of which were sophisticated U.S. investors. The American taxpayers bailed them out. Here today we are seeing that that effort to try to stabilize the Mexican Government apparently has failed.

Mr. President, I have concluded my remarks. I wish the President a good day, and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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 President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. GRAHAM. Mr. President, pursuant to a previous order, I believe I have 20 minutes during morning business.

The PRESIDING OFFICER. The Senator is correct.

## MEDICAID PROGRAM

Mr. GRAHAM. Mr. President, today I conclude a series of talks on the Medicaid Program. I began a four-part presentation last Friday by debunking the myth that the Medicaid Program has been a failure. In fact, an objective review of the accomplishments of this Federal-State partnership tells us that the Medicaid Program has been an American success story.

Just a few examples: The decrease in infant mortality rate from 10.6 deaths per thousand livebirths as recently as 1985 to 8.5 in 1992, largely attributable to an expanded effort in the Medicaid Program;

The improved quality of long-term care for millions of elderly citizens in a manner befitting their human dignity;

The deinstitutionalization of 125,000 profoundly handicapped Americans.

With that record of accomplishment established, on Tuesday of this week, I examined why Federal spending on Medicaid has increased throughout its history and why it is expected to increase in the next years. I pointed to such things as the demographic changes in America, particularly the increasing longevity which has driven up the number of persons who are in need of long-term care.

I addressed the numerous programmatic expansions in Medicaid that reflected compelling policy decisions, such as the decision to reduce infant mortality. That has led to increased costs as well.

Finally, I cited the erosion of private health coverage for millions of children, an issue which has become a major subject of public concern this week with the publication of a study in the Journal of the American Medical Association on that very topic, documenting the trend that as private sector insurance abandon children and their parents, the Medicaid Program picked up the slack, helping them get immunizations, checkups, and, when needed, specialty care.

Mr. President, this is not to say that part of the increase in the cost of Medicaid was not attributable to abusive or wasteful practices. Yesterday, I spoke about the abuses in the Disproportionate Share Hospital Program, known as DSH. I decried how the Senate, by its vote on October 27, rewarded with millions, and in some cases billions, of dollars those very States that gamed the DSH program. What is worse, the Senate majority voted to fund these rewards by raiding the Social Security trust fund and by perverting sound budgetary practices.

Mr. President, with that backdrop in place, I come to the Senate floor today with a message of hope. I bring to this Chamber a proposal that recognizes the importance of maintaining the Federal-State partnership in Medicaid and restraining costs.

The Senate is not in a posture of block grants or bust. There is another way. Why should we consider an alternative? We should consider an alternative because the alleged benefits of block grants—flexibility to the States particularly—are minimal, and the costs and loss of a Federal partner in a time of need for the most vulnerable of Americans are great.

The foundation upon which the block grants have been built, that they enhance flexibility for the States, is on shaky ground—shaky ground which erodes by close examination; shaky, that is, unless you define ''flexibility'' as the freedom to raise State taxes or local property taxes, or the flexibility to pit the elderly against children as beneficiaries for the Medicaid Program. Otherwise, there is precious little flexibility the States can receive that they cannot already get under the current Medicaid program waiver.

The Department of Health and Human Services has pioneered, with willing States, extraordinary demonstration projects where statutory and regulatory requirements can be waived to permit new approaches to health care. In my State of Florida, we have been in the vanguard of this waiver movement, particularly in the area of providing community-based services for older citizens and expanding the use of managed care for poor children.

Before the Senate brought the Medicaid legislation to the floor, I met with Mr. Bruce Vladeck of the Health Care Financing Administration, generally known as HCFA. My question to him was:

What flexibility, to allow innovation, would the block grants give States that they cannot get today through the waiver program?

Here is a summary of his answer:

States today can test new approaches to publicly supported health care by obtaining waivers to statutory requirements and limitations. Waivers permit States flexibility from Federal Medicaid statutory and regulatory requirements. State Medicaid demonstrations present valuable opportunities to both State and Federal policymakers to refine and test policies that improve access to the quality of care for vulnerable Medicaid populations and to more effectively manage the cost of providing that care.

Mr. President, I ask unanimous consent that the full statement by Mr. Vladeck be printed in the RECORD following my remarks.

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

(See exhibit 1.)

