

NELSON) was added as a cosponsor of S. 1076, a bill to authorize construction of an education center at or near the Vietnam Veterans Memorial.

S. 1119

At the request of Mr. GRAHAM of Florida, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1119, a bill to amend the Internal Revenue Code of 1986 to clarify the eligibility of certain expenses for the low-income housing credit.

S. 1120

At the request of Mr. BAUCUS, the names of the Senator from Connecticut (Mr. DODD), the Senator from California (Mrs. FEINSTEIN) and the Senator from Arkansas (Mrs. LINCOLN) were added as cosponsors of S. 1120, a bill to establish an Office of Trade Adjustment Assistance, and for other purposes.

S. 1126

At the request of Mr. JOHNSON, the names of the Senator from Hawaii (Mr. AKAKA), the Senator from Montana (Mr. BAUCUS), the Senator from New Mexico (Mr. BINGAMAN), the Senator from South Dakota (Mr. DASCHLE), the Senator from Washington (Ms. CANTWELL), the Senator from Washington (Mrs. MURRAY) and the Senator from Michigan (Ms. STABENOW) were added as cosponsors of S. 1126, a bill to establish the Office of Native American Affairs within the Small Business Administration, to create the Native American Small Business Development Program, and for other purposes.

S. 1127

At the request of Ms. STABENOW, the names of the Senator from North Dakota (Mr. DORGAN) and the Senator from Nevada (Mr. REID) were added as cosponsors of S. 1127, a bill to establish administrative law judges involved in the appeals process provided for under the medicare program under title XVIII of the Social Security Act within the Department of Health and Human Services, to ensure the independence of, and preserve the role of, such administrative law judges, and for other purposes.

S. RES. 140

At the request of Mr. CAMPBELL, the name of the Senator from Illinois (Mr. FITZGERALD) was added as a cosponsor of S. Res. 140, a resolution designating the week of August 10, 2003, as "National Health Center Week".

#### STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BINGAMAN (for himself, Mr. COCHRAN, Mrs. LINCOLN, Ms. COLLINS, Mr. DASCHLE, Mr. JEFFORDS, Ms. CANTWELL, Mrs. CLINTON, and Mr. JOHNSON):

S. 1142. A bill to provide disadvantaged children with access to dental services; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, the legislation I am introducing today with Senators COCHRAN, LINCOLN, COLLINS,

DASCHLE, JEFFORDS, CLINTON, CANTWELL, and JOHNSON is entitled the Children's Dental Health Improvement Act of 2003. This legislation is designed to improve the access and delivery of dental health services to our Nation's children through Medicaid, the State Children's Health Insurance Program, (CHIP), the Indian Health Services, IHS, and our Nation's safety net of community health centers.

The oral health problems facing children are highlighted in a landmark report issued by the Surgeon General and the Department of Health and Human Services, HHS, in 2000 entitled "Oral Health in America: A report of the Surgeon General" in which he observed that our Nation is facing what amounts to "a silent epidemic" of dental and oral diseases."

In fact, dental caries, which refers to both decayed teeth or filled cavities, is the most common childhood disease. According to the Surgeon General, "Among 5- to 17-years olds, dental caries is more than 5 times as common as a reported history of asthma and 7 times as common as hay fever." In short, dental care is, as the Surgeon General adds, "the most prevalent unmet health need among American children."

I was pleased to chair a hearing in the Health, Education, Labor and Pensions Committee on June 25, 2002, entitled "The Crisis in Children's Dental Health: A Silent Epidemic" in which the Surgeon General, Dr. David Satcher, testified. Dr. Satcher's testimony was strong and compelling.

In his words, "Over 108 million children and adults lack dental insurance, which is over 2.5 times the number who lack medical insurance." Dr. Satcher also highlight the following information specific to the oral health problems in children:

There are striking disparities in dental disease by income. Poor children suffer twice as much dental cries as their more affluent peers, and their disease is more likely to be untreated. These poor-nonpoor differences continue into adolescence. One out of four children in America is born into poverty, and children living below the poverty line—annual income of \$17,000 for a family of four—have more severe and untreated decay.

Other birth defects such as hereditary ectodermal dysplasias, where all or most teeth are missing or misshapen, cause lifetime problems that can be devastating to children and adults.

Unintentional injuries, many of which include head, mouth, and neck injuries, are common in children.

Intentional injuries commonly affect the craniofacial tissues.

Tobacco-related oral lesions are prevalent in adolescents who currently use smokeless—spit tobacco.

Professional care is necessary for maintaining oral health, yet 25 percent of poor children have not seen a dentist before entering kindergarten.

Medical insurance is a strong predictor of access to dental care. Uninsured children are 2.5 times less likely than insured children to receive dental care. Children from families without dental insurance are three times more likely to have dental needs than children with either public or private insurance. For each child without medical insurance, there are at least 2.6 children without dental insurance.

Medicaid has not been able to fill the gap in providing dental care to poor children. Fewer than one in five Medicaid-covered children received a single dental visit in a recent year-long study period. While recent CMS data indicate progress in this area with 1 million more Medicaid-eligible children now receiving annual dental care than was the case in 1996, there is still a long way to go to ensuring greater access. Although new programs such as the State Children's Health Insurance Program, SCHIP, may increase the number of insured children, many will still be left without effective dental coverage.

The social impact of oral diseases in children is substantial. More than 51 million school hours are lost each year to dental-related illness. Poor children suffer nearly 12 times more restricted-activity days than children from higher income families. Pain and suffering due to untreated diseases can lead to problems in eating, speaking, and attending to learning.

Over 50 percent of 5- to 9-year-old children have at least one cavity or filling, and that proportion increases to 78 percent among 17-year-olds. Nevertheless, these figures represent improvements in the oral health of children compared to a generation ago.

The Senate also heard the testimony of Dr. Burton Edelstein, founding director of the Children's Dental Health Project; Dr. Gregory Chadwick, president of the American Dental Association; Dr. Lynn Douglass Moundon, director of oral health in the Arkansas Department of Health; Ed Martinez, chief executive officer at San Ysidro Health Center in California; and, Dr. Timothy Shriver, president and chief executive officer of Special Olympics, Inc.

Dr. Edelstein underscored the need for more attention to this issue. As he said, "The too-widespread belief that childhood dental disease has been vanquished states in contrast to the thousands upon thousands of toothaches and acute abscesses experienced daily by America's children—many as young as 2 years of age."

In endorsing this legislation, Dr. Chadwick added, ". . . we cannot forget the fact that millions of people in this country—particularly children—aren't getting even basic preventive and restorative dental care. These children are out there suffering."

The Children's Dental Health Improvement Act of 2003 seeks to end that suffering. One important provision in the bill would grant States flexibility

to provide dental coverage to low-income children through the State Children's Health Insurance Program, or SCHIP, just as States currently are able to do through Medicaid.

Unfortunately, SCHIP law prohibits coverage of children for services unless they are completely uninsured. As authors Ruth Almeida, Ian Hill, and Genevieve Kenney of an Urban Institute report entitled "Does SCHIP Spell Better Dental Care for Children? An Early Look at New Initiatives write", "... many low-income children are covered by employer-based or other private health insurance for their medical care, but do not have a comprehensive dental benefit. Because these children are privately insured, they are not eligible for SCHIP and cannot avail themselves of dental coverage under SCHIP. Expanding SCHIP to furnish dental services on a wraparound basis to private covered low-income children without dental coverage could help achieve broader improvements in children's oral health."

For low-income children with medical coverage but no dental insurance through the private sector, their only option would be to completely dump their private coverage for their children in order to access SCHIP coverage.

Instead, the Children's Dental Health Improvement Act of 2003 creates an option for States to provide low-income families with the ability to receive wraparound dental coverage through SCHIP without having to completely drop their private insurance. This reduces the crowd-out of private insurance, which was a priority of the Congress during passage of SCHIP, and it provides low-income children with dental services that other children in the same economic circumstance are already receiving through SCHIP.

In implementing such a change, I want to make it clear that I am in strong support of providing additional funding to SCHIP to ensure that these services are provided without reducing current levels of SCHIP funding. With those additional funds, I strongly believe that SCHIP, just as Medicaid, should provide services to low-income children who are both uninsured and underinsured. Children need a comprehensive set of child health services, including dental services, to ensure their appropriate health and development.

