

important contribution. I applaud Senator FEINSTEIN and others for making the effort, as they have, to get to this point. But his legislation is very, very narrowly focused.

He said he supports clinical trials. We want to give him the opportunity to vote for it. He says he supports access to specialists. We want to give him the opportunity to vote for it. He wants to protect the information, the records of patients. Let's give him and others a chance to vote for it. That is what our bill does. It goes way beyond simply the right, that a woman surely should have, to be more confident about her ability to get the proper treatment when in a situation as sensitive as a mastectomy. But let's provide them the protection through clinical trials. Let's ensure that they can see necessary specialists. Let's ensure that their records are going to be protected. Let's do it all. Let's not do half a job, let's do the whole job. That is what we are talking about here.

So I object.

The PRESIDING OFFICER. Objection is heard.

Several Senators addressed the Chair.

Mr. D'AMATO. I call for the regular order.

The PRESIDING OFFICER. The Senator from New York has the floor.

#### WOMEN'S HEALTH AND CANCER RIGHTS ACT

Mr. D'AMATO. I yield 10 minutes to the Senator from California, Senator FEINSTEIN.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS addressed the Chair.

The PRESIDING OFFICER. The Senator from Montana.

Mr. D'AMATO. Regular order. I believe under the regular order I control up to an hour.

The PRESIDING OFFICER. The Senator is correct.

Mr. BAUCUS. Mr. President, I make a point of order.

Mr. D'AMATO. Mr. President, I yield to the Senator from California, for up to 10 minutes, for a question.

Mr. FORD. Mr. President, take charge and give direction to these Senators.

The PRESIDING OFFICER. The Senator from New York has been recognized under the regular order. The Senator from New York does not control the floor. If he seeks to yield time, that requires a unanimous consent.

Is there objection to yielding time?

Mr. D'AMATO. Mr. President, my colleague from California has a question. I would like to yield for a question to the Senator from California.

Mrs. FEINSTEIN addressed the Chair.

The PRESIDING OFFICER. The Senator from New York has a right to yield for a question. The Senator from California.

Mrs. FEINSTEIN. Mr. President, I would like to ask the Senator from New York a question.

As I recall, we introduced this amendment as a bill on January 30, 1997. That was 16 months ago. The Patients' Bill of Rights, I believe, was introduced on March 31st of this year. Is that not correct?

Mr. D'AMATO. Would the Senator—

Mrs. FEINSTEIN. My question about when we introduced this bill, a bill that would give a woman and her physician the right to determine the length of a hospital stay when she has a mastectomy, and quite possibly a radical mastectomy. The length of stay in the hospital would be the decision of her physician, not the HMO; we introduced this bill 16 months ago. Correct? The Patients' Bill of Rights was introduced in March of this year. Is that not correct?

Mr. D'AMATO. That is correct. The Senator is correct. We introduced this on January 30, 1997.

Mrs. FEINSTEIN. And, am I correct in that the Senate Finance Committee held a hearing on our bill on November 5, 1997?

Mr. D'AMATO. That is also correct. And the Senator testified—the Senator from California came and gave some very cohesive and forceful testimony as to the need for this legislation.

Mrs. FEINSTEIN. Is it not true that we have filed this bill to be considered by the Senate two times and you offered it in the Finance Committee two times? On March 16, we filed it as an amendment to H.R. 2646, the Parent and Students Savings Account Plus Act. Is that not correct?

Mr. D'AMATO. Absolutely. The Senator is absolutely correct.

Mrs. FEINSTEIN. On May 6, we filed it as an amendment to H.R. 2676, the IRS restructuring bill. Is that not correct?

Mr. D'AMATO. That is absolutely correct.

Mrs. FEINSTEIN. And on March 31 and on February 10 of this year, did my colleague not offer it as an amendment in the Finance Committee?

Mr. D'AMATO. I did. I did. My colleague is right. We brought it to a vote.

Mrs. FEINSTEIN. Is it not true that the Senator has been unable to get the Finance Committee to move this bill to the floor?

Mr. D'AMATO. Absolutely true. Again, procedurally this is raised, just as an analogy, as is being done here—there they raised germaneness, and, unfortunately, they kept the women of America from having the opportunity to have this bill considered at that time. That is correct.

Mrs. FEINSTEIN. Is it not true that the D'Amato-Feinstein mastectomy bill has 21 cosponsors, including a bipartisan group of women Senators—Senators SNOWE, MOSELEY-BRAUN, HUTCHISON, MIKULSKI, and BOXER?

Mr. D'AMATO. Absolutely. It is a bipartisan effort. It has been that way. I applaud my colleague from California for her leadership in this matter. We have done this and conducted this in a

manner that has sought to eliminate politics and think about the women of America and the families of America, because we are talking about a disease and procedures that are hurting, harming the families of America.

Mrs. FEINSTEIN. I would like the Senator from New York to know that I am a cosponsor, also, of the Patients' Bill of Rights Act. I understand the importance of this bill. I would very much welcome floor time to consider this bill as well.

However, I did indicate in our Democratic caucus that absent that opportunity, and because women all across this Nation are going through some of the same events that two women who brought this to my attention 3 years ago in California went through, and that is to show up to have a radical mastectomy at 7:30 in the morning, and then to be pushed out on the street at 4:30 that afternoon with drains in them, the effects of anesthetics still upon them, really unable even to walk—is it not true that what we strive to do is make a simple reform and say that no woman without the permission of her physician will be subject to this kind of treatment ever again in the United States of America?

Mr. D'AMATO. The Senator from California is absolutely correct.

Let me say that we worked long and hard on this. We have many of our colleagues who, because of their commitment to deal with this—it is tragic when it hits a family it has so much of an impact—said you have to have at least 48 hours. In other words, 72 hours. And we finally have been working with the people in the medical community, and I must say we built a consensus where we recognize that we should not put any time limitation whatsoever.

If I might, Mr. President, we have the Senator from Montana who is waiting to make a statement. Might I propound a unanimous consent request that he be permitted to speak for up to 3 or 4 minutes as if in morning business, and that might we also have an additional 5 minutes then—we started late—so that he could make his statement, and then without my losing the right to continue and to hold the floor and continue our discussion with respect to this?

Mr. KENNEDY. Reserving right to object, I don't want to object. I would like to have a very brief time to be able to respond. I think, as I understand it, at 11 o'clock under the consent agreement we are going to the agricultural matter.

Mr. D'AMATO. That is why I asked for an additional 5 minutes.

Mr. KENNEDY. I would like to see if we could have, say, 15 minutes to be able to respond to that time.

