Tribe reservations;

(8) the Navajo Nation and the Ute Mountain Ute Tribe have entered into a Memorandum of Understanding governing the planning and future development of the Four Corners Monument Tribal Park;

(9) in 1992 through agreements executed by the governors of Arizona, Colorado, New Mexico, and Utah, the Four Corners Heritage Council was established as a coalition of State, Federal, tribal, and private interests;

(10) the State of Arizona has obligated $45,000 for planning efforts and $250,000 for construction of an interpretive center at the Four Corners Monument Tribal Park;

(11) numerous studies and extensive consultation with American Indians have demonstrated that development at the Four Corners Monument Tribal Park would greatly benefit the people of the Navajo Nation and the Ute Mountain Ute Tribe;

(12) the Arizona Department of Transportation has completed preliminary cost estimates that are based on field experience with rest-area development for the construction of a Four Corners Monument Interpretive Center and surrounding infrastructure, including restrooms, roadways, parking, water, electrical, telephone, and sewage facilities;

(13) an interpretive center would provide important education and enrichment opportunities for all Americans.

(14) Federal financial assistance and technical expertise are needed for the construction of an interpretive center.

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

(1) to recognize the importance of the Four Corners Monument and surrounding landscape as a distinct area in the heritage of the United States that is worthy of interpretation and preservation;

(2) To assist the Navajo Nation and the Ute Mountain Ute Tribe in establishing the Four Corners Interpretive Center and related facilities to meet the needs of the general public;

(3) To highlight and showcase the collaborative resource stewardship of private individuals, Indian tribes, universities, Federal agencies, and the governments of States and political subdivisions thereof (including counties);

(4) to promote knowledge of the life, art, culture, politics, and history of the culturally diverse groups of the Four Corners region.

SEC. 3. DEFINITIONS.

As used in this Act—

(1) CENTER.—The term ''Center'' means the Four Corners Interpretive Center established under section 4, including restrooms, parking areas, vendor facilities, sidewalks, utilities, exhibits, and other visitor facilities.

(2) FOUR CORNERS HERITAGE COUNCIL.—The term ''Four Corners Heritage Council'' means the nonprofit coalition of Federal, State, and tribal entities established in 1992 by agreements of the Governors of the States of Arizona, Colorado, New Mexico, and Utah.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of the Interior.

(4) RECIPIENT.—The term ''Recipient'' means the State of Arizona, Colorado, New Mexico, or Utah, or any consortium of two or more of these states.

(5) FOUR CORNERS MONUMENT.—The term ''Four Corners Monument'' means the physical monument where the boundaries of the states of Arizona, Colorado, New Mexico and Utah meet.

(6) FOUR CORNERS MONUMENT TRIBAL PARK.—The term ''Four Corners Monument Tribal Park'' means lands within the legally defined boundary of the Four Corners Monument Tribal Park.

SEC. 4. FOUR CORNERS MONUMENT INTERPRETIVE CENTER.

(a) ESTABLISHMENT.—Subject to the availability of appropriations, the Secretary is authorized to establish within the boundaries of the Four Corners Monument Tribal Park a center for the interpretation and commemoration of the Four Corners Monument, to be known as the ''Four Corners Interpretive Center.''

(b) Land for the Center shall be designated and made available by the Navajo Nation or the Ute Mountain Ute Tribe within the boundary of the Four Corners Monument Tribal Park in consultation with the Four Corners Heritage Council and in accordance with—

(1) the memorandum of understanding between the Navajo Nation and the Ute Mountain Ute Tribe that was entered into on October 22, 1996; and

(2) applicable supplemental agreements with the Bureau of Land Management, the National Park Service, the United States Forest Service.

(c) CONCURRENCE.—Notwithstanding any other provision of this Act, no such center shall be established without the consent of the Navajo Nation and the Ute Mountain Ute Tribe.