However, coverage for these services is often not enough. Even when children do have dental coverage, the access to care is often sorely lacking. Medicaid is the largest insurer of dental coverage to children. Yet despite the design of the Medicaid Program to ensure access to comprehensive services for children, including dental care, the inspector general of the Department of Health and Human Services reported in 1996 that only 18 percent of children eligible for Medicaid received even a single preventive dental service. The same report shows that no State

provides preventive services to more than 50 percent of eligible children. The factors are complex but the primary one is due to limited dental participation in Medicaid.

According to GAO, in its September 2000 report entitled "Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations." "Of 39 states that provided information about dentists' participation in Medicaid, 23 reported that fewer than half of the states' dentists saw at least one Medicaid patient during 1999." Even worse, a 1998 survey by the National Conference of State Legislatures indicates that fewer than 20 percent of dentists participate in the Medicaid Program nationwide.

The GAO concludes poor participation rates by dentists is due in large part to poor reimbursement rates in Medicaid. As the GAO points out, "Our analysis showed that Medicaid payment rates are often well below dentists' normal fees. Only 13 states had Medicaid rates that exceeded two-thirds of the average regional fees dentists charged. . . ."

Clearly, Medicaid is chronically underfunded with respect to dental care. The Surgeon General's report notes, "On average, state Medicaid agencies contribute only 2.3 percent of their child health expenditures to dental care, whereas nationally, the percentage of all child health expenditures dedicated to dental care is more than 10 times that rate, almost 30 percent."

The good news is that many States, including New Mexico, have taken recent actions to improve the participation of dentists in the Medicaid Program by raising low payment rates and reducing administrative requirements. These efforts were highlighted by the GAO in its September 2000 report. To further encourage such efforts, the "Children's Dental Health Improvement Act of 2003" provides \$50 million annually as financial incentives and planning grants to States to undertake additional improvements in their Medicaid Programs delivery of dental health services to children.

In addition to Medicaid and SCHIP, the Federal Government administers other health care programs providing dental services or providers for low-income children and their families, including services administered by community health centers and the Indian Health Service, or IHS. Unfortunately, both of these programs are underfunded and, as the GAO found, "report difficulty in meeting the dental needs of their target populations."

For example, the GAO found that "HHS and health center officials report that the demand for dental services significantly exceeds the [urban and rural health] centers' capacity to deliver it. In 1998 . . . , a little more than half of the nearly 700 health center grantees funded under this program had active dental programs." This is also true for public health departments across the country.

To assist the health centers and public health departments with this need, the Children's Dental Health Improvement Act of 2003 provides \$40 million to community health centers and public health departments to expand dental health services through the hiring of additional dental health professionals to serve low-income populations.

This is particularly a problem that needs to be addressed in areas with severe dental health professional shortages, such as New Mexico. For example, New Mexico ranked next to last in the Nation with just 32.1 dentists per 100,000 population in 1998, according to HHS. This compares to the national average of 48.4 per 100,000. Moreover, the number of dentists in New Mexico declined by 7 percent between 1991 and 1998 while the State's population grew 12 percent. The result was a 17 percent decline in dentists per capita during the period.

With regard to American Indian and Alaska Native populations, the need is so great and the funding so little that a comprehensive solution is requiring throughout the IHS system. With respect to the unmet need, the GAO notes that "American Indian and Alaska Native children aged 2 to 4 years old have five times the rate of decay that all children have."

Unfortunately, the GAO adds, "... about one-fourth of IHS' dentist positions at 269 IHS and tribal facilities were vacant in April 2000. Vacancies have been chronic at IHS facilities—in the past 5 years, at least 67 facilities have had one or more dentist positions vacant for at least a year. According to IHS officials, the primary reason for these vacancies is that IHS is unable to provide a competitive salary for new dentists. . . ."

The GAO continues, "The IHS' dental personnel shortages translate into a large unmet need for dental services among American Indians and Alaska Natives. IHS reports that only 24 percent of the eligible population had a dental visit in 1998. The personnel shortages have also reduced the scope of services that facilities are able to provide. According to IHS officials, available services have concentrated more on acute and emergency care, while routine and restorative care have dropped as a percentage of workload. Emergency services increased from one-fifth of the workload in 1990 to more than one-third of the workload in 1999."

To help alleviate this workforce shortage, the Children's Dental Health Improvement Act of 2003 provides IHS with the authority to offer multiyear retention bonuses to dental providers offering services through the IHS and tribal programs.

The bill also provides for some technical amendments to ensure that tribal organizations and community health centers are allowed to apply for school-based dental sealant funding from the Centers for Disease Control and Prevention, or CDC.

The legislation also has a new provision that addresses a technical and unintended problem with the implementation of provisions changing the way Medicare graduate medical education, or GME, is funded. As background in the Balanced Budget Act of 1997, or BBA, Congress recognized the unfairness of subjecting dentistry to GME policies based on the oversupply of physician specialists by exempting dental residency positions from caps placed on the number of residents supported by Medicare GME.

However, the two provisions in that law—both enacted primarily to alleviate the impact on hospitals that decrease physician slots—have had the opposite impact on hospitals that increase their dental residency positions. While successful in achieving the purpose of reducing the number of physicians being trained, these provisions have hurt dentistry and access to oral health care in the United States and are contrary to the congressional goal in 1997 to increase the number of postgraduate dental residency slots. As a result, the legislation would exempt dental residency training positions from the 3-year rolling average provision used to calculate the number of residents for Medicare GME payments.

The bipartisan legislation I am introducing today would improve the access and delivery of dental health services to our Nation's children through Medicaid, SCHIP, IHS, and our Nation's safety net of community health centers. These problems are well documented and call out for congressional action as soon as possible.

I would like to thank the American Dental Association, the American Dental Education Association, the American Academy of Pediatric Dentistry, the National Association of Community Health Centers, Inc., the National Association of Children's Hospitals, the American Dental Hygienists' Association, and the Children's Dental Health Project for their outstanding support and/or their technical advice on this legislation. This bill is a result of their outstanding work.

In particular, I want to thank Dr. Burt Edelstein, Libby Mullin, and Ann De Biasi of the Children's Dental Health Project for their vast knowledge and technical assistance on this issue. I want to thank Judy Sherman of the American Dental Association, Myla Moss and Jack Bresch of the American Dental Education Association, Dr. Herber Simmons and Scott Litch of the American Academy of Pediatric Dentistry, Karen Sealander of the American Dental Hygienists' Association, Dr. Jim Richeson and Judy Kloss Bynum of the Academy of General Dentistry, Dr. Stephen Corbin of Special Olympics, Inc., and Dan Hawkins, Chris Koppen, and Roger Schwartz of the National Association of Community Health Centers, Inc., for their valuable insight, technical advice, and continued support for this legislation. I look forward to working with them all to

ensure that we achieve increased access to oral health care for our children.

In addition to those organizations, I would like to thank the following groups for their support of the bill, whether in the past session of Congress or this year. They include: the Academy of General Dentistry, American Academy of Child and Adolescent Psychiatry, American Academy of Oral and Maxillofacial Pathology, American Academy of Periodontology, American Association of Dental Examiners, American Association of Dental Research, American Association of Endodontists, American Association of Public Health Dentistry, American Association of Oral and Maxillofacial Surgeons, American Association of Orthodontists, American Association of Women Dentists, American College of Dentists, American College of Preventive Medicine, American Dental Trade Association, American Public Health Association, American Society of Dentistry for Children, American Student Dental Association, Association of Clinicians for the Underserved, Association of Maternal and Child Health Programs, Association of State and Territorial Dental Directors, Dental Dealers of America, Dental Manufacturers of America, Inc., Family Voices, Hispanic Dental Association, International College of Dentists—USA, March of Dimes, National Association of City and County Health Officers, National Association of Local Boards of Health, National Dental Association, National Health Law Program, New Mexico Department of Health, Partnership for Prevention, Society of American Indian Dentists, Special Care Dentistry, and United Cerebral Palsy Associations.

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

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

S. 1142

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

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) **SHORT TITLE.**—This Act may be cited as the "Children's Dental Health Improvement Act of 2003".

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

Sec. 1. Short title; table of contents.

**TITLE I—IMPROVING DELIVERY OF PEDIATRIC DENTAL SERVICES UNDER MEDICAID AND SCHIP**

Sec. 101. Grants to improve the provision of dental services under medicaid and SCHIP.

Sec. 102. State option to provide wrap-around SCHIP coverage to children who have other health coverage.