Mr. GRAHAM. What do the States relinquish in exchange for the marginal new flexibility that they will allegedly receive? The Federal partnership to assist them, if they experience caseload growth, will be surrendered. The Federal partnership, during times of economic hardship or recession, will be surrendered. And the Federal partnership, if there is a natural disaster—when Hurricane Andrew hit south Florida, Mr. President, our Medicaid caseload shot up by 12,000 people. Not only had their homes been blown away, their jobs had been blown away. Therefore, people who had been employed and self-supporting needed the assistance of Medicaid during that time of crisis.

Under block grants, a State that is knocked down to its knees by a flood, earthquake, hurricane, would not find a helping hand from the Federal Government at the time it needed help to get back on its feet. No, Mr. President, acts of God and block grants do not mix.

Mr. President, this is not a new debate. In January 1982, during his State of the Union Address, on the 26th day of that month, President Reagan recognized the issue of the States and the Federal Government's partnership in Medicaid. Did President Reagan advocate that Medicaid ought to be turned back to the States in the form of a block grant? Did he advocate that the States be left alone to deal with issues of changes in their growth, changes in economic circumstances, natural disasters? No, Mr. President, that was not the position of President Reagan.

Let me quote from his State of the Union Address what President Reagan said on January 26, 1982:

Starting in fiscal year 1984, the Federal Government will assume full responsibility for the cost of the rapidly growing Medicaid Program, to go along with its existing responsibility for Medicare. As part of this financially equal swap, the States will simultaneously take full responsibility for Aid for Families with Dependent Children and food stamps.

Mr. President, that was the swap that President Reagan proposed on January 26, 1982. I believe the President's advice, in terms of a greater, not a lesser, Federal role in Medicaid, was wise then, and it is advice that we should seriously consider following today.

If block grants are as bad as I suggest they are, is the only alternative to them business as usual? No, Mr. President. There is a way to have the best of both worlds, and to contain costs while maintaining the Federal-State partnership in Medicaid.

The best of both worlds is the per capita cap proposal that is gaining momentum as the win-win answer to the block grants' lose-lose proposition.

The per capita cap approach provides that health care and coverage could be protected, and costs can be controlled by disciplining the program with an annual limit in Federal spending per beneficiary.

This approach maintains the individual guarantee to Medicaid services and creates an incentive to maintain health care coverage. Funding would follow the people in need, not some political entity.

The per capita cap approach, which I presented to the Senate 2 weeks ago, saves $62 billion over the next 7 years. It enhances State flexibility, and it reduces the rate of growth in Federal Medicaid spending to a level that is sustainable for the States, the beneficiaries, and the Federal Government.

The per capita cap assures that States with innovative demonstrations already underway can continue to operate their programs, and that other States wishing to innovate have the resources and ability to do so.

Let me briefly outline how the per capita cap approach would work.

Federal funding would be allocated to States on a per person in need basis. For example, one of those categories of per persons in need are poor children. If the cost of providing services to a poor child in California, for example, has been $1,000, then the Federal Government would continue its Federal-State matching share, which in the case of that State is 50 percent State, 50 percent Federal, and the Federal Government would continue to provide $500 per each poor child qualifying for Medicaid services in the State of California.

If needs increase because the population of poor children goes up, or if they decrease because the population goes down, or if there is a natural disaster or a public health calamity and more children become eligible for coverage, the Federal partnership and the contribution of $500 per child would be guaranteed, unlike a block grant, where a fixed sum of money is allocated regardless of change in circumstances.

The incentive is to reduce costs and not cut people off coverage because if you arbitrarily cut children off, you lose the Federal match.

Costs are what must be controlled. If, for example, California were to spend more than $1,000 per child, then the State of California would be required to make up the difference between the actual cost and what Medicaid would cover—$500 of State and $500 of Federal funds.

Again, under a per capita cap, the money follows the need and the person. As a result, during economic booms, or if health care needs decline, the Federal Government would share in the savings—also unlike a block grant which straitjackets and obligates money regardless of need.

The Federal Government would make payments to each State based on the statutory Federal matching rate or the per capita rate, whichever is lower. The cap would be stated in inflation terms.

Our proposal, Mr. President, is that that inflation term be stated at 1 percentage point below the projected rate of medical inflation in the Nation. Today it is projected that the medical rate of inflation for the next 7 years will average 7.1 percent per year per person. We would, therefore, propose to set the inflation rate under the per capita cap at 6.1 percent, thus producing the $62 billion in savings over the next 7 years.

The cap would be cumulative and thus allow States enough flexibility to apply savings under the cap from one year to the next. Caps would be applied separately to each of the four principle categories of Medicaid beneficiaries: the elderly, the disabled, children and their mothers. This separation into four distinct groups avoids the sinister zero-sum game that is endemic to block grants, where one group's interests are pitted against another.