(d) COMPONENTS OF CENTER.—The Center shall include—

(1) a location for permanent and temporary exhibits depicting the archaeological, cultural, and natural heritage of the Four Corners region;

(2) a venue for public education programs;

(3) a location to highlight the importance of efforts to preserve southwestern archaeological sites and museum collections;

(4) a location to provide information to the general public about cultural and natural resources, parks, museums, and travel in the Four Corners region; and

(5) visitor amenities including restrooms, public telephones, and other basic facilities.

SEC. 5. CONSTRUCTION GRANT.

(a) GRANT.—The Secretary is authorized to award a Federal grant to the Recipient described in section 3(4) for up to 50 percent of the cost to construct the Center. To be eligible for the grant, the Recipient shall provide assurances that—

(1) The non-Federal share of the costs of construction is paid from non-Federal sources. The non-Federal sources may include contributions made by States, private sources, the Navajo Nation and the Ute Mountain Ute Tribe for planning, design, construction, furnishing, startup, and operational expenses.

(2) The aggregate amount of non-Federal funds contributed by the States used to carry out the activities specified in subparagraph (A) will not be less than $2,000,000, of which each of the states that is party to the grant will contribute equally in cash or in kind.

(3) States may use private funds to meet the requirements of paragraph (2).

(4) The State of Arizona may apply $45,000 authorized by the State of Arizona during fiscal year 1998 for planning and $250,000 that is held in reserve by that State for construction towards the Arizona share.

(b) GRANT REQUIREMENTS.—In order to receive a grant under this Act, the Recipient shall—

(1) submit to the Secretary a proposal that meets all applicable—

(A) laws, including building codes and regulations;

(B) requirements under the Memorandum of Understanding described in paragraph (2) of this subsection; and

(C) provides such information and assurances as the Secretary may require.

(2) The Recipient shall enter into a Memorandum of Understanding (MOU) with the Secretary providing—

(A) a timetable for completion of construction and opening of the Center;

(B) assurances that design, architectural and construction contracts will be competitively awarded;

(C) specifications meeting all applicable Federal, State, and local building codes and laws;

(D) arrangements for operations and maintenance upon completion of construction;

(E) a description of center collections and educational programming;

(F) a plan for design of exhibits including, but not limited to, collections to be exhibited, security, preservation, protection, environmental controls, and presentations in accordance with professional museum standards;

(G) an agreement with the Navajo Nation and the Ute Mountain Ute Tribe relative to site selection and public access to the facilities;

(H) a financing plan developed jointly by the Navajo Nation and the Ute Mountain Ute Tribe outlining the long-term management of the Center, including but not limited to—

(i) the acceptance and use of funds derived from public and private sources to minimize the use of appropriated or borrowed funds;

(ii) the payment of the operating costs of the Center through the assessment of fees or other income generated by the Center;

(iii) a strategy for achieving financial self-sufficiency with respect to the Center by not later than 5 years after the date of enactment of this Act; and

(iv) defining appropriate vendor standards and business activities at the Four Corners Monument Tribal Park.

SEC. 6. SELECTION OF GRANT RECIPIENT.

The Secretary is authorized to award a grant in accordance with the provisions of this Act. The Four Corners Heritage Council may make recommendations to the Secretary on grant proposals regarding the design of facilities at the Four Corners Monument Tribal Park.

SEC. 7. AUTHORIZATION OF APPROPRIATIONS.

IN GENERAL.—(a) AUTHORIZATIONS.—There are authorized to be appropriated to carry out this Act—

(1) $2,000,000 for fiscal year 1999;

(2) $50,000 for each of fiscal years 2000–2004 for maintenance and operation of the Center, program development, or staffing in a manner consistent with the requirements of section 5(b).

(b) CARRYOVER.—Any funds made available under this section that are unexpended at the end of the fiscal year for which those funds are appropriated may be used by the Secretary through fiscal year 2001 for the purposes for which those funds were made available.

(c) RESERVATION OF FUNDS.—The Secretary may reserve funds appropriated pursuant to this Act until a proposal meeting the requirements of this Act is submitted, but no later than September 30, 2000.

SEC. 8. DONATIONS.