**TITLE II—CORRECTING GME PAYMENTS FOR DENTAL RESIDENCY TRAINING PROGRAMS**

Sec. 201. Limitation on the application of the 1-year lag in the indirect medical education ratio (IME) changes and the 3-year rolling average for counting interns and residents for IME and direct graduate medical education (D-GME) payments under the medicare program.

**TITLE III—IMPROVING DELIVERY OF PEDIATRIC DENTAL SERVICES UNDER COMMUNITY HEALTH CENTERS, PUBLIC HEALTH DEPARTMENTS, AND THE INDIAN HEALTH SERVICE**

Sec. 301. Grants to improve the provision of dental health services through community health centers and public health departments.

Sec. 302. Dental officer multiyear retention bonus for the Indian Health Service.

Sec. 303. Demonstration projects to increase access to pediatric dental services in underserved areas.

Sec. 304. Technical correction.

**TITLE IV—IMPROVING ORAL HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS**

Sec. 401. Oral health initiative.

Sec. 402. CDC reports.

Sec. 403. Early childhood caries.

Sec. 404. School-based dental sealant program.

Sec. 405. Basic oral health promotion.

**TITLE I—IMPROVING DELIVERY OF PEDIATRIC DENTAL SERVICES UNDER MEDICAID AND SCHIP**

**SEC. 101. GRANTS TO IMPROVE THE PROVISION OF DENTAL SERVICES UNDER MEDICAID AND SCHIP.**

Title V of the Social Security Act (42 U.S.C. 701 et seq.) is amended by adding at the end the following:

**"SEC. 511. GRANTS TO IMPROVE THE PROVISION OF DENTAL SERVICES UNDER MEDICAID AND SCHIP.**

"(a) **AUTHORITY TO MAKE GRANTS.**—In addition to any other payments made under this title to a State, the Secretary shall award grants to States that satisfy the requirements of subsection (b) to improve the provision of dental services to children who are enrolled in a State plan under title XIX or a State child health plan under title XXI (in this section, collectively referred to as the 'State plans').

"(b) **REQUIREMENTS.**—In order to be eligible for a grant under this section, a State shall provide the Secretary with the following assurances:

"(1) **IMPROVED SERVICE DELIVERY.**—The State shall have a plan to improve the delivery of dental services to children, including children with special health care needs, who are enrolled in the State plans, including providing outreach and administrative case management, improving collection and reporting of claims data, and providing incentives, in addition to raising reimbursement rates, to increase provider participation.

"(2) **ADEQUATE PAYMENT RATES.**—The State has provided for payment under the State plans for dental services for children at levels consistent with the market-based rates and sufficient enough to enlist providers to treat children in need of dental services.

"(3) **ENSURED ACCESS.**—The State shall ensure it will make dental services available to children enrolled in the State plans to the same extent as such services are available to the general population of the State.

"(c) **USE OF FUNDS.**—

“(1) IN GENERAL.—Funds provided under this section may be used to provide administrative resources (such as program development, provider training, data collection and analysis, and research-related tasks) to assist States in providing and assessing services that include preventive and therapeutic dental care regimens.

“(2) LIMITATION.—Funds provided under this section may not be used for payment of direct dental, medical, or other services or to obtain Federal matching funds under any Federal program.

“(d) APPLICATION.—A State shall submit an application to the Secretary for a grant under this section in such form and manner and containing such information as the Secretary may require.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make grants under this section \$50,000,000 for fiscal year 2004 and each fiscal year thereafter.

“(f) APPLICATION OF OTHER PROVISIONS OF TITLE.—

“(1) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

“(2) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under subsection (a) to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

“(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

“(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

“(C) Section 504(d) (relating to a limitation on administrative expenditures).

“(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

“(E) Section 507 (relating to penalties for false statements).

“(F) Section 508 (relating to non-discrimination).

“(G) Section 509 (relating to the administration of the grant program).”

**SEC. 102. STATE OPTION TO PROVIDE WRAP-AROUND SCHIP COVERAGE TO CHILDREN WHO HAVE OTHER HEALTH COVERAGE.**

(a) IN GENERAL.—

(1) SCHIP.—

(A) STATE OPTION TO PROVIDE WRAP-AROUND COVERAGE.—Section 2110(b) of the Social Security Act (42 U.S.C. 1397jj(b)) is amended—

(i) in paragraph (1)(C), by inserting “, subject to paragraph (5),” after “under title XIX or”; and

(ii) by adding at the end the following:

“(5) STATE OPTION TO PROVIDE WRAP-AROUND COVERAGE.—A State may waive the requirement of paragraph (1)(C) that a targeted low-income child may not be covered under a group health plan or under health insurance coverage, if the State satisfies the conditions described in subsection (c)(8). The State may waive such requirement in order to provide—

“(A) dental services;

“(B) cost-sharing protection; or

“(C) all services.

In waiving such requirement, a State may limit the application of the waiver to children whose family income does not exceed a level specified by the State, so long as the level so specified does not exceed the maximum income level otherwise established for other children under the State child health plan.”

(B) CONDITIONS DESCRIBED.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by adding at the end the following:

“(8) CONDITIONS FOR PROVISION OF WRAP-AROUND COVERAGE.—For purposes of section 2110(b)(5), the conditions described in this paragraph are the following:

“(A) INCOME ELIGIBILITY.—The State child health plan (whether implemented under title XIX or this XXI)—

“(i) has the highest income eligibility standard permitted under this title as of January 1, 2002;

“(ii) subject to subparagraph (B), does not limit the acceptance of applications for children; and

“(iii) provides benefits to all children in the State who apply for and meet eligibility standards.

“(B) NO WAITING LIST IMPOSED.—With respect to children whose family income is at or below 200 percent of the poverty line, the State does not impose any numerical limitation, waiting list, or similar limitation on the eligibility of such children for child health assistance under such State plan.

“(C) NO MORE FAVORABLE TREATMENT.—The State child health plan may not provide more favorable coverage of dental services to the children covered under section 2110(b)(5) than to children otherwise covered under this title.”

(C) STATE OPTION TO WAIVE WAITING PERIOD.—Section 2102(b)(1)(B) of the Social Security Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(i) in clause (i), by striking “and” at the end;

(ii) in clause (ii), by striking the period and inserting “; and”; and

(iii) by adding at the end the following:

“(iii) at State option, may not apply a waiting period in the case of a child described in section 2110(b)(5), if the State satisfies the requirements of section 2105(c)(8).”

(2) APPLICATION OF ENHANCED MATCH UNDER MEDICAID.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(A) in subsection (b), in the fourth sentence, by striking “or subsection (u)(3)” and inserting “(u)(3), or (u)(4)”; and

(B) in subsection (u)—

(i) by redesignating paragraph (4) as paragraph (5); and

(ii) by inserting after paragraph (3) the following:

“(4) For purposes of subsection (b), the expenditures described in this paragraph are expenditures for items and services for children described in section 2110(b)(5), but only in the case of a State that satisfies the requirements of section 2105(c)(8).”

(3) APPLICATION OF SECONDARY PAYOR PROVISIONS.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (B) through (D) as subparagraphs (C) through (E), respectively; and

(B) by inserting after subparagraph (A) the following:

“(B) Section 1902(a)(25) (relating to coordination of benefits and secondary payor provisions) with respect to children covered under a waiver described in section 2110(b)(5).”

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on January 1, 2003, and shall apply to child health assistance and medical assistance provided on or after that date.

**TITLE II—CORRECTING GME PAYMENTS FOR DENTAL RESIDENCY TRAINING PROGRAMS**

**SEC. 201. LIMITATION ON THE APPLICATION OF THE 1-YEAR LAG IN THE INDIRECT MEDICAL EDUCATION RATIO (IME) CHANGES AND THE 3-YEAR ROLLING AVERAGE FOR COUNTING INTERNS AND RESIDENTS FOR IME AND DIRECT GRADUATE MEDICAL EDUCATION (D-GME) PAYMENTS UNDER THE MEDICARE PROGRAM.**

(a) IME RATIO AND ROLLING AVERAGE.—Section 1886(d)(5)(B)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(vi)) is amended by adding at the end the following new sentence: “For cost reporting periods beginning during fiscal years beginning on or after October 1, 2003, subclauses (I) and (II) shall be applied only with respect to a hospital’s approved medical residency training program in the fields of allopathic medicine and osteopathic medicine.”

(b) D-GME ROLLING AVERAGE.—Section 1886(h)(4)(G) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(G)) is amended by adding at the end the following new clause:

“(iv) APPLICATION FOR FY 2004 AND SUBSEQUENT YEARS.—For cost reporting periods beginning during fiscal years beginning on or after October 1, 2003, clauses (i) through (iii) shall be applied only with respect to a hospital’s approved medical residency training program in the fields of allopathic medicine and osteopathic medicine.”