Mr. President, on first hearing this formula, some may say it sounds very complicated. For those who have had a background in State government, it really is a clone of the way States allocate and distribute school dollars to individual school districts. In fact, with only four categories of beneficiaries to consider, it is far simpler than most per pupil school district formulas.

The per capita cap idea is not a new idea. It is one which should be familiar to many of our Republican colleagues. It is a concept that was supported in health care proposals introduced within the last year by Senators DOLE, Packwood, GRAMM, and CHAFEE.

Mr. President, among those merits, the Medicaid per capita cap approach permits the States to move toward managed care and other types of arrangements which save money without having to secure specific Federal waivers. That, Mr. President, is real flexibility.

Another advantage of the per capita cap approach is that many other detailed rules and process-oriented requirements would be phased out. States would be held accountable to performance outcomes with respect to certain quality access measures. The Federal Government would be interested in the outcomes of State health long-term care delivery systems but would not be mandating how to achieve those outcomes.

Finally, the per capita cap approach would cap and retarget future growth in the Disproportionate Share Hospital Program, referred to as DSH. My colleagues who have read about or possibly heard my remarks yesterday on the flagrant, unflinching abuse of the DSH program by some States will no doubt breathe a sigh of relief.

Mr. President, the per capita cap approach I outlined today would assure 18 million children, 8 million low-income women, 6 million disabled, and 4 million elderly Americans continued coverage for hospital, physician, and nursing home care services. This approach would cut costs, not cut people.

Mr. President, suppose for a moment that in 2 years oil prices fell as they did in the early and late 1970's, another economic recession were to strike a region of our country such as the southwestern States. Suppose the same phenomenon ensued with layoffs, real estate fire sales, and businesses start canceling health insurance coverage.

As we know from the history of the last 15 years, suppose, further, that families ran through their savings, ran out of money to care for their elders. This may sound far-fetched, but it was not that long ago that the former Governor of Texas held a garage sale and sold personal items to generate cash during those hard times.

For purposes of this discussion, we will say that the citizens of the Southwest ran out of money, so their frail elderly turned to Government for long-term care. With no help from the Federal Government in their hour of need, those States would be in a financial straitjacket under block grant.

Mr. President, this is insanity, and unnecessary insanity.

Under per capita caps, those same States would get help. The Federal Government's contribution would increase as the need increased. Most important, the elderly, the disabled, the children, and pregnant mothers would not pay for the economic downturn with their help if not with their lives.

Mr. President, this makes sense. There is a legitimate national interest in such an outcome. The $62 billion reduction in spending amounts to a surgical cut, not the meat-ax approach that the $176 billion block grant legislation that passed the Senate 2 weeks ago represents.

Further, Mr. President, the per capita cap approach would continue the Federal-State partnership in detecting fraud and punishing defrauders. Medicaid fraud, the DSH abuse and the uncontained spending amount to a cancer on our Nation's health and long-term care delivery systems. But it is treatable—not a terminal condition. In our zeal to cure this affliction, let us not kill the patient in the process; let us not kill the very Federal-State partnership that has served this Nation so well for 30 years.

For the past week, Mr. President, I have attempted to spotlight the Medicaid Program, to expose the recklessness of $176 billion in block grant cuts and the raid on the Social Security to reward DSH abusers.

Today, I propose another way, a way that maintains the Federal-State partnership while still containing costs. After all, Mr. President, behind those $176 billion in cuts are human beings who will pay the price for our freelance legislating, for our don't-ask, don't-care indifference, to the casualties of these block grants.

Mr. President, I ask unanimous consent that a column by Mr. David Broder, which appeared in the Washington Post on August 6, 1995, entitled ''Race to the Bottom?'' be printed in the RECORD at the conclusion of my remarks.

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

(See exhibit 2.)

Mr. GRAHAM. Mr. President, we will all be able to read that in addressing the Medicaid and welfare block grant debates, Mr. Broder wrote eloquently of the fear that under block grants the States will engage in a ''race to the bottom that shreds the social safety net.''

He predicted the likeliest scenario under block grants would be as follows: ''What would happen when Federal funding is reduced and Federal standards are eliminated is that 50 legislatures would become the arena, each year, in which the welfare population would have to compete against other claimants for scarce dollars.''

Mr. President, I share this view of the future in America under block grants. You cannot have a race to the bottom without casualties along the way. Along the way in the block grant race to the bottom will be eye glasses for elderly, unfilled prescriptions that used to be covered under Medicaid. They will not survive the race to the bottom.