Mr. D'AMATO. Unfortunately, I am not in a position to agree to that. Let me say this to Senator KENNEDY. Let's say that in one-half hour we would yield to the Senator from New York 10 minutes. Is that fine?

Mr. KENNEDY. That would be very generous.

Mr. D'AMATO. Could Senator BAUCUS' remarks be contained in morning business without interrupting the debate for up to 5 minutes?

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I thank all Senators very much for accommodating me.

First of all, I hope that the bill to be offered by the Senator from California and the Senator from New York will be brought up quickly and passed. I think every Member of the Senate does. I very much favor it. At the same time, I very strongly believe the Patients' Bill of Rights, the basic protection bill, we have to pass that. It is very regrettable, frankly, that we are at loggerheads. We need to get that bill passed. I think we should work that out fairly soon. Frankly, it is in the interest of the American people we get this passed very quickly. But it is not going to be resolved right now.

By unanimous consent, the remarks of Mr. BAUCUS pertaining to "Montana Pole Vaulters" are printed in today's RECORD under "Morning Business."

Mr. D'AMATO. Mr. President, might I ask unanimous consent that Senator JOHNSON from South Dakota be given 3 minutes to speak on this issue?

Mr. DORGAN. Mr. President, reserving the right to object, my understanding is that the order by unanimous consent at 10 o'clock required that Senator D'AMATO be recognized to propound a unanimous consent request; not that Senator D'AMATO be recognized between 10 and 11 o'clock. I am wondering. Am I correct on that?

Mr. D'AMATO addressed the Chair.

The PRESIDING OFFICER. The order provides for the recognition of Senator D'AMATO of New York.

Mr. D'AMATO. I believe I was going to be recognized, and indeed I am attempting to accommodate this. I could speak for this 1 hour. I am attempting to accommodate the needs of my colleagues. That is why I yielded 10 minutes. I am prepared to yield 10 minutes to Senator KENNEDY. The time is clicking off here.

Mr. DORGAN. I will not object. But my understanding of the UC was that the Senator from New York would be recognized to propound a unanimous consent request at which point the floor would be open. I guess I understand the Senator from New York intends to retain the floor until 11 and simply by consent allow others to speak for a certain amount of time.

Mr. D'AMATO. Yes.

Mr. DORGAN. He certainly has that right. Under the unanimous consent agreement he has the right of recognition. So I will not object.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. JOHNSON. Mr. President, I thank the Senator from New York and the Senator from California for their extraordinary work on this important legislation.

Mr. President, frankly, I have to share a great level of frustration, and to be candid, anger at where we find ourselves this morning: unable to move forward with the breast cancer legislation for which there is broad bipartisan support and little controversy. I have more than simply a public policy concern about this issue. I have a personal concern in my own family, having gone through my wife's breast cancer challenge over the past 2 years. She is doing very well. But we had a situation where she remained in the hospital for one night following surgery. She went home with the drains, and the other complications. We were able to do that all right because we don't have small children at home. We had no complications. But I know of other women in my State of South Dakota who have small children at home who cannot take a great amount of time from work, who have no extra help, who have extra complications, and who have all sorts of matters that are debilitating that cause complications. And 24 hours for many of them is simply not adequate. We have an opportunity here to correct that problem. This doesn't correct everything.

I share the support of the Senator from California for the Patients' Bill of Rights. I am frustrated, as well, that we haven't made greater progress there. I hope that before this session is over we will in fact deal with the more comprehensive health care reform legislation.

I applaud Senator DASCHLE's leadership on the Patients' Bill of Rights legislation. But I do not want to make the perfect the enemy of the good. What we have here is a piece of legislation which we should be able to pass this very day.

It is certainly my hope, while we have the continued discussion about a more comprehensive approach to managed care and ensuring the rights of all patients, that before this session of the 105th Congress expires—and we are running out of time quickly—that, in fact, we get this breast cancer bill to the floor and deal with it in an expeditious fashion.

Again, I simply want to applaud the leadership of the Senators from California and New York on this issue, one that we really should not allow to be delayed longer than it already has.

I yield my time.

Mr. D'AMATO addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

Mr. D'AMATO. Mr. President, I ask unanimous consent that the time be extended until 11:05, because we did not start nearly on time, and I further ask unanimous consent that Senator KENNEDY be recognized now for up to 10 minutes.

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

Mr. KENNEDY. Mr. President, I yield myself 7 minutes.

Mr. President, let me be clear: I am all in favor of Senator D'AMATO's bill.

Its provisions are included in the Patients' Bill of Rights. I was an original cosponsor of Senator DASCHLE's legislation, which preceded the legislation authored by my colleague from New York, that guaranteed breast cancer patients a minimum length of stay in the hospital following a mastectomy. And I worked with the breast cancer community—patients and providers—to write and introduce a bill that would require plans that cover mastectomies to also cover reconstructive surgery, prostheses and treatment for lymphedema, a complication of the surgery. In fact, Senator D'AMATO modified his original bill, which covered only reconstructive surgery, to conform it more closely to mine. We share a commitment to this legislation.

But his proposal does not include other provisions that are in our bill and which are equally important to breast cancer patients, their families and their doctors. The following protections, all of which are in the Patients' Bill of Rights remain unaddressed in the legislation proposed by Senator D'AMATO:

It does not guarantee access to specialists—provisions that would allow an oncologist to act as a cancer patient's care coordinator, or would allow a patient to see an oncologist directly, without first making an unnecessary visit to a so-called "gatekeeper."

It does not ensure for a smooth transition between new and existing doctors for breast cancer patients and survivors whose employers change plans or whose plans change providers in the network.

It does not include access to and coverage of participation in clinical trials, which can so often mean the difference between life and death for patients with nowhere else to turn.

It does not establish the right to an independent and timely appeal—a critical feature for those times when coverage decisions fall into a grey area.

It does not create access to prescription drugs that are not on the formulary, if they are medically indicated in the case at hand.

It does not guarantee that emergency care will be covered, provided a layperson believed they were in an emergency.

With the limited exception for post-mastectomy length-of-stay determinations, it does not fully restore the doctor-patient relationship by returning treatment decisions to the attending physician.

Finally, it does not allow patients to hold health plans accountable for their medical decision-making.

Clearly, the problems are not with what is in the bill, but with what is not in the bill.

We are effectively precluded from including these particular provisions in the D'Amato proposal. And that is why these matters are linked, Mr. President. The items contained in our Patient Protection Act are critically important to breast cancer patients and

survivors. Our bill has the broad support from virtually all the various cancer groups and breast cancer groups. But, if we move forward on only those included in the D'Amato proposal, we effectively preclude movement on the rest of the provisions.