**TITLE III—IMPROVING DELIVERY OF PEDIATRIC DENTAL SERVICES UNDER COMMUNITY HEALTH CENTERS, PUBLIC HEALTH DEPARTMENTS, AND THE INDIAN HEALTH SERVICE**

**SEC. 301. GRANTS TO IMPROVE THE PROVISION OF DENTAL HEALTH SERVICES THROUGH COMMUNITY HEALTH CENTERS AND PUBLIC HEALTH DEPARTMENTS.**

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by insert before section 330, the following:

**“SEC. 329. GRANT PROGRAM TO EXPAND THE AVAILABILITY OF SERVICES.**

“(a) IN GENERAL.—The Secretary, acting through the Health Resources and Services Administration, shall establish a program under which the Secretary may award grants to eligible entities and eligible individuals to expand the availability of primary dental care services in dental health professional shortage areas or medically underserved areas.

“(b) ELIGIBILITY.—

“(1) ENTITIES.—To be eligible to receive a grant under this section an entity—

“(A) shall be—

“(i) a health center receiving funds under section 330 or designated as a Federally qualified health center;

“(ii) a county or local public health department, if located in a federally-designated dental health professional shortage area;

“(iii) an Indian tribe or tribal organization (as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b));

“(iv) a dental education program accredited by the Commission on Dental Accreditation;

“(v) a community-based program whose child service population is made up of at least 33 percent of children who are eligible children, including at least 25 percent of such children being children with mental retardation or related developmental disabilities, unless specific documentation of a lack of need for access by this sub-population is established; and

“(B) shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as

the Secretary may require, including information concerning dental provider capacity to serve individuals with developmental disabilities.

"(2) INDIVIDUALS.—To be eligible to receive a grant under this section an individual shall—

"(A) be a dental health professional licensed or certified in accordance with the laws of State in which such individual provides dental services;

"(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

"(C) provide assurances that—

"(i) the individual will practice in a federally-designated dental health professional shortage area; or

"(ii) not less than 25 percent of the patients of such individual are—

"(I) receiving assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

"(II) receiving assistance under a State plan under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.); or

"(III) uninsured.

"(c) USE OF FUNDS.—

"(1) ENTITIES.—An entity shall use amounts received under a grant under this section to provide for the increased availability of primary dental services in the areas described in subsection (a). Such amounts may be used to supplement the salaries offered for individuals accepting employment as dentists in such areas.

"(2) INDIVIDUALS.—A grant to an individual under subsection (a) shall be in the form of a \$1,000 bonus payment for each month in which such individual is in compliance with the eligibility requirements of subsection (b)(2)(C).

"(d) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—Notwithstanding any other amounts appropriated under section 330 for health centers, there is authorized to be appropriated \$40,000,000 for each of fiscal years 2004 through 2008 to hire and retain dental health care providers under this section.

"(2) USE OF FUNDS.—Of the amount appropriated for a fiscal year under paragraph (1), the Secretary shall use—

"(A) not less than 65 percent of such amount to make grants to eligible entities; and

"(B) not more than 35 percent of such amount to make grants to eligible individuals."

#### SEC. 302. DENTAL OFFICER MULTIYEAR RETENTION BONUS FOR THE INDIAN HEALTH SERVICE.

(a) TERMS AND DEFINITIONS.—In this section:

(1) CREDITABLE SERVICE.—The term "creditable service" includes all periods that a dental officer spent in graduate dental educational (GDE) training programs while not on active duty in the Indian Health Service and all periods of active duty in the Indian Health Service as a dental officer.

(2) DENTAL OFFICER.—The term "dental officer" means an officer of the Indian Health Service designated as a dental officer.

(3) DIRECTOR.—The term "Director" means the Director of the Indian Health Service.

(4) RESIDENCY.—The term "residency" means a graduate dental educational (GDE) training program of at least 12 months leading to a specialty, including general practice residency (GPR) or an advanced education general dentistry (AEGD).

(5) SPECIALTY.—The term "specialty" means a dental specialty for which there is an Indian Health Service specialty code number.

(b) REQUIREMENTS FOR BONUS.—

(1) IN GENERAL.—An eligible dental officer of the Indian Health Service who executes a written agreement to remain on active duty for 2, 3, or 4 years after the completion of any other active duty service commitment to the Indian Health Service may, upon acceptance of the written agreement by the Director, be authorized to receive a dental officer multiyear retention bonus under this section. The Director may, based on requirements of the Indian Health Service, decline to offer such a retention bonus to any specialty that is otherwise eligible, or to restrict the length of such a retention bonus contract for a specialty to less than 4 years.

(2) LIMITATIONS.—Each annual dental officer multiyear retention bonus authorized under this section shall not exceed the following:

(A) \$14,000 for a 4-year written agreement.

(B) \$8,000 for a 3-year written agreement.

(C) \$4,000 for a 2-year written agreement.

(c) ELIGIBILITY.—

(1) IN GENERAL.—In order to be eligible to receive a dental officer multiyear retention bonus under this section, a dental officer shall—

(A) be at or below such grade as the Director shall determine;

(B) have completed any active duty service commitment of the Indian Health Service incurred for dental education and training or have 8 years of creditable service;

(C) have completed initial residency training, or be scheduled to complete initial residency training before September 30 of the fiscal year in which the officer enters into a dental officer multiyear retention bonus written service agreement under this section; and

(D) have a dental specialty in pediatric dentistry or oral and maxillofacial surgery.

(2) EXTENSION TO OTHER OFFICERS.—The Director may extend the retention bonus to dental officers other than officers with a dental specialty in pediatric dentistry, as well as to other dental hygienists with a minimum of a baccalaureate degree, based on demonstrated need.

(d) TERMINATION OF ENTITLEMENT TO SPECIAL PAY.—The Director may terminate, with cause, at any time a dental officer's multiyear retention bonus contract under this section. If such a contract is terminated, the unearned portion of the retention bonus contract shall be recouped on a pro rata basis. The Director shall establish regulations that specify the conditions and procedures under which termination may take place. The regulations and conditions for termination shall be included in the written service contract for a dental officer multiyear retention bonus under this section.

(e) REFUNDS.—

(1) IN GENERAL.—Prorated refunds shall be required for sums paid under a retention bonus contract under this section if a dental officer who has received the retention bonus fails to complete the total period of service specified in the contract, as conditions and circumstances warrant.

(2) DEBT TO UNITED STATES.—An obligation to reimburse the United States imposed under paragraph (1) is a debt owed to the United States.

(3) NO DISCHARGE IN BANKRUPTCY.—Notwithstanding any other provision of law, a discharge in bankruptcy under title 11, United States Code, that is entered less than 5 years after the termination of a retention bonus contract under this section does not discharge the dental officer who signed such a contract from a debt arising under the contract or under paragraph (1).

#### SEC. 303. DEMONSTRATION PROJECTS TO INCREASE ACCESS TO PEDIATRIC DENTAL SERVICES IN UNDERSERVED AREAS.

(a) AUTHORITY TO CONDUCT PROJECTS.—The Secretary of Health and Human Services, through the Administrator of the Health Resources and Services Administration and the Director of the Indian Health Service, shall establish demonstration projects that are designed to increase access to dental services for children in underserved areas, as determined by the Secretary.

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

#### SEC. 304. TECHNICAL CORRECTION.

Section 340G(b)(1)(B) of the Public Health Service Act (42 U.S.C. 256g(b)(1)(B)) is amended by striking "and" at the end and inserting "or".

#### TITLE IV—IMPROVING ORAL HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS

##### SEC. 401. ORAL HEALTH INITIATIVE.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish an oral health initiative to reduce the profound disparities in oral health by improving the health status of vulnerable populations, particularly low-income children and children with developmental disabilities, to the level of health status that is enjoyed by the majority of Americans.

(b) ACTIVITIES.—The Secretary of Health and Human Services shall, through the oral health initiative—

(1) carry out activities to improve intra- and inter-agency collaborations, including activities to identify, engage, and encourage existing Federal and State programs to maximize their potential to address oral health;

(2) carry out activities to encourage public-private partnerships to engage private sector communities of interest (including health professionals, educators, State policymakers, foundations, business, and the public) in partnerships that promote oral health and dental care;

(3) carry out activities to reduce the disease burden in high risk populations through the application of best-science in oral health, including programs such as community water fluoridation and dental sealants; and

(4) carry out activities to improve the oral health literacy of the public through school-based education programs.