Along the way in the race for block grants, the race to the bottom, will be families torn apart by unnecessary nursing home placements and institutionalization. Communities' care for the elderly and other Medicaid waiver services are not likely to survive the race to the bottom.

Along the way in the block grant race to the bottom will be ugly legislative sessions in 50 States, legislatures where the frail elderly will be pitted against children, and the mentally retarded against the AIDS sufferer in a battle royal for block grant money.

Is that what we want for America? Mr. President, there is another way. The race to the bottom has yet to begin and it need not begin. There is still time.

Per capita cap legislation is our way out of the race to the bottom and is our ticket to a 21st century that maintains an American Federal-State stake in the health and welfare of its citizens.

EXHIBIT 1

STATEMENT OF BRUCE VLADECK

Senator GRAHAM. What cannot be waived under this 1115 program for either legal or administrative policy reasons?

Mr. VLADECK. States can test new approaches to publicly supported health care by obtaining waivers of statutory requirements and limitations from the Secretary of the Department of Health and Human Services. Waivers permit States flexibility from the Federal Medicaid statutory and regulatory requirements that cannot be altered through the Medicaid State plan amendment process. State Medicaid demonstrations present valuable opportunities to both States and Federal policy makers to refine and test policies that improve access to, and quality of care for vulnerable Medicaid populations, and to more effectively manage the costs of providing that care.

Although, section 1115 authority is very broad, certain statutory restrictions exist for State demonstrations. In addition, HHS has made a number of policy decisions that affect statutory provisions we will and will not waive for demonstration programs.

STATUTORY PROVISIONS

FMAP Rates. The rate at which the Federal government matches States expenditures cannot be waived.

Services for Pregnant Women and Children. The obligation to cover certain women and children described in section 1902(1) cannot be waived under section 1115 authority.

Drug Rebate Provisions. Section 1902 also requires that a State provide medical assistance for covered outpatient drugs in accordance with section 1927, which also contains the drug rebate program provisions. Section 1927 excludes drugs dispensed by HMOs from the requirements of the drug rebate program. Since the drug rebate provisions are imposed on drug manufacturers, and not on the State, this provision cannot be waived through a waiver of section 1902. Only those drug rebate and best price provisions of section 1927 which apply directly to the State may be waived, not those which apply to drug manufacturers.

*Copayments and Other Cost Sharing*. Section 1916 enables States to impose deductibles, copayments and other cost sharing requirements on Medicaid beneficiaries, but also prohibits States from requiring copayments from categorically-eligible beneficiaries who are enrolled in managed care systems. The Secretary's authority to waive this restriction is limited. These limitations make it impractical to waive section 1916 to enable states to require copayments. Copayments and other cost sharing can be imposed for managed care services, however, in the case of medically needy individually and on individuals who are newly Medicaid-eligible due to the demonstration.

*Spousal Impoverishment Provisions*. Section 1924 prohibits the Secretary from waiving spousal impoverishment provisions for institutionalized individuals.

*Work Transition*. Section 1925 prohibits waiving work transition provisions extending Medicaid eligibility for certain individuals who lose their eligibility for Medicaid through their loss of eligibility for Aid to Families with Dependent Children.

*Qualified Medicare Beneficiaries, Specified Low Income Beneficiaries, and Qualified Working Disabled Individuals*. Section 1905 requires States to provide coverage to these groups of individuals regardless of an 1115 demonstration.

*Competitive Bidding*. Procurement rules in Part 74 of the Code of Federal Regulations require States and other entities to use competitive bidding ''to the extent practical''. Because the statutory basis for these rules exists outside of Title XIX, section 1115 cannot be used to waive this requirement.

POLICY POSITIONS

*Reduced Quality of Care*. Programs or policies which inappropriately reduce access, benefits, or otherwise reduce quality of care for current eligibles cannot be approved.

*Quality Assurance*. States are expected to maintain quality assurance processes (e.g., eligibility quality control, external medical review requirements, etc.).

*Budget Neutrality*. Demonstrations must be budget neutral. That is, Federal expenditures under the demonstration may not exceed the projected level of Federal payments to the State in the absence of a demonstration.

Through negotiations with the National Governors Association, HHS has agreed that States may achieve budget neutrality over the life of the project, rather than on a year by year basis.

*Unnecessary Utilization and Access Safeguards*. Section 1902 requires safeguards against unnecessary utilization of services. The statute also protects access to care by requiring States to make adequate payments to providers. Such safeguards must be maintained.