One can say, "Well, we are still making some progress." I understand, but there is no reason in the world—none, no reason—that we cannot include these particular provisions for women today—none, make no mistake about it.

We have had eight hearings on the issues relating to the Patients' Bill of Rights. I introduced the original legislation on this issue more than a year ago—over a year ago. The President's advisory commission, which included among its members representation from the business community and insurance industry, reported unanimously last November about what ought to be included in a patients' bill of rights. We have incorporated their recommendations in our bill. They are needed today by women across this country.

All we are asking is for the opportunity to have the Senate debate and go on record with regard to these kinds of protections. But we are foreclosed from acting today. We are denied doing it. We cannot even get a reasonable period of time. The Republican leadership is sitting somewhere in this building. They could have listened to the exchange that was done by the Democratic leader and the Senator from New York. They know what is going on on the floor of the U.S. Senate. They can just come out here and say, "All right, you got it, you are going to have an opportunity to debate this issue; we won't have a time limitation, call the roll and let's have a debate on what is the No. 1 issue before American families." But, no, we are precluded from that.

You don't have to be around here a great deal of time to understand what is going on. We are effectively excluded because of the power of the insurance industry. Do you hear that? We are excluded from having an opportunity to debate this because of the power of the insurance industry. That is what is going on here. That is the issue this morning on the floor of the U.S. Senate.

The industry does not want to provide patients with the protections to which they are entitled and have paid for, and their allies in the Senate are holding this up, Mr. President, by using parliamentary techniques to deny us the chance to consider this legislation. We cannot get a report out of our Labor and Human Resources Committee. We cannot take it up on the floor of the U.S. Senate. It is time for action, and we are denied an opportunity, not just today, not just tomorrow, not just June, but anytime whatsoever—whatsoever.

We are asking the Republican leadership to give us a time. Call the Demo-

cratic leader. Bring it up in 2 days. Bring it up in 2 weeks. Bring it up in a month. But give us a time to bring this up. That is what this issue is all about, and that is where we are going, Mr. President. We will bring this issue up time in and time out, again and again. We may be foreclosed now, but the American people are going to demand it. Those women who have or have had breast cancer are going to understand it and demand it as well.

I yield the remaining time to the Senator from California.

I thank the Senator from New York for granting the time.

Mrs. BOXER. Mr. President, how much time remains?

The PRESIDING OFFICER. Four minutes 15 seconds.

Mrs. BOXER. Mr. President, I say to my colleague, I will reserve 2 minutes for him.

Sometimes we set up false fights, and it is a real false fight between those who want to ban drive-through mastectomies, which I would guess is every single Senator in this Chamber, and those who want to go even further and grant patients protections across the board for breast cancer patients, prostate cancer patients, children, the elderly, anyone who gets sick. There is no fight. Why are we having a fight? We are having a fight because, as the Senator from Massachusetts has said, we are unable to make this a broader bill.

I am very proud to be a sponsor of the D'Amato-Feinstein bill, and I am going to be very excited when this bill becomes law, and it will become law.

We need to do more, and there is no reason why the leadership of the Senate won't give us that opportunity, except that there are many special interests who don't want us to do more, who are pocketing—into deep pockets—profits on a HMO system that short-changes patients, and that is wrong.

I was visited by a man named Harry Christie. I have told his story on the Senate floor before. His daughter was diagnosed with a rare tumor in her kidney. She was 9 years old. There were two doctors who had experience operating on that type of tumor. His HMO said, "That's too bad, you have to go with a general surgeon."

He said, "This is my only child."

And they said, "You're out of luck."

Fortunately, Mr. Christie was able to come up with the \$50,000 he needed, and he saved his daughter's life. Six years later, she is alive and, yes, the HMO was fined a hefty sum by the State of California. If Mr. Christie had listened to the HMO, he might not have his daughter today.

All the Senator from Massachusetts and the Democratic leader are saying is we love this mastectomy bill, we want to help you get this bill through, but help us, help us do more. We can stop a woman from having to go through a horrific, outrageous, demeaning, dangerous drive-through mastectomy, and we will with this bill.

But what happens when she is out of hope a couple of years later, and she needs to get into a clinical trial where she can have access to certain drugs because nothing else is working? The mastectomy bill is narrow, it doesn't address that. The broader patient rights bill addresses it.

I want to speak to the issue of the dates when these various bills were put into the hopper, because Senator FEINSTEIN made a good point on that. However, Senator KENNEDY had a bill that was offered before the drive-through mastectomy bill. Others had bills that were offered before as well. We don't need to have this argument which pits one against the other. We should be able to pass this bill banning drive-through mastectomies, and allow it to be amended to take up these broader issues, so that if someone has chest pains and goes to the emergency room, they are not going to be told by their HMO that they can't qualify for a payment because, guess what, they didn't actually die and have a heart attack, they actually lived. But it was a prudent person who made that decision to walk into that emergency room. Why should they be penalized?

I am very hopeful we will pass this drive-through mastectomy bill, but also a broader Patients' Bill of Rights for breast cancer patients, for prostate cancer patients, for Alzheimer's patients, for all the patients, and let's not set up a false argument here. We can do both. Somebody once said you should be able to walk and chew gum at the same time. Well, we should be able to do this very narrow bill and then debate a broader bill and give all of our patients the protection they so richly deserve.

I yield the remaining time to Senator KENNEDY.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. D'AMATO. Mr. President, I ask unanimous consent that my colleague from California, Senator FEINSTEIN, be recognized for 5 minutes.

The PRESIDING OFFICER. The Senator from California.

Mrs. FEINSTEIN. I thank the Senator from New York.

I must say that I think what is happening here is unfortunate. I think what we are seeing overwhelmingly all across the United States is a state of medical care and health insurance in this country that is becoming much more oriented toward business and much less oriented toward medicine. And this is prompting, I think, all across this land a terrible situation for physicians and for patients.

What prompted me to introduce this bill was two California women who wrote to me. I want to read them to you and enter their full statements in the RECORD.

One was from a woman in Newark, CA. And she wrote—and this was almost 2½ years ago—that she had a modified radical mastectomy as an outpatient at the Fremont Kaiser outpatient clinic. She was operated on at

11:30 in the morning and was released at 4:30 that afternoon, with no attempt made to see if she could even walk to the bathroom. She was 60 years old. And the discovery of cancer and the subsequent surgery were extremely draining both emotionally and psychologically.

That is one case. Same day. Let me read you about another case.