(c) COORDINATION.—The Secretary of Health and Human Services shall—

(1) through the Administrator of the Centers for Medicare & Medicaid Services, establish the Chief Dental Officer for the Medicaid and State children's health insurance programs established under titles XIX and XXI, respectively, of the Social Security Act (42 U.S.C. 1396 et seq. 1397aa et seq.);

(2) through the Administrator of the Health Resources and Services Administration, establish the Chief Dental Office for all oral health programs within the Health Resources and Services Administration;

(3) through the Director of the Centers for Disease Control and Prevention, establish the Chief Dental Officer for all oral health programs within such Centers; and

(4) carry out this section in collaboration with the Administrators and Chief Dental Officers described in paragraphs (1), (2), and (3).

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$25,000,000 for fiscal year 2004, and such sums as may be necessary for each subsequent fiscal year.

**SEC. 402. CDC REPORTS.**

(a) **COLLECTION OF DATA.**—The Director of the Centers for Disease Control and Prevention, in collaboration with other organizations and agencies, shall collect data through State-based oral health surveillance systems describing the dental, craniofacial, and oral health of residents of all 50 States and certain Indian tribes.

(b) **REPORTS.**—The Director of the Centers for Disease Control and Prevention shall compile and analyze data collection under subsection (a) and annually prepare and submit to the appropriate committees of Congress a report concerning the oral health of States and Indian tribes.

**SEC. 403. EARLY CHILDHOOD CARIES.**

(a) **IN GENERAL.**—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall—

(1) expand existing surveillance activities to include the identification of children at high risk of early childhood caries, including sub-populations such as children with developmental disabilities;

(2) assist State, local, and tribal health agencies and departments in collecting, analyzing and disseminating data on early childhood caries; and

(3) provide for the development of public health nursing programs and public health education programs on early childhood caries prevention.

(b) **APPROPRIATENESS OF ACTIVITIES.**—The Secretary of Health and Human Services shall carry out programs and activities under subsection (a) in a culturally appropriate manner with respect to populations at risk of early childhood caries.

(c) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each fiscal year.

**SEC. 404. SCHOOL-BASED DENTAL SEALANT PROGRAM.**

Section 317M(c) of the Public Health Service Act (as added by section 1602 of Public Law 106-310) is amended—

(1) in paragraph (1), by inserting “and school-linked” after “school-based”;

(2) in the first sentence of paragraph (2)—

(A) by inserting “and school-linked” after “school-based”; and

(B) by inserting “or Indian tribe” after “State”; and

(3) by striking paragraph (3) and inserting the following:

“(3) **ELIGIBILITY.**—To be eligible to receive funds under paragraph (1), an entity shall—

“(A) prepare and submit to the State or Indian tribe an application at such time, in such manner and containing such information as the State or Indian tribe may require; and

“(B) be a—

“(i) public elementary or secondary school—

“(I) that is located in an urban area in which more than 50 percent of the student population is participating in Federal or State free or reduced meal programs; or

“(II) that is located in a rural area and, with respect to the school district in which the school is located, the district involved has a median income that is at or below 235 percent of the poverty line, as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)); or

“(ii) public or non-profit organization, including a grantee under section 330 and urban Indian clinics under title V of the Indian Health Care Improvement Act, that is under contract with an elementary or secondary school described in subparagraph (B) to provide dental services to school-age children.”.

**SEC. 405. BASIC ORAL HEALTH PROMOTION.**

(a) **IN GENERAL.**—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention and in consultation with dental organizations (including organizations having expertise in the prevention and treatment of oral disease in underserved pediatric populations), shall award grants to States and Indian tribes to improve the basic capacity of such States and tribes to improve the oral health of children and their families.

(b) **REQUIREMENTS.**—A State or Indian tribes shall use amounts received under a grant under this section to conduct one or more of the following activities:

(1) Establish an oral health plan, policies, effective prevention programs, and accountability measures and systems.

(2) Establish and guide coalitions, partnerships, and alliances to accomplish the establishment of the plan, policies, programs and systems under paragraph (1).

(3) Monitor changes in oral disease burden, disparities, and the utilization of preventive services by high-risk populations.

(4) Identify, test, establish, support, and evaluate prevention interventions to reduce oral health disparities.

(5) Promote public awareness and education in support of improvements of oral health.

(6) Support training programs for dental and other health professions needed to strengthen oral health prevention programs.

(7) Establish, enhance, or expand oral disease prevention and disparity reduction programs.

(8) Evaluate the progress and effectiveness of the State’s oral disease prevention and disparity reduction program.

(c) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this section, such sums as may be necessary for fiscal year 2004 and each subsequent fiscal year.

By Mrs. HUTCHISON (for herself, Mr. KENNEDY, Mr. CAMPBELL, Mr. BIDEN, Mr. SMITH, Mr. DODD, Mr. CORNYN, Mr. BINGAMAN, Mr. DASCHLE, Mr. BREAU, Mr. JOHNSON, Mr. SCHUMER, Mrs. CLINTON, and Mr. JEFFORDS):

S. 1143. A bill to amend the Public Health Service Act to direct the Secretary of Health and Human Services to establish, promote, and support a comprehensive prevention, research, and medical management referral program for hepatitis C virus infection; to the Committee on Health, Education, Labor, and Pensions.

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

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

S. 1143

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the “Hepatitis C Epidemic Control and Prevention Act”.

**SEC. 2. FINDINGS.**

Congress makes the following findings:

(1) Over 3,000,000 individuals in the United States are chronically infected with the hepatitis C virus (referred to in this section as “HCV”), making it the Nation’s most common blood borne virus infection.

(2) Nearly 2 percent of the population of the United States have been infected with HCV.

(3) Conservative estimates indicate that approximately 35,000 Americans are newly infected with HCV each year.

(4) HCV infection can cause life-threatening liver disease.

(5) Individuals infected with HCV serve as a source of transmission to others and, since few individuals are aware they are infected, are unlikely to take precautions to prevent the spread or exacerbation of their infection.

(6) There is no vaccine available to prevent HCV infection.

(7) Treatments are available to slow the progression of chronic hepatitis C.

(8) An estimated 2,400,000 to 2,700,000 people who are chronically infected with hepatitis C are receiving no treatment.

(9) Conservative estimates place the costs of lost productivity and medical care arising from chronic hepatitis C in the United States at more than \$600,000,000 annually and such costs will undoubtedly increase in the absence of expanded prevention and treatment efforts.

(10) To combat the HCV epidemic in the United States, the Centers for Disease Control and Prevention developed *Recommendations for Prevention and Control of Hepatitis C Virus (HCV) Infection and HCV-Related Chronic Disease* in 1998 and the *National Hepatitis C Prevention Strategy* in 2001, and the National Institutes of Health convened Consensus Development Conferences on the Management of Hepatitis C in 1997 and 2002. These recommendations and guidelines provide a framework for hepatitis C prevention, control, research, and medical management referral programs.

(11) Federal support is necessary to increase knowledge and awareness of hepatitis C and to assist State and local prevention and control efforts.

**SEC. 3. PREVENTION, CONTROL, AND MEDICAL MANAGEMENT OF HEPATITIS C.**

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

**“PART R—PREVENTION, CONTROL, AND MEDICAL MANAGEMENT OF HEPATITIS C  
“SEC. 399AA. FEDERAL PLAN FOR THE PREVENTION, CONTROL, AND MEDICAL MANAGEMENT OF HEPATITIS C.**

“(a) **IN GENERAL.**—The Secretary shall develop and implement a plan for the prevention, control, and medical management of hepatitis C which includes strategies for education and training, surveillance and early detection, and research.

“(b) **INPUT IN DEVELOPMENT OF PLAN.**—In developing the plan under subsection (a), the Secretary shall—

“(1) be guided by existing recommendations of the Centers for Disease Control and Prevention and the National Institutes of Health; and

“(2) consult with—

“(A) the Director of the Centers for Disease Control and Prevention;

“(B) the Director of the National Institutes of Health;

“(C) the Director of the Health Resources and Services Administration;

“(D) the heads of other Federal agencies or offices providing services to individuals with hepatitis C virus (referred to in this part as “HCV”) infections or the functions of which otherwise involve hepatitis C;

“(E) medical advisory bodies that address issues related to HCV; and

“(F) the public, including—

“(i) individuals infected with the HCV; and

“(ii) advocates concerned with issues related to HCV.