*Boren Amendment*. States must meet the Boren amendment's access and payment requirements in fee-for-service settings. Because these provisions do not apply to managed care settings, States do not need a waiver of the Boren amendment for managed care programs.

*Contract Provisions*. Most existing contract requirements for comprehensive managed care plans in section 1903(m) will continue to apply to managed care demonstrations. HCFA will consider waiving the enrollment composition requirement (the ''75/25 rule'') and disenrollment on demand if the State plans to substitute a data-oriented, quality improvement system for these statutory provisions.

*Duration*. The terms ''experiment,'' ''pilot'', and ''demonstration'' all suggest that programs authorized under section 1115 should, some point, conclude. Thus, States and health care providers potentially affected by section 1115 demonstration projects should be aware that section 1115 demonstrations are time-limited.

EXHIBIT 2

RACE TO THE BOTTOM

(By David S. Broder)

The Republicans in Congress are proposing a revolution in domestic policy and in the relationship between the federal government and the states. Last week, at their meeting in Burlington, Vt., the nation's governors tried but failed to agree whether the proposed changes would be a blessing or a disaster. The 30 Republicans, 19 Democrats and one independent could agree only to disagree.

Now the proposition is before Congress. This month the Senate is debating several alternatives to the House-passed welfare reform. After Labor Day, the House will launch a similar debate on Medicaid.

On the face of it, the fight is about money. The welfare bill was blocked for weeks in the Senate by a dispute between states like Wisconsin and Massachusetts, which have high benefits and little growth in their welfare populations, and those like Texas, which have low benefits but are experiencing rapid growth. Senate Majority Leader Bob Dole found a solution by coming up with enough money to guarantee current allocations to the first group of states while providing a bonus for the second.

That will be much harder when it comes to Medicaid, the program that provides long-term care for the indigent elderly and disabled and basic medical services for other welfare families. It is by far the biggest single federal-state program today, and the Republican budget calls for $181 billion in savings from it in the next seven years. Finding a way to distribute the pain will be difficult.

But money is just one of the dimensions of this struggle. Equally important is the question of minimum standards—and where they will be set. Until now the floors have been established in Washington for Medicaid and for the main welfare program, Aid to Families with Dependent Children (AFDC). The states have been the junior partners, both in designing and paying for these basic ''safety net'' programs.

What the Republicans want to do is reverse that. By capping the amount of money the

federal government would appropriate for these two programs and converting them from individual entitlements to state block grants, they would force the states, over time, to pay for a bigger share. In return, the states would be given much wider leeway, immediately, to redesign the programs to their own taste.

The hope is that this will encourage experimentation that may reduce costs while actually improving outcomes for beneficiaries. The Medicaid population could benefit from moving into managed-care programs, it is argued. Welfare programs could be tailored more easily to local circumstances, helping people move off the dole and into paying work.

The critics' fear is that instead of innovating, the states will engage in a ''race to the bottom'' that shreds the social safety net.

In back-to-back speeches to the governors, Dole argued that the first of those results is likeliest; Clinton said he worried that the second would be the case.

No one can be certain, but logic and experience suggest that the second scenario is more likely. What would happen when federal funding is reduced and federal standards are eliminated is that the 50 legislatures would become the arena, each year, in which the welfare population would have to compete against other claimants for scarce dollars.

The reality is that, as Clinton said, ''the poor children's lobby is a poor match'' for other interests that pressure the legislatures. Teachers, road builders, law enforcement people, county and local governments, universities all have more clout. That was demonstrated this year in states from New York to California, where welfare benefits were trimmed to avert deeper cuts in other parts of the budget.

Dole, who is shepherding the welfare bill in the Senate and who would like to challenge Clinton in next year's presidential race, cozied up to the governors by expressing his indignation at Clinton's ''race to the bottom'' charge. ''I wonder which states he thinks would participate in such a race,'' Dole said. ''Which states does he believe cannot be trusted with welfare, education and protection of their people?''

But it is not a question of trust. The political realities of the legislatures are much as Clinton described them. To ignore that reality is to court trouble—not just for the aged and the poor but for the federal system.

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

The PRESIDING OFFICER (Mr. COATS). The Clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

## LANDMINES—A DEADLY THREAT TO AMERICANS ABROAD

Mr. LEAHY. Mr. President, last night, I along with a number of our colleagues in both bodies, Republican and Democrat, those who have responsibility for foreign policy decisions, gathered with the President for nearly a couple of hours to talk about the situation in Bosnia, and whether and under what circumstance American troops might be sent there.