My mastectomy and lymph node removal took place at 7:30 a.m., November 13. I was released at 2:30 p.m. that same day. I received notice, the day before surgery, from my doctor that mastectomy was an outpatient procedure at Kaiser and I'd be released the same day. Shocked by this news, I told my surgeon of my previous complications with anesthesia and the fact that I have a cervical spine condition, which adds an additional consideration for any surgery.

Then she goes on and she says:

While in a groggy, postoperative daze, swimming in pain and nausea, I was given some perfunctory instructions on how to empty the two bloody drains attached to my body. I was told to dress myself and go home. My doctor's written chart instructions for a room assignment, if I developed acute nausea or pain, were ignored by the nursing staff.

This is the problem we are trying to stop right here and now. I frankly am sorry that the bill isn't broader. But this is something whose cost is small—\$100 million. We know it can be accommodated. We know we can get the job done.

This bill is simple. It requires every insurance plan in the United States of America to cover the hospital length of stay determined by the physician to be medically necessary. It does not prescribe a fixed number of days. It does not set a minimum. It leaves the length of the hospital stay for the mastectomy up to the treating physician.

Secondly, it requires health insurance plans to cover breast reconstruction following a mastectomy.

Thirdly, it requires insurance plans to cover breast prostheses and complications of mastectomy, including lymphedema.

And, finally, it prohibits insurance plans from financially penalizing or rewarding a physician for providing medically necessary care or for referring a patient for a second opinion.

This is a simple bill. It is a direct bill. It is going to directly benefit the lives of tens of thousands of women. I regret that it isn't more comprehensive. But we know it is doable, we know what it does, and we know women will immediately be better off because of it.

So I am very proud to stand here with my colleague from New York and with others in the Senate. The great bulk of women Senators are supporting this. This is tangible; it is doable. We believe it can become law quickly. And we say, let us seize the moment and let us accomplish at least this for women of America.

So I thank my colleague from New York for his authorship. I was very proud to be an original sponsor on this

bill. We did have a hearing. We have tried to get the job done before, but hopefully it will get done this morning.

As an original cosponsor of S. 249, the Women's Health and Cancer Rights Act, I am pleased to sponsor the amendment on mastectomy hospital length of stay that Senator D'AMATO is urging the Senate to consider. It is time to pass it.

Senator D'AMATO and I introduced this amendment as a bill on January 30, 1997, 16 months ago. The Senate Finance Committee held a hearing on the bill, S. 249, on November 5, 1997. We have filed this as an amendment, to be considered by the Senate, three times:

On March 16, we filed it as an amendment to H.R. 2646, the Parent and Student Savings Account PLUS Act.

On May 6, we filed it as an amendment to H. R. 2676, the IRS restructuring bill.

On March 31 and on February 10 of this year, Senator D'AMATO offered it as an amendment in the Finance Committee.

In sum, we have made numerous efforts to get the Senate to consider this bill.

The D'Amato-Feinstein mastectomy bill has 21 cosponsors, including a bipartisan group of women Senators: Senators SNOWE, MOSELEY-BRAUN, KAY BAILEY HUTCHISON, MIKULSKI and BOXER.

This amendment has four important provisions: For treatment of breast cancer:

1. It requires insurance plans to cover the hospital length of stay determined by the physician to be medically necessary. Importantly, our bill does not prescribe a fixed number of days or set a minimum. It leaves the length of hospital stay up to the treating physician.

2. It requires health insurance plans to cover breast reconstruction following a mastectomy.

3. It requires insurance plans to cover breast prostheses and complications of mastectomy, including lymphedemas. For treatment of all cancers:

4. It prohibits insurance plans from financially penalizing or rewarding a physician for providing medically necessary care or for referring a patient for a second opinion

Let me share with you two firsthand experiences, two California women describing their treatment by insurance companies in having a mastectomy.

Nancy Couchot, age 60, of Newark, California, wrote me that she had a modified radical mastectomy on November 4, 1996, at 11:30 a.m. and was released by 4:30 p.m. She could not walk and the hospital staff did not help her "even walk to the bathroom." She says, "Any woman, under these circumstances, should be able to opt for an overnight stay to receive professional help and strong pain relief."

Victoria Berck, of Los Angeles, wrote that she had a mastectomy and lymph node removal at 7:30 a.m. on November 13, 1996, and was released from the hospital 7 hours later, at 2:30 p.m. Ms. Berck was given instructions on how to empty two drains attached to her body and sent home. She concludes, "No civ-

ilized country in the world has mastectomy as an outpatient procedure."

These are but two examples of what, unfortunately, is symptomatic of a growing trend and a national nightmare—insurance plans interfering with professional medical judgment and arbitrarily reducing care without a medical basis.

Premature discharges for mastectomy, with insurance plans strong-arming physicians to send women home, are one glaring example of the growing torrent of abuses faced by patients and physicians who have to "battle" with their HMOs to get coverage of the care that physicians believe is medically necessary.

Increasingly, insurance companies are reducing inpatient hospital coverage and pressuring physicians to discharge patients who have had mastectomies. This is beyond the pale. It is unconscionable.

The Wall Street Journal on November 6, 1996, reported that "some health maintenance organizations are creating an uproar by ordering that mastectomies be performed on an outpatient basis. At a growing number of HMOs, surgeons must document 'medical necessity' to justify even a one-night hospital admission."

A July 7, 1997 study by the Connecticut Office of Health Care Access found the average hospital length of stay for breast cancer patients undergoing mastectomies decreased from three days in 1991 and 1993 to two days in 1994 and 1995. This study said, "The percentage of mastectomy patients discharged after one-day stays grew about 700 percent from 1991 to 1996."

In the last ten years, the length of overnight hospital stays for mastectomies has declined from 4 to 6 days to 2 to 3 days to, in some cases, "no days." The average cost of one day in a community hospital in 1995 nationwide was \$968.00. In California, in 1997, the average cost for one day was \$1,329.77. When insurance plans refuse to cover a hospital stay, most Californians have difficulty coughing up \$1,300.00. They are forced to go home.

In 1997, over 180,000 women (or one in every 8 American women) were diagnosed with invasive breast cancer and 44,000 women died from breast cancer. Only lung cancer causes more cancer deaths in American women. 2.6 million American women are living with breast cancer today.

In my state, this year, 19,399 women will be diagnosed with breast cancer and 4,585 will die. The San Francisco Bay Area has some of the highest rates of breast cancer in the world. According to the Northern California Cancer Center, San Francisco's 9-county area's rate of breast cancer in 1994 was 50 percent higher than most European countries and 5 times higher than Japan. In September 1997, the Northern California Cancer Center gave us some mixed news: "The good news is we're seeing the rates go down. The bad news is we don't know why," said Angela Witt

Prehn. But officials there say, the bottom line is that incidence rates are still higher than national rates.