Notwithstanding any other provision of law, for purposes of the planning, construction, and operation of the Center, the Secretary may accept, retain, and expend donations of funds, and use property or services donated from private persons and entities or from public entities.

SEC. 9. STATUTORY CONSTRUCTION.

Nothing in this Act is intended to abrogate, modify, or impair any right or claim of the Navajo Nation or the Ute Mountain Ute Tribe, that is based on any law (including any treaty, Executive order, agreement, or Act of Congress).

Mr. BINGAMAN. Mr. President, I am pleased to rise today to co-sponsor this important legislation introduced by my friend from Utah, Senator HATCH. The bill authorizes the construction of an interpretive visitor center at the Four Corners Monument. As I am sure

all senators know, the Four Corners is the only place in America where the boundaries of four states meet in one spot. The monument is located on the Navajo and Ute Mountain Ute Reservations and operated as a Tribal Park. Nearly a quarter of a million people visit this unique site every year. However, currently there are no facilities for tourists at the park and nothing that explains the very special features of the Four Corners region. The bill authorizes the Department of the Interior to contribute $2 million toward the construction of a much needed interpretive center for visitors.

Mr. President, the Four Corners Monument is more than a geographic curiosity. It also serves as a focal point for some of the most beautiful landscape and significant cultural attractions in our country. An interpretive center will help visitors appreciate the many special features of the region. For example, within a short distance of the monument are the cliff dwellings of Mesa Verde, Colorado; the Red Rock and Natural Bridges areas of Utah; and in Arizona, Monument Valley and Canyon de Chelly. The beautiful San Juan River, one of the top trout streams in the Southwest, flows through Colorado, New Mexico, and Utah.

In my state of New Mexico, both the legendary mountain known as Shiprock and the Chaco Canyon Culture National Historical Park are a short distance from the Four Corners.

Mr. President, Shiprock is one of the best known and most beautiful landmarks in New Mexico. The giant volcanic monolith rises nearly 2,000 feet straight up from the surrounding plain. Ancient legend tells us the mountain was created when a giant bird settled to earth and turned to stone. In the Navajo language, the mountain is named Tse' bi t'ai or the Winged Rock. Early Anglo settlers saw the mountain's soaring spires and thought they resembled the sails of a huge ship, so they named it Shiprock.

The Four Corners is also the site of Chaco Canyon. Chaco was an important Anasazi cultural center from about 900 through 1130 A.D. Pre-Columbian civilization in the Southwest reached its greatest development there. The massive stone ruins, containing hundreds of rooms, attest to Chaco's cultural importance. As many as 7,000 people may have lived at Chaco at one time. Some of the structures are thought to house ancient astronomical observatories to mark the passage of the seasons. The discovery of jewelry from Mexico and California and a vast network of roads is evidence of the advanced trading carried on at Chaco. Perhaps, the most spectacular accomplishment at Chaco was in architecture. Pueblo Bonito, the largest structure, contains more than 800 rooms and 32 kivas. Some parts are more than five stories high. The masonry work is truly exquisite. Stones were so finely worked and fitted together that no mortar was needed. Remarkably all this was accomplished without metal tools or the wheel.

Mr. President, 1999 marks the centennial year of the first monument at the Four Corners. An interpretive center is urgently needed today to showcase the history, culture, and scenery of this very special place. New facilities at the monument will attract visitors and help stimulate economic development throughout the region. I am pleased to co-sponsor this bill with Senator HATCH, and I thank him for his efforts.

ADDITIONAL COSPONSORS

S. 1021

At the request of Mrs. MURRAY, her name was added as a cosponsor of S. 1021, a bill to amend title 5, United States Code, to provide that consideration may not be denied to preference eligibles applying for certain positions in the competitive service, and for other purposes.

S. 1180

At the request of Mr. KEMPTHORNE, the name of the Senator from Florida [Mr. MACK] was added as a cosponsor of S. 1180, a bill to reauthorize the Endangered Species Act.