“(c) **BIENNIAL UPDATE OF PLAN.**—

“(1) IN GENERAL.—The Secretary shall conduct a biennial assessment of the plan developed under subsection (a) for the purpose of incorporating into such plan new knowledge or observations relating to HCV and chronic HCV (such as knowledge and observations that may be derived from clinical, laboratory, and epidemiological research and disease detection, prevention, and surveillance outcomes) and addressing gaps in the coverage or effectiveness of the plan.

“(2) PUBLICATION OF NOTICE OF ASSESSMENTS.—Not later than October 1 of the first even numbered year beginning after the date of enactment of this part, and October 1 of each even numbered year thereafter, the Secretary shall publish in the Federal Register a notice of the results of the assessments conducted under paragraph (1). Such notice shall include—

“(A) a description of any revisions to the plan developed under subsection (a) as a result of the assessment;

“(B) an explanation of the basis for any such revisions, including the ways in which such revisions can reasonably be expected to further promote the original goals and objectives of the plan; and

“(C) in the case of a determination by the Secretary that the plan does not need revision, an explanation of the basis for such determination.

**“SEC. 399BB. ELEMENTS OF THE FEDERAL PLAN FOR THE PREVENTION, CONTROL, AND MEDICAL MANAGEMENT OF HEPATITIS C.**

“(a) EDUCATION AND TRAINING.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall implement programs to increase awareness and enhance knowledge and understanding of hepatitis C. Such programs shall include—

“(1) the conduct of health education, public awareness campaigns, and community outreach activities to promote public awareness and knowledge about risk factors, the transmission and prevention of infection with HCV, the value of screening for the early detection of HCV infection, and options available for the treatment of chronic hepatitis C;

“(2) the training of health care professionals regarding the prevention, detection, and medical management of hepatitis B and hepatitis C, and the importance of vaccinating HCV-infected individuals and those at risk for HCV infection against the hepatitis A virus and hepatitis B virus (referred to in this part as ‘HBV’); and

“(3) the development and distribution of curricula (including information relating to the special needs of individuals infected with HBV or HCV, such as the importance of early intervention and treatment and the recognition of psychosocial needs) for individuals providing hepatitis counseling, as well as support for the implementation of such curricula by State and local public health agencies.

“(b) EARLY DETECTION AND SURVEILLANCE.—

“(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall support activities described in paragraph (2) to promote the early detection of HCV infection, identify risk factors for infection, and conduct surveillance of HCV infection trends.

“(2) ACTIVITIES.—

“(A) VOLUNTARY TESTING PROGRAMS.—

“(i) IN GENERAL.—The Secretary shall support and promote the development of State, local, and tribal voluntary hepatitis C testing programs to aid in the early identification of infected individuals.

“(ii) CONFIDENTIALITY OF TEST RESULTS.—The results of a hepatitis C test conducted

by a testing program developed or supported under this subparagraph shall be considered protected health information (in a manner consistent with regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note) and may not be used for any of the following:

“(I) Issues relating to health insurance.

“(II) To screen or determine suitability for employment.

“(III) To discharge a person from employment.

“(B) COUNSELING REGARDING VIRAL HEPATITIS.—The Secretary shall support State, local, and tribal programs in a wide variety of settings, including those providing primary and specialty health care services in the private and the public sectors, to—

“(i) provide individuals with information about ongoing risk factors for hepatitis C virus infection with client-centered education and counseling which concentrates on changing behaviors that place them at risk for infection; and

“(ii) provide individuals infected with hepatitis C virus with education and counseling to reduce the risk of harm to themselves and transmission of the virus to others.

“(C) VACCINATION AGAINST VIRAL HEPATITIS.—With respect to individuals infected, or at risk for infection, with HCV, the Secretary shall provide for—

“(i) the vaccination of such individuals against hepatitis A virus, HBV, and other infectious diseases, as appropriate, for which such individuals may be at increased risk; and

“(ii) the counseling of such individuals regarding hepatitis A, hepatitis B, and other viral hepatitis.

“(D) MEDICAL REFERRAL.—The Secretary shall support—

“(i) referral of persons infected with or at risk for HCV, for drug or alcohol abuse treatment where appropriate; and

“(ii) referral of persons infected with HCV—

“(I) for medical evaluation to determine their stage of chronic hepatitis C and suitability for antiviral treatment; and

“(II) for ongoing medical management of hepatitis C.

“(3) HEPATITIS C COORDINATORS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall, upon request, provide a Hepatitis C Coordinator to a State health department in order to enhance the additional management, networking, and technical expertise needed to ensure successful integration of hepatitis C prevention and control activities into existing public health programs.

“(c) SURVEILLANCE AND EPIDEMIOLOGY.—

“(1) IN GENERAL.—The Secretary shall promote and support the establishment and maintenance of State HCV surveillance databases, in order to—

“(A) identify risk factors for HCV infection;

“(B) identify trends in the incidence of acute and chronic HCV;

“(C) identify trends in the prevalence of HCV infection among groups that may be disproportionately affected by hepatitis C, including individuals living with HIV, military veterans, emergency first responders, racial or ethnic minorities, and individuals who engage in high risk behaviors, such as intravenous drug use; and

“(D) assess and improve HCV infection prevention programs.

“(2) SEROPREVALENCE STUDIES.—The Secretary shall conduct a population-based seroprevalence study to estimate the current and future impact of hepatitis C. Such studies shall consider the economic and clinical

impacts of hepatitis C, as well as the impact of hepatitis C on quality of life.

“(3) CONFIDENTIALITY.—Information contained in the databases under paragraph (1) or derived through studies under paragraph (2) shall be de-identified in a manner consistent with regulations under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

“(d) RESEARCH NETWORK.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health, shall—

“(1) conduct epidemiologic research to identify best practices for HCV prevention;

“(2) establish and support a Hepatitis C Clinical Research Network for the purpose of conducting research related to the treatment and medical management of hepatitis C; and

“(3) conduct basic research to identify new approaches to prevention (such as vaccines) and treatment for HCV.

“(e) REFERRAL FOR MEDICAL MANAGEMENT OF CHRONIC HEPATITIS C.—The Secretary shall support and promote State, local, and tribal programs to provide HCV-positive individuals with referral for medical evaluation and management, including currently recommended antiviral therapy when appropriate.

“(f) UNDERSERVED AND DISPROPORTIONATELY AFFECTED POPULATIONS.—In carrying out this section, the Secretary shall provide expanded support for individuals with limited access to health education, testing, and health care services and groups that may be disproportionately affected by hepatitis C.

“(g) EVALUATION OF PROGRAM.—The Secretary shall develop benchmarks for evaluating the effectiveness of the programs and activities conducted under this section and make determinations as to whether such benchmarks have been achieved.

**“SEC. 399CC. GRANTS.**

“(a) IN GENERAL.—The Secretary may award grants to, or enter into contracts or cooperative agreements with, States, political subdivisions of States, Indian tribes, or non-profit entities that have special expertise relating to HCV, to carry out activities under this part.

“(b) APPLICATION.—To be eligible for a grant, contract, or cooperative agreement under subsection (a), an entity shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

**“SEC. 399DD. AUTHORIZATION OF APPROPRIATIONS.**

“There are authorized to be appropriated to carry out this part \$90,000,000 for fiscal year 2004, and such sums as may be necessary for each of fiscal years 2005 through 2008.”

**SEC. 4. LIVER DISEASE RESEARCH ADVISORY BOARD.**

Part A of title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended by adding at the end the following:

**“SEC. 409J. LIVER DISEASE RESEARCH ADVISORY BOARD.**

“(a) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this section, the Director of the National Institutes of Health shall establish a board to be known as the Liver Disease Research Advisory Board (referred to in this section as the ‘Advisory Board’).

“(b) DUTIES.—The Advisory Board shall advise and assist the Director of the Centers for Disease Control and Prevention concerning matters relating to liver disease research, including by developing and revising the Liver Disease Research Action Plan.

“(c) VOTING MEMBERS.—The Advisory Board shall be composed of 18 voting members to be appointed by the Director of the

National Institutes of Health, in consultation with the Director of the Institute of Allergy and Infectious Diseases, of whom 12 such individuals shall be eminent scientists and 6 such individuals shall be lay persons. The Director of the National Institutes of Health, in consultation with the Director of the Institute, shall select 1 of the members to serve as the Chair of the Advisory Board.