After a mastectomy, patients must cope with pain from the surgery, with drainage tubes and with psychological loss—the trauma of an amputation. These patients need medical care from trained professionals, medical care that they cannot provide themselves at home.

A woman fighting for her life and her dignity should not also be saddled with a battle with her health insurance plan. A physician trying to provide medically necessary care

As the National Breast Cancer Coalition wrote me on March 12, 1998: “The NBCC applauds this effort and believes this compromise will put an end to the dangerous health insurance practices that allow cost and not medical evidence to determine when a woman leaves a hospital after breast cancer surgery.”

Insurance plans also refuse to cover breast reconstruction and breast prostheses. Our bill requires coverage.

Joseph Aita, Executive Vice President and Medical Director of LifeGuard, was quoted in the San Jose, California, Mercury News, as saying “Looking normal is not medically necessary.”

Let me contradict Mr. Aita. Looking normal is medically necessary. Breast reconstruction is important to recovery. According to Dr. Ronald Iverson, a Stanford University surgeon, “Breast reconstruction is a reconstructive and not a cosmetic procedure.”

He cites a study which found that 84 percent of plastic surgeons reported up to 10 patients each who were denied insurance coverage for reconstruction of the removed breast. This could mean 40,000 cases per year.

Commendably, my state has enacted a law requiring coverage of breast reconstruction after a mastectomy. We need a national standard, covering all insurance policies. Let's follow California's need.

Finally, our amendment prohibits insurance plans from including financial or other incentives to influence the care a doctor's provides, similar to a law passed by the California legislature last year. Many physicians have complained that insurance plans include financial bonuses or other incentives for cutting patient visits or for not referring patients to specialists. Our bill bans financial incentives linked to how a doctor provides care. Our intent is to restore medical decision-making to health care.

For example, a California physician wrote me, “Financial incentives under managed care plans often remove access to pediatric specialty care.” A June 1995 report in the Journal of the National Cancer Institute cited the suit filed by the husband of a 34-year old California woman who died from colon cancer, claiming that HMO incentives encouraged her physicians not to order additional tests that could have saved her life.

Our amendment today tries to restore professional medical decision-making to medical doctors, those whom we trust to take care of us. It should not take an act of Congress to guarantee good health care, but unfortunately that is where we are today. As the National Breast Cancer Coalition wrote us on March 12, “. . . until guaranteed access to quality health care coverage and service is available for all women and their families, there are some very serious patient concerns that must be met. Without meaningful health care reform, market forces propel the changes in the health care system and women are at risk of being forced to pay the price by having inappropriate limits placed on their access to quality health care.”

This amendment is an important protection for millions of Americans who face the fear, the reality and the costs of cancer every day. When any cancer strikes, it is not just the victim who suffers. It becomes a family matter.

Today I say, enough is enough. It is time for this Senate, for this Congress to send a strong message to insurance companies that we must put care back into health care. Medical decisions must be made by medical professionals, not anonymous insurance clerks.

I ask unanimous consent to have items I referred to previously printed in the RECORD.

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

NEWARK, CA, NOVEMBER 16, 1996.

Senator FEINSTEIN.

Senator BOXER.

I recently called your office to express my anger at having been forced on Nov. 4 to have a modified radical mastectomy as an outpatient at the Fremont Kaiser Outpatient Clinic. I was operated on at 11:30 am and was released by 4:30 with no attempt made to see if I could even walk to the bathroom.

I am 60 years old and the discovery of cancer and the subsequent surgery was extremely draining both emotionally and psychologically. I feel that Kaiser completely disregarded these feelings, along with my fear of coming home so soon with no professional help. We received a call from Kaiser the following morning but visit by a home health nurse.

Any woman, under these circumstances, should be able to opt for an overnight stay to receive professional help and strong pain relief.

I am interested in your view of this issue. Contact me if you want further details.

NANCY COUCHOT.

Sorry I am still wobbly writing.

[From the Los Angeles Times, Nov. 21, 1996]

#### OUTPATIENT MASTECTOMY SURGERY

My thanks to Ellen Goodman for “The Latest HMO Outrage: Drive-Thru Mastectomy” (Commentary, Nov. 18). Last week I became an uninformed victim of this inhumane practice at Kaiser-Permanente, Los Angeles.

I want to acquaint women with my firsthand experience of this degradation and urge my fellow HMO patients to contact their Washington legislators.

My mastectomy and lymph node removal took place at 7:30 a.m., Nov. 13. I was released at 2:30 p.m. that same day. I received

notice, the day before surgery, from my doctor that mastectomy was an outpatient procedure at Kaiser and I'd be released the same day. Shocked by this news, I told my surgeon of my previous complications with anesthesia and the fact that I have a cervical spine condition, which adds an additional consideration for any surgery. The pleasant doctor assured me that I'd be admitted, for the night, if I experienced excessive pain or nausea. This was noted in my chart.

In the recovery room and the holding area, I felt like a wounded soldier in a hospital tent during the Civil War. I was surrounded by moaning patients and placed directly next to a screaming infant. When I finally found a voice, I shouted, “Get me out of here!” A nurse flitted by, shot me a disapproving glance, and commented, “Some folks just don't know when to be grateful.” This was the ultimate humiliation.

While in a groggy, postoperative daze, swimming in pain and nausea, I was given some perfunctory instructions on how to empty the two bloody drains attached to my body. I was told to dress myself and go home. My doctor's written chart instructions for a room assignment, if I developed acute nausea or pain, were ignored by the nursing staff. Obviously, the reassurance had been given to placate me at the time of my discussion with the doctor but everyone knew an overnight stay was against Kaiser hospital rules. Everyone knew, except me. I had no time to mourn the loss of my breast or regain a sense of composure.

This experience was especially shocking because four years previously, I had undergone a hysterectomy and received excellent treatment and a four-night stay at the very same Kaiser facility.

We women can allow ourselves to be discounted or we can demand more from the HMOs. No civilized country in the world has mastectomy as an outpatient procedure.

VICTORIA BERCK.

Mrs. FEINSTEIN. I yield the floor.

Mr. D'AMATO. Mr. President, I ask unanimous consent that the Senator from Maine, Senator SNOWE, be recognized to speak for up to 5 minutes.

The PRESIDING OFFICER. The Senator from Maine is recognized.

Ms. SNOWE. Thank you.

Mr. President, I thank Senator D'AMATO for yielding me such time. I want to applaud him for his leadership on this very important issue for women in America. And I thank my colleague, Senator FEINSTEIN, for her leadership as well and commitment that she has demonstrated on this issue.