And in the future, when the discussions in Dayton, OH, are over, I will speak more about what I think can be and should be America's role in Bosnia, as the leader of NATO. But during the discussion last night, I could not help but think, whoever goes into the former Yugoslavia, assuming there is a peace agreement and the fighting has stopped, and the tanks are rolled back and the troops withdrawn, there is 1 killer that will remain—actually, not 1 killer, there are over 2 million killers that will remain in the former Yugoslavia. Those are, of course, the landmines that have been put there.

These landmines do not sign peace agreements. The landmines do not withdraw. The landmines do not say, ''We have agreed to stop killing.'' In fact, the landmines do not agree that they will kill and maim only combatants. They will destroy the life of whoever steps on them, civilian or combatant.

I have spoken many times about landmines on the floor of the Senate, and also in the halls of the United Nations where I had the privilege of serving as a delegate from the United States.

The immense human misery that is caused by landmines is finally becoming known. Just last week, on the CBS program ''60 Minutes,'' they showed how Cambodia has become a land of amputees from the millions of landmines that have littered the country. Tim Rieser from my office has been there and seen that, as have many others who have worked with me on the landmine problem.

Each one of those landmines waits silently. It is hidden until some unsuspecting child steps on it, loses a leg or their face or eyes or their life from loss of blood. And people who have come back from Cambodia, like so many of the countries that are strewn with landmines, and have told me that after awhile they become almost inured to walking down the street and seeing men, women, and children with a leg missing or an arm missing or their face horribly scarred and blinded, all from landmines.

We think how terrible it is in these countries, where unlike in our own country where we can walk safely almost anywhere, the people there cannot even go out to the fields to raise crops or to feed their animals, get water, or go to school. Whenever they venture outside they know that any minute could be their last.

But ours is a false sense of security, Mr. President, because landmines also maim and kill Americans, whether those are Americans in combat missions, the brave men and women of our Armed Forces who are sent into combat or on peacekeeping missions, or Americans who are on other missions overseas.

I have spoken many times about my friend Ken Rutherford of Boulder, CO. Two years ago, he lost a leg from a landmine in Somalia where he was working for the International Rescue Committee, a noncombatant on a humanitarian mission. He has undergone at least seven operations to save his other foot that was badly damaged.

Those who were in the Senate hearing room when he testified about the explosion when the landmine blew apart the vehicle he was riding in, remember the image of him sitting there in shock holding his foot in his hand trying to put it back onto his leg—an impossibility, of course—those who were there remember, as did people operating the cameras from networks who stood there with tears running down their faces, witnesses and others who had heard similar horrible stories before, were stunned into silence listening to this man.

Last June, two Americans, one from Long Island, the other from Minnesota, both in the military but on their honeymoon—on their honeymoon—were killed from a landmine in the Sinai Desert on their way to a resort on the Red Sea, even though peace had long since come to the area.

Less than 2 weeks ago, another American fell victim to a landmine in Zaire. Marianne Holtz of Seattle, WA, was working for the American Refugee Committee on the Rwanda border doing the highest of missionary and humanitarian work. She was following, really, the precepts of the Bible, of caring for these, the least fortunate of our brothers. She lost both legs, part of her face and today she is on a respirator in a hospital thousands of miles from home fighting for her life from internal injuries, because the vehicle she was riding in was blown apart by a landmine.

That is not an isolated incident. Four people have died and over 20 were injured in two separate incidents in the past 2 months in Rwanda where landmines blew up a Red Cross ambulance and a truck filled with refugees.

Mr. President, if there were a Red Cross ambulance filled with refugees and humanitarian workers, and a soldier were to fire a weapon at them and blow up that truck, we would say, ''What an outrageous thing. Don't they know this is the Red Cross? Don't they know these are noncombatants?'' It would be a war crime. But the landmine does not know that, and the landmine exploded and it is just as horrible.

This is happening, Mr. President, every 22 minutes of every day. Somebody in one of the 60 countries infested with mines loses an arm, leg, or is killed.

I have talked about four Americans who are among the tens of thousands of innocent people who have been killed or horribly mutilated by landmines in recent months. They are in addition to the 18 Americans who died from landmines in the Persian Gulf. In fact, a quarter of all the American soldiers who died in the Persian Gulf war died from landmines.

With 100 million landmines in over 60 countries, more Americans will be among their victims. Millions more landmines are being laid each year, and