“(d) EX OFFICIO MEMBERS.—The Director of the National Institutes of Health shall appoint each director of a national research institute that funds liver disease research to serve as a nonvoting, ex officio member of the Advisory Board. The Director of the National Institutes of Health shall invite 1 representative of the Centers for Disease Control and Prevention, 1 representative of the Food and Drug Administration, and 1 representative of the Department of Veterans Affairs to serve as such a member. Each ex officio member of the Advisory Board may appoint an individual to serve as that member's representative on the Advisory Board.

“(e) LIVER DISEASE RESEARCH ACTION PLAN.—

“(1) DEVELOPMENT.—Not later than 15 months after the date of the enactment of this section, the Advisory Board shall develop (with appropriate support from the Director and staff of the Center) a comprehensive plan for the conduct and support of liver disease research to be known as the Liver Disease Research Action Plan. The Advisory Board shall submit the Plan to the Director of NIH and the head of each institute or center within the National Institutes of Health that funds liver disease research.

“(2) CONTENT.—The Liver Disease Research Action Plan shall identify scientific opportunities and priorities of liver disease research necessary to increase understanding of and to prevent, cure, and develop better treatment protocols for liver diseases.

“(3) REVISION.—The Advisory Board shall revise every 3 years the Liver Disease Research Action Plan, but shall meet annually to review progress and to amend the Plan as may be appropriate because of new scientific discoveries.”

Mr. KENNEDY. Mr. President, It's a privilege to join my colleague, Senator KAY BAILEY HUTCHISON, in introducing this legislation to address the growing problem of Hepatitis C. Senator HUTCHISON's leadership has been essential in preparing this proposal to help establish nationwide programs for Hepatitis C that have been so effective in Texas. We are also indebted to the leadership of Senator SMITH, Senator CAMPBELL, Senator DASCHLE, and many other colleagues on both sides of the aisle for taking action to reduce the serious toll of Hepatitis C on so many of our fellow citizens.

Hepatitis C is a rapidly growing health care crisis. More than 3.9 million Americans are infected with the virus, making it the nation's most common blood-borne viral illness, and the numbers continue to rise. 10,000 Americans die each year of chronic complications related to the virus. Hepatitis C virus infection is a major cause of death in AIDS patients, and nearly 40 percent of all HIV-positive people are also infected with Hepatitis C virus.

Hepatitis C leads to life-threatening conditions, including cirrhosis and liver cancer, which cost our country more than \$600 million every year. This bill supports liver disease research to

encourage the development of an effective vaccine against the virus.

Unlike Hepatitis A and B, there is currently no vaccine available to prevent this epidemic. It is critical that infected individuals are identified early, so that they can obtain treatment and take other steps to reduce the likelihood that the disease will lead to permanent liver damage or spread of the virus to others.

The bill we are introducing today takes a new approach to fighting this virus by establishing a nationwide plan to provide the most effective ways of prevention, control and medical management of Hepatitis C. The bill also seeks to increase knowledge and awareness of the infection by patients, health care professionals, and the public.

This strategy was successfully implemented in Texas. Public health counseling and testing sites were established to reach people at high risk for Hepatitis C, and to make referrals to health and social services. In the first year, more than 13,000 clients received counseling services, one-third of whom tested positive for Hepatitis C. In addition, media campaigns were conducted to alert the public to the dangers of Hepatitis C. The savings for Texas were estimated to be almost \$500,000 a year.

Using this model, the Department of Health and Human Service will develop a plan to combat the Hepatitis C epidemic, with advice from the public including physicians, researchers, patients, and advocates. Confidential counseling and voluntary testing programs will be offered, as well as immunization against Hepatitis A and B. Individuals at high risk will be referred for further evaluation and management, including treatment with antiviral therapy.

Our bill calls for Hepatitis C coordinators, to be assigned by CDC, at state, local, and tribal levels to carry out education and supervision of local health care workers. The Liver Disease Research Advisory Board will be established to assist and advise CDC on liver disease research. A confidential database will be created to enhance studies the epidemiology of the illness.

The fight against Hepatitis C must begin with the underserved populations who are disproportionately affected by the virus, especially minority populations, the uninsured, and veterans. We must also do all we can to protect hemophiliacs, renal dialysis patients, and AIDS patients.

Hepatitis C is a devastating disease, and this bill can be a major step in fighting it. I look forward to working with my colleagues to enact this bill into law.

Mr. JOHNSON. Mr. President, I rise today with my colleagues, Senators KENNEDY, CLINTON, DASCHLE, BREAUX, JEFFORDS, BIDEN, DODD, BINGAMAN, HUTCHISON, CAMPBELL, SCHUMER, and SMITH to introduce the Hepatitis C Epidemic Control and Prevention Act of 2003. I thank my colleagues for joining

me in introducing this legislation that will improve the prevention, control, and medical management of hepatitis C.

Hepatitis C is the most common chronic bloodborne viral infection in the United States, and it is the seventh leading cause of death in our country. Almost 4 million U.S. citizens are infected with hepatitis C, and of those 2.7 million are chronically infected and at least 2.5 million do not receive any treatment, which results in the continued spread of this devastating, yet preventable illness. The estimated direct and indirect costs of hepatitis C infection are at least \$600 million annually.

Symptoms of hepatitis C can include jaundice, fatigue, loss of appetite, and abdominal pain. While this disease may be asymptomatic in most patients initially, between 50 and 80 percent will develop a chronic infection, and of these half will eventually develop cirrhosis or cancer of the liver. While diagnostic tests are available to identify the disease, there is no vaccine to prevent hepatitis C, which makes prevention and control measures crucial to reducing its incidence and prevalence.

The importance of improving hepatitis C prevention and control activities was brought to my attention this past year by the family of Christen Graeber Winter. Christen was from Aberdeen, SD, and passed away 5 years ago at the age of 42. She had been very ill two decades earlier and required a blood transfusion. Christen became very sick a little over 5 years ago and was diagnosed with hepatitis C, a disease that she had contracted from that blood transfusion that she had so many years earlier. Christen died in 1998, and during the last months of her life she remained as active as possible and was committed to finishing up her bachelor's degree at Presentation College, even though she was very ill.

Everyone who knew Christen said she was a warm and caring person, and even towards the end of her life, she remained strong and was determined not to burden others with her deteriorating health. After her death, Christen's sister Carey started conducting research to learn about hepatitis C. She knew nothing of the disease and was surprised to learn how many people suffered from it. She learned that physicians are largely unaware of hepatitis C and therefore cases often go undetected. Carey is now a strong advocate of promoting increased funding for education, treatment, and prevention of this disease and has helped me understand how important it is that we in Congress establish the programs and appropriate the funds necessary to prevent needless deaths like the death of Christen.

The hepatitis C Epidemic Prevention and Control Act will help reduce the number of people affected by this horrible illness and prevent stories like Carey's sister from continuing. The bill requires that the Department of Health and Human Services develop and implement an integrated plan to combat

hepatitis C. While we know how to prevent the spread of this disease, there have been limited programs to educate health professionals, at-risk populations, and the general public on how to do so. This bill will focus on increasing knowledge and awareness of such infections among providers and patients.

In addition to education, surveillance, early detection, and counseling are important tools that must be used in order to control this disease. Less than 50 percent of local health departments providing counseling and only 23 percent provide testing for hepatitis C. This bill will require that CDC promote confidential testing programs by working with State and local governments in order to catch hepatitis C cases early. It will also provide access to important counseling activities in a variety of private and public health care settings to help patients reduce the risk of harm to themselves and others.

This important legislation is supported by a tripartisan coalition of my colleagues. We have recognized that hepatitis C is a preventable disease that can be halted with a strong emphasis on prevention and control. I do not want to see more cases like that of Carey's sister. We have an opportunity to make a real difference here, and I urge the Senate to support this bill.

By Mr. CONRAD (for himself and Mr. DORGAN):

S. 1146. A bill to implement the recommendations of the Garrison Unit Tribal Advisory Committee by providing authorization for the construction of a rural health care facility on the Fort Berthold Indian Reservation, North Dakota; to the Committee on Indian Affairs.

Mr. CONRAD. Mr. President, I rise today, joined by my colleague Senator DORGAN, to introduce the Three Affiliated Tribes Health Facility Compensation Act. This legislation fulfills a longstanding Federal commitment to the Three Affiliated Tribes of Fort Berthold in my State of North Dakota.