Mr. President, I regret that we have reached a point here where we cannot pass one bill because it is being held hostage to another. No one disagrees with the Senator from Massachusetts in terms of the importance of some of the issues that he has raised with respect to a Patients' bill of rights. But this legislation should not be held hostage to that legislation.

We all know that there are many questions with respect to the approach that he has taken—relevant questions, understandable concerns—that should be appropriately discussed and explored in the committee process and then ultimately here on the floor. But this should not hold up this particular bill. And Senator D'AMATO is absolutely correct, we should move forward, because this has strong bipartisan support.

There is not a Senator on the floor who would not support this legislation. So the women of America should not be held hostage because of internal divisions, because of parliamentary maneuvers, because of legislative gridlock.

This legislation has the support of Democrats as well as Republicans. We have 180,000 women every year who are diagnosed with breast cancer. One in eight women in their lifetime will be detected with breast cancer. We have now discovered that, in many instances, mastectomies are being performed on an outpatient basis, and we need to take action to prevent that. Mastectomies are very complicated surgical procedures.

There is no way that that is a decision that should be made by a bureaucrat; but rather, the length of a woman's stay in a hospital, how that procedure will be handled, should be determined by her as well as her doctor. Those are the only two individuals who ought to be making that decision. It should not be a bureaucrat's bottom line.

We have found time and time again women who have had to endure this procedure on an outpatient basis. The physical scars left by mastectomy, which can be complicated and difficult to care for, often require supervision. Women prematurely released may not have the information they need, let alone the care. And dangerous complications have arisen hours after the operation. And all of this is occurring within the context of a traumatic circumstance, and that is having a mastectomy. We want to make sure that this decision is made appropriately within the confines of medical supervision and medical providers.

We have also found that breast reconstructive surgery is considered cosmetic surgery. Well, it is not. Forty-three percent of women who want to undergo breast reconstructive surgery cannot because it is deemed cosmetic. And that is wrong. Breast reconstructive surgery is designed to restore a woman's wholeness. Fortunately, my State has passed legislation to guard against that and to require health insurance companies to consider it as breast reconstructive surgery. But unfortunately for those who are employed by those who are self-insured, they do not receive this kind of coverage.

That is why this legislation that is offered by Senator D'AMATO is so essential. We cannot allow women to have to endure this kind of decision-making under the most arduous circumstances because of the indecision and the difficulties that have arisen here.

This legislation had a hearing back in November of 1997 before the Senate Finance Committee. We are entitled to get this legislation through the legislative process. In fact, the President, during his State of the Union Address in January of 1997, had a physician in the gallery who drew attention to the need to change the guidelines that had

encouraged outpatient mastectomies. Therefore, he called on Congress in January of 1997 to pass this legislation.

The PRESIDING OFFICER. The time of the Senator has expired.

Ms. SNOWE. I thank Senator D'AMATO for his leadership. I urge the Senate to move this legislation forward. We will have another day to raise the issues raised by the Senator from Massachusetts.

Mr. D'AMATO. Mr. President, I ask unanimous consent that the Senator from Alaska be recognized for 2 minutes.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Mr. MURKOWSKI. Let me commend the chairman on his efforts to bring this to the floor. This is the second or third time he has done it. I am certainly pleased to be a cosponsor of the Women's Health and Cancer Rights Act.

In our State of Alaska, we have an effort relative to awareness being put on by the Breast Cancer Detection Center of Alaska, which has provided 25,000 women in 81 villages throughout the State an opportunity for free mammograms. This has been done not with government support but with private support. We have raised about \$830,000 through a series of fishing tournaments each year, which some Senators have been a party to.

Mr. President, I think that the significance of this bill, which means so much to so many, is that it would put an end to the "drive-through" mastectomies, as we know them today. Many of my colleagues have already spoken on this issue. The bill ensures that mastectomy patients would have access to reconstruction surgery. Scores of women have been denied this procedure because insurers have deemed this procedure to be "cosmetic." Far too often, breast cancer victims who believe they have adequate health coverage have become horrified when they learn that reconstruction is not covered.

In my State of Alaska, of the 324 mastectomies and lumpectomies performed in Alaska in 1996, reconstruction only occurred on 11 of the patients. That means that only 3.4 percent of the women who have a breast removed have reconstructive surgery, compared to the national average of 23 percent.

The reason is cost, Mr. President. And if we look at one of the physicians in my State, Dr. Troxel, of Providence Hospital in Anchorage, who states:

Women who are not able to receive reconstructive surgery suffer from depression, a sense of loss, and need more cancer survivor counseling. . . . Additionally, reconstructive surgery can be preventive medicine—women who don't have reconstructive surgery often develop back problems and other difficulties.

Mr. President, one out of nine American women will suffer the tragedy of breast cancer. It is today the leading cause of death for women between the ages of 35 to 54.

Alaskan women are particularly vulnerable to this disease. We have the second highest rate of breast cancer in the nation: 1 in 7 Alaska women will get breast cancer and tragically it is the Number One cause of death among Native Alaskan women.

Mr. President, these tragic Alaska deaths are not inevitable. Health experts agree that the best hope for lowering the death rate is early detection and treatment. It is estimated that breast cancer deaths can be reduced by 30 percent if all women avail themselves of regular clinical breast examination and mammography.

But for many Alaska women, especially native women living in one of our 230 remote villages, regular screening and early detection are often hopeless dreams.

For more than 20 years, my wife Nancy has recognized this problem and tried to do something about it. In 1974, she and a group of Fairbanks' women created the Breast Cancer Detection Center, for the purpose of offering mammographies to women in remote areas of Alaska—regardless of a woman's ability to pay.

Now, the Center uses a small portable mammography unit which can be flown to remote areas of Alaska, offering women in the most rural of areas easy access to mammographies at no cost. Additionally, the Center uses a 43-foot-long, 14-foot-high and 26,000-pound mobile mammography van to travel through rural areas of Alaska. The van makes regular trips, usually by river barge, to remote areas in Interior Alaska such as Tanana.

Julie Roberts, a 42-year-old woman of Tanana, who receives regular mammographies from the mobile mammography van, knows the importance of early screening:

There's a lot of cancer here (in Tanana)—a lot of cancer. That's why it's important to have the mobile van here . . . I know that if I get checked, I can catch it early and can probably save my life. I have three children and I want to see my grandchildren.

I am proud to say that the Fairbanks Center now serves about 2,200 women a year and has provided screenings to more than 25,000 Alaska women in 81 villages throughout the state. To help fund the efforts of the Fairbanks Center, each year Nancy and I sponsor a fishing tournament to raise money for the operation of the van and mobile mammography unit. After just three years, donations from the tournament have totalled \$830,000.