S. 1334

At the request of Mr. BOND, the name of the Senator from California [Mrs. BOXER] was added as a cosponsor of S. 1334, a bill to amend title 10, United States Code, to establish a demonstration project to evaluate the feasibility of using the Federal Employees Health Benefits program to ensure the availability of adequate health care for Medicare-eligible beneficiaries under the military health care system.

S. 1413

At the request of Mr. LUGAR, the name of the Senator from Alaska [Mr. MURKOWSKI] was added as a cosponsor of S. 1413, a bill to provide a framework for consideration by the legislative and executive branches of unilateral economic sanctions.

S. 1427

At the request of Mr. FORD, the name of the Senator from Michigan [Mr. ABRAHAM] was added as a cosponsor of S. 1427, a bill to amend the Communications Act of 1934 to require the Federal Communications Commission to preserve lowpower television stations that provide community broadcasting, and for other purposes.

S. 1578

At the request of Mr. MCCAIN, the name of the Senator from Mississippi [Mr. LOTT] was added as a cosponsor of S. 1578, a bill to make available on the Internet, for purposes of access and retrieval by the public, certain information available through the Congressional Research Service web site.

S. 1645

At the request of Mr. ABRAHAM, the name of the Senator from Arizona [Mr. MCCAIN] was added as a cosponsor of S. 1645, a bill to amend title 18, United States Code, to prohibit taking minors across State lines to avoid laws requiring the involvement of parents in abortion decisions.

S. 1677

At the request of Mr. CHAFEE, the names of the Senator from Kansas [Mr. ROBERTS], the Senator from Georgia [Mr. COVERDELL], the Senator from Iowa [Mr. GRASSLEY], and the Senator from South Carolina [Mr. THURMOND] were added as cosponsors of S. 1677, a bill to reauthorize the North American Wetlands Conservation Act and the Partnerships for Wildlife Act.

S. 1862

At the request of Mr. DEWINE, the name of the Senator from Hawaii [Mr. INOUYE] was added as a cosponsor of S. 1862, a bill to provide assistance for poison prevention and to stabilize the funding of regional poison control centers.

S. 1917

At the request of Mr. DURBIN, the names of the Senator from Massachusetts [Mr. KENNEDY] and the Senator from Illinois [Ms. MOSELEY-BRAUN] were added as cosponsors of S. 1917, a bill to prevent children from injuring themselves and others with firearms.

S. 1963

At the request of Mr. THURMOND, the name of the Senator from South Carolina [Mr. HOLLINGS] was added as a cosponsor of S. 1963, a bill to amend title 10, United States Code, to permit certain beneficiaries of the military health care system to enroll in Federal employees health benefits plans.

SENATE CONCURRENT RESOLUTION 30

At the request of Mr. HELMS, the name of the Senator from Arizona [Mr. MCCAIN] was added as a cosponsor of Senate Concurrent Resolution 30, a concurrent resolution expressing the sense of the Congress that the Republic of China should be admitted to multilateral economic institutions, including the International Monetary Fund and the International Bank for Reconstruction and Development.

SENATE CONCURRENT RESOLUTION 80

At the request of Ms. MOSELEY-BRAUN, the name of the Senator from North Dakota [Mr. DORGAN] was added as a cosponsor of Senate Concurrent Resolution 80, a concurrent resolution urging that the railroad industry, including rail labor, management and retiree organization, open discussions for adequately funding an amendment to the Railroad Retirement Act of 1974 to modify the guaranteed minimum benefit for widows and widowers whose annuities are converted from a spouse to a widow or widower annuity.

SENATE CONCURRENT RESOLUTION 83

At the request of Mr. WARNER, the names of the Senator from Indiana [Mr. LUGAR], the Senator from New York [Mr. D'AMATO], the Senator from Georgia [Mr. COVERDELL], the Senator from Alabama [Mr. SHELBY], the Senator from Connecticut [Mr. DODD], the Senator from Wisconsin [Mr. KOHL], the Senator from New Jersey [Mr. LAUTENBERG], the Senator from Michigan [Mr. LEVIN], the Senator from New York [Mr. MOYNIHAN], the Senator from Illinois [Ms. MOSELEY-BRAUN], the