Mr. President, Nancy and I are committed to raising more funds for this important program so that every woman in Alaska can benefit from the advances of modern technology and reduce their risk of facing this killer disease.

The importance of mammography and screening cannot be stressed enough—however, there has long been a tragic result of the disease that Congress has either ignored or failed to recognize—and that is the so-called "drive-through" mastectomy.

Currently victims of breast cancer who receive mastectomies are being forced to get out of their surgery bed and vacate the hospital only hours after their surgery. The reason? Because far too often it is the practice of insurance companies to treat the procedure of a mastectomy as merely an "out-patient service."

Here's the horror that many insurance companies cause:

Nancy Couchot, a 60-year-old woman had a radical mastectomy at 11:30 a.m. She was released from the hospital only hours later at 4:30 p.m.—even though she was not able to walk or use the rest room without assistance.

Victoria Berck, had a mastectomy and lymph node removal at 7:30 a.m. and was released at 2:30 p.m. She was given instructions on how to empty two drains attached to her body and sent home. Ms. Berck concludes, "No civilized country in the world has a mastectomy as an out-patient service."

Mr. President that is why I am proud to co-sponsor of S. 249, the Women's Health and Cancer Rights Act. This bill would put an end to the drive-through mastectomies.

Specifically, the Act will require health insurance companies to allow physicians to determine the length of a mastectomy patient's hospital stay according to medical necessity. In other words, the bill makes it illegal to punish a doctor for following good medical judgment and sound medical treatment.

Another important provision of this bill ensures that mastectomy patients will have access to reconstructive surgery. Scores of women have been denied reconstructive surgery following mastectomies because insurers have deemed the procedure to be "cosmetic" and, therefore, not medically necessary.

Mr. President, far too often breast cancer victims, who believe that they have adequate health care coverage, become horrified when they learn that reconstruction is not covered in their health plan.

In Alaska, the problem is even more tragic. Of the 324 mastectomies and lumpectomies performed in Alaska in 1996, reconstruction only occurred on 11 of the patients. That means that only 3.4% of women who have their breast removed have reconstructive surgery, compared to the national average of 23 percent.

The simple reason for this tragically low figure is simple: women can't afford the procedure.

Breast reconstruction costs average about \$5,000 for just the procedure. If hospital, physician and other costs are included—the cost averages around \$15,000.

Dr. Sarah Troxel, of Providence hospital in Anchorage, states the importance of reconstruction:

Women who are not able to receive reconstructive surgery suffer from depression, a sense of loss, and need more cancer survivor counseling . . . Additionally, reconstructive

surgery can be preventative medicine—women who don't have reconstructive surgery often develop back problems and other difficulties.

Mr. President, insurance companies commonly provide reconstructive surgery for other types of cancers that alter or disfigure the surface of the skin—such as melanomas and all skin cancers.

Here is why federal legislation is needed: Thirty-four states, including Alaska have no state law requiring breast reconstruction after surgery. And in addition, 70 million Americans receive health benefits through federally regulated self-funded ERISA plans which are not covered by state insurance requirements.

These issues are not partisan issues. We may have our differences regarding managing and financing health reform, but I think we all endorse accessible and affordable health care that preserves patient choice and physician discretion. Cancer does not look to see the politics of its victims.

Mr. President, I urge my colleagues to support this important legislation.

Mr. FAIRCLOTH. Mr. President, I rise to support the efforts of my good friend Senator D'AMATO in his efforts to assure that women who need surgery for breast cancer will be able to do so in the hospital if that's what they desire.

I'm disturbed by the recent trend that takes choice away from patients and their doctors in the name of cost savings.

There are some things we just can't sacrifice. Patient's rights to seek care from specialty doctors and have access to cherished healers is a basic right we need to protect.

Breast cancer is a traumatic enough experience for a woman and her family to suffer through. These families need our help in gaining as much support from our medical care system as they can get to bring them through this terrible time in their lives.

This bill is simple. It simply guarantees a woman's right to a proper length of time in the hospital following her surgery. It guarantees the right to have a complete reconstruction of her breast to restore her body and sense of self-esteem.

The bill gives every person diagnosed with cancer the right to a second opinion, and would direct the HMO to pay for this second opinion. Also, the bill directs HMO's to pay for a specialist even if that doctor happens to be outside the plan.

Lastly, and most importantly, this bill prohibits HMO's from paying doctors to reduce or limit their patient care.

This is managed care's dirty little secret. They pay doctors to limit the time spent with their patients and pay doctors not to provide care.

I've heard from many, many, many constituents and doctors who are frustrated with this situation. If a doctor needs to spend time with a patient—

time essential to healing—if a woman needs to be supported as she decides what to do for her breast cancer, I say give them all the time they need!

I rise to support Senator D'AMATO's bill today. We need to support our doctors and our women and their families.

Mr. D'AMATO. Mr. President, I believe my colleague from California has a question.

Mrs. FEINSTEIN. Mr. President, I have a question for the author, the Senator from New York. I believe this bill has strong support and a low cost. Its cause is just and correct, and it would be passed by this body overwhelmingly. When might we expect a vote on this bill?

Mr. D'AMATO. Mr. President, I am glad my colleague raised that question. Let me say this: It is disingenuous to say that the women of America are being denied proper health care here when something so basic and elementary is being tied up by procedures. That is exactly what is taking place. This legislation would stop the kind of abuse we see taking place every day. I have women calling and saying they are being denied reconstructive surgery, being denied the kind of health care that everybody agrees on. We have found a methodology of paying for this, and it is not right to tie it to something so comprehensive and say, "unless we get this one, we are not going to get the other."

The women of America are being denied this. I intend to hold hostage, with my colleagues, important legislation that moves through until we get a vote on this—whether it is on a defense bill, a tobacco bill, appropriations bills. When we come down to the floor and—

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. D'AMATO. I ask unanimous consent for an additional 5 minutes.

The PRESIDING OFFICER (Mr. ROBERTS). Is there objection?

Mr. HARKIN. Reserving the right to object, Mr. President. By unanimous consent, yesterday, we were supposed to come up with the research bill at 11 o'clock. We are up against kind of a time problem here. I would like to have some idea as to how soon that will happen. I see the chairman of the Agriculture Committee is here. We are here to begin our debate. I wonder how much longer can we expect to wait.

Mr. D'AMATO. Mr. President, I will withdraw my request and ask that I be given just 2 minutes, because I have yielded more time to more people. I want to set the stage.

The PRESIDING OFFICER. Is there objection to the Senator's request?

Mr. KENNEDY. For 2 minutes?

The PRESIDING OFFICER. Yes.

Mr. KENNEDY. No.

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

Mr. D'AMATO. Mr. President, let me say that we have been thwarted time and time again, procedurally—by both sides, I might say. But now I find what

took place today absolutely horrendous.

Again, it is disingenuous to suggest that we would have to consider both when one is so clear cut, and the need is so necessary, and women are being denied. That is what is going on here. It is wrong. So when we have a bill that is going to be acted on, I will come to the floor—I hope with a number of my colleagues—to offer this legislation as an amendment and get a vote. Let the people of America see this. The people are going to be so full of pride that we will not allow something that is so obviously necessary that they are going to hold it hostage, because that is what is taking place with this legislation. It has been held hostage, and it is disingenuous to come down here and say you have to take this great big piece of legislation or we can't even let the women of America have freedom from the fear that they will be denied that which they should have—reconstructive surgery and to stay in the hospital until their doctor says now is the time to go home, not a bean counter, someone who limits you to 24 or 48 hours.

I hope my colleagues will join with me in this endeavor, making it a bipartisan fight to see that the women and families of America get justice.

Mrs. FEINSTEIN. Mr. President, I certainly will. I thank the Senator for his leadership and commitment to this issue.

#### AGRICULTURE RESEARCH, EXTENSION, AND EDUCATION REFORM ACT OF 1998—CONFERENCE REPORT

The PRESIDING OFFICER. Under the previous order, the Senate will now proceed to the conference report.

The clerk will report.

The bill clerk read as follows:

The committee on conference on the disagreeing votes of the two Houses on the amendment of the House to the bill (S. 1150), have agreed to recommend and do recommend to their respective Houses this report, signed by all of the conferees.

The Senate proceeded to consider the conference report.

(The conference report is printed in the House proceedings of the RECORD of April 22, 1998.)

The PRESIDING OFFICER. Under the previous order, the Senator from Indiana is recognized to speak for up to 30 minutes.

Mr. LUGAR. Mr. President, I will consume much of my time at this juncture, reserve the balance, and yield to other colleagues.

I am very pleased that the Senate is now prepared to debate the conference report on S. 1150, the Agriculture Research, Extension and Education Reform Act of 1998.

I thank especially Senator TOM HARKIN, the ranking minority member of the committee, and all committee members for their efforts to work together to fashion legislation to garner the support of 74 Senators and a large

host of agricultural, nutrition and religious organizations.

I point out that we had a good conference with our House colleagues. This is complex legislation. This is not the first time the Congress has had a conference report. It is usual, at least in matters of this variety, for the report to attract less attention. But ours is important. And I appreciate this opportunity to highlight that importance this morning.

Our initiatives will help farmers in this country to produce food for the world's people and to do so at a profit while guarding the environment of this country and the world. S. 1150 also resolves a funding crisis for the Federal Crop Insurance Program, preventing the loss of coverage for farmers in every State. The bill extends an important initiative from the 1996 farm bill that provides resources for rural development and research priorities. And, finally, S. 1150 allows food stamp benefits to be provided to limited groups of the disabled, the elderly, political refugees, and children who immigrated to this country legally.

Many of our colleagues have called for dramatic increases in funding for Federal scientific research. This advocacy is altogether appropriate. Unfortunately, agricultural research has received much less attention. Funding has declined in real terms for some years, and Mr. President, has declined in some areas to a point that we are no longer prepared to resist some of the insect and other disease pests that endanger our food supply.

It took visionaries like Nobel Peace Prize winner Dr. Norman Borlaug who came before our committee and eloquently pointed out how agricultural research is the future of mankind. It is the basis upon which mankind will be able to persist by the year 2050. Millions of people are now alive who would have died from malnutrition had it not been for the food productivity gains from people like Dr. Borlaug, and the thousands of other scientists. Whether it is through the "Green Revolution" of the 1960s, or today's biotechnology, researchers have found ways to coax more food from each acre, tapping more fully the potential of plant and animal food sources.

Further gains in output are not only possible but they are essential if the food needs of the 21st century are to be met. An increasing world population with rising incomes will require more and better food, feed and fiber. It is estimated, as a matter of fact, that their demand will be three times the demand for food which we now have in this year.

Not every farm around the globe is well suited for food production. We have an interest in avoiding the further deforestation and the exploitation of rain forests around the world and other sensitive ecosystems that will be farmed only at a terrible environmental price. Production must be trimmed in areas most appropriate for agriculture such as the United States.

An important part of the answer to this global crisis is our bill, S. 1150. It devotes \$600 million over the next 5 years in mandatory funding to the initiative for future agriculture and food systems. These funds will be competitively awarded to scientists who will undertake cutting-edge research in priority areas such as genome studies, biotechnology, precision agriculture, and other critical fields of work. The new funds will augment the \$1.8 billion existing annual budget for research within the Department of Agriculture.

To make certain the existing budget is spent in the most efficient way, S. 1150 also makes a number of reforms to the Nation's research and extension statutes. These reforms will establish benchmarks and set new requirements for coordination of work among universities, placing new emphasis on activities that cut across several disciplines, involve multiple institutions, and integrate research with public dissemination of those results.

S. 1150 will provide \$200 million per year in mandatory spending to continue fully funding the Federal Crop Insurance Program. These funds, which under current law would need to be appropriated from discretionary accounts, are an integral part of the agreement between private insurers and the Agriculture Department that allows affordable crop insurance to be afforded to the Nation's farmers. Current caps on discretionary spending do not take these expenses into account. Therefore, if the conference report is not approved soon, Congress will either search for discretionary accounts in USDA and other agencies that can be sacrificed to provide the crop insurance funding, or, failing that, contemplate the prospect of insurance policies being canceled for thousands of farmers who annually face the uncertainty of how the weather will affect their crops.

S. 1150 offsets about half of these crop insurance costs. For the remaining half, the conferees found reforms and spending cuts within the Crop Insurance Program itself that saved the requisite amount of money. These cuts, such as reducing the level of reimbursement provided for companies' administrative costs, set the stage for further reform and improvement of the crop insurance system in the future.

The conference report also provides for \$100 million in new funding for Funds for Rural America, recognizing the pressing needs of those in rural areas and working to improve the quality of life for those living in rural America.

The conference report restores food stamp benefits to about 250,000 legal immigrants who otherwise would be ineligible for this portion of the Nation's safety net. Generally, the categories of immigrants covered by S. 1150 correspond to those who last year regained access to the Supplemental Security Income—the SSI Program—under separate legislation; namely, the