In 1949, the Three Affiliated Tribes lost 156,000 acres of land, one-quarter of its land base, for the construction of the Garrison Dam along the Missouri River. Three hundred twenty five families—eighty percent of the tribal membership—were forcibly relocated. Ninety-four percent of the agricultural lands of these farmers and ranchers was destroyed. The Indian Health Service's hospital at the community of Elbowoods was completely flooded. At the time, the Federal Government committed to replacing the hospital.

On May 10, 1985, then Interior Secretary Donald P. Hodel signed a charter creating the Garrison Unit Joint Tribal Advisory Committee, which was charged with examining the effects of the construction of the Garrison Dam and Reservoir on the tribe and making recommendations on compensation. In its final report released on May 23, 1986, the committee found that the

Three Affiliated Tribes were entitled to financial compensation as well as the replacement of lost infrastructure including its health facility. The committee specifically noted that the replacement of the health facility was an "emergency need."

In 1992, Congress acted on some of the committee's recommendations by passing the Three Affiliated Tribes and Standing Rock Sioux Tribe Equitable Compensation Act. However, at the time, due to budget limitations, Congress was not able to fulfill the commitments on infrastructure replacement. The Senate Committee on Indian Affairs in its report on the Act specifically noted that "every effort should be made by the Administration and Congress to provide additional federal funding for these infrastructure priorities." More than 10 years later, many of the infrastructure priorities still have not been met.

The legislative history on this matter is clear, a commitment was made to the tribe that must be kept. The bill I am introducing will authorize \$20 million to construct for a health facility on the Fort Berthold Indian Reservation to fulfill this longstanding promise to the Three Affiliated Tribes.

Mrs. BOXER. Mr. President, today I am introducing a bill to increase security and prevent terrorist attacks at our Nation's ports.

Ports are extremely important to our nation's economy, especially to my State of California. The ports of LA, Long Beach, and Oakland handle 40 percent of our Nation's cargo and generate billions of dollars in economic activity each year in California alone.

The tragic events of September 11 demonstrated that we needed to make improvements in our nation's security. Our ports are no exception.

We have begun to make improvements. As a member of the Senate Commerce Committee, I served as a conferee on the port security bill that became law last November. This legislation mandated the creation of national and regional port security plans and better coordination of Federal, State, local, and private enforcement agencies. It also established a grant program for port authorities, waterfront operators, and state and local agencies to provide security infrastructure improvements such as video cameras and more secure fencing. In addition, it calls for the development of regulations to determine secure areas in ports and to limit access through background checks and a transportation security identification card.

This legislation was a good first step. But, we need to do more. And I believe we should harness the best of our high-tech capabilities to improve port security. That is why today I am introducing the High-Tech Port Security Act.

This legislation has three high tech improvements for our nation's ports.

First, the bill would require that all containers used in our Nation's ports

be blast resistant. The U.S. Department of Homeland Security would develop a standard for such containers and would work with shipping companies to ensure that all new containers are blast resistant.

Second, the bill would require that all containers be inspected with advanced technology before leaving our ports and entering our roads, highways, and communities. The Department of Homeland Security would establish a standard for cargo screening technology and ensure that this technology is installed at all ports, so every incoming container is screened before it leaves the port. This is extremely important because currently only two to three percent of all containers are inspected.

Third, this bill will focus protection on the Nation's largest ports by establishing high tech command and control centers to coordinate and monitor security at the 20 busiest ports in the United States.

The technologies needed to secure our Nation's vital ports are available today, and they should start being used now. There is no time to lose. The vulnerability of our seaports is no secret; it is a well known gap in our homeland defense. This legislation will help close that gap.

By Mrs. FEINSTEIN:

S. 1150. A bill to establish the Bob Hope American Patriot Award; to the Committee on the Judiciary.

Mrs. FEINSTEIN. Mr. President, I rise today to introduce the Bob Hope American Patriot Award Act of 2003. This legislation would create a presidential commemorative award for an individual or organization that demonstrates "extraordinary love of this Nation and devotion to its citizens in the form of true patriotism."

In addition, this legislation would honor one of the most respected figures in America, who for seven decades has served our Nation with his talents in entertainment. As many are familiar, I am speaking today of Bob Hope.

To celebrate Bob Hope's 100th birthday on May 29, 2003, this legislation would give the President the opportunity to annually recognize the wonderful trait of "patriotism," so well exemplified by Hope throughout his lifetime. Mr. Hope has long demonstrated that entertainment can positively influence "love of country and dedication to the spiritual well-being of America's troops."

A master of the skills of acting and singing, Bob Hope may be the most talented and prolific entertainer of our time. Many of us will recall his work in the series of "Road" films with Bing Crosby and Dorothy Lamour. His expansive career has involved stage musical comedy, motion pictures, and live appearances at the USO shows.

On May 6, 1941, Bob Hope began a 50-year service with the United States Armed Forces, in which he did approximately 60 USO tours. He has toured

U.S. military stations all over the world, including Germany, the South Pacific, and Vietnam. Veterans and U.S. soldiers alike will always remember his variety shows, which included skits, dancers, specialty acts, and comedic monologues. These monologues were particularly touching as they commiserated with the daily travails of a soldier's life.

Over the years, Bob Hope has received well-deserved recognition for his dedication to our Nation. He has been honored with numerous awards, including the Congressional Gold Medal, the Presidential Medal of Freedom, and the Distinguished Service Medal from each of the branches of the military. Several years ago, I co-sponsored legislation naming him an Honorary Veteran for his humanitarian services to the U.S. Armed Forces.

Bob Hope epitomizes true patriotism and service to our country, and I cannot think of anybody better to name this new award after.

This legislation is important because it would not only carry on the name of such an honorable figure, but would recognize future individuals or organizations who have dedicated themselves to promoting the values of freedom, democracy, and goodwill. This award would be the first of its kind—honoring American civilians specifically for patriotism.

This legislation would give the President the authority to annually select either one individual or one organization to receive this commemorative award at a White House ceremony. The President would also be given the power to interpret the selection criteria and determine the form that the award would take, such as a plaque, medal or flag.

I believe this legislation is timely and befitting of both Mr. Hope and the great citizens of our Nation. In these challenging times, it is important to encourage and recognize Americans who have given so much to the cause of patriotism, asking for nothing in return.

My hope is that this award, established through this legislation, will both carry on the wonderful legacy of Bob Hope and bring awareness to the magnanimous spirit of our fellow citizens. I call on this body to enact this legislation promptly.

By Mr. FEINGOLD:

S. 1151. A bill to rescind the Department of Veterans Affairs memorandum of July 18, 2002, in which Directors of health service networks in the Department of Veterans Affairs are directed to ensure that no marketing activities to enroll new veterans occur within their networks; to the Committee on Veterans' Affairs.

Mr. FEINGOLD. Mr. President, today I am introducing legislation that would restore a valuable—and statutorily mandated—service to our Nation's veterans and their families.

In July 2002, Department of Veterans Affairs Deputy Under Secretary for

Health for Operations and Management Laura Miller sent a memo to Veterans Integrated Service Network Directors ordering them to "ensure that no marketing activities to enroll new veterans occur within [their] networks."

This memo cited an increased demand for VA health care services as the reason for this change in policy. While it is clear that more funding should be provided for VA health care and other programs, it is inappropriate for the VA to institute a policy to stop making veterans aware of the health care services for which they may be eligible.

I joined with a number of our colleagues last year in sending a letter to the President asking that this policy be immediately reversed. I regret that the VA's reply indicated that the Secretary of Veterans Affairs stands by this policy, which remains in effect.

The bill that I am introducing today, Veterans Outreach Protection Act, would rescind the policy issued in this memorandum and prohibit the VA from using Federal funding to enforce this policy. This bill is a companion to legislation introduced in the House by Congressman PAUL KANJORSKI earlier this year.

I have long been concerned that tens of thousands of our veterans are unaware of federal health care and other benefits for which they may be eligible. We can and should do more to educate our veterans and their families about these benefits, and to provide adequate funding to ensure that all veterans who wish to take advantage of their benefits are able to do so. Halting health care marketing activities is not the answer. Our brave veterans have earned these benefits. The Federal department that is charged with advocating for and providing benefits to our veterans should not be allowed to continue to restrict health care outreach activities.

In addition to this bill, I am currently working to draft legislation to improve VA-wide outreach efforts. Our veterans and their families have made great personal sacrifices to protect our freedoms. We owe them a great debt of gratitude. Making sure that our veterans know about the benefits that they have earned is an important first step in starting to repay this debt.

I ask unanimous consent that the text of my bill be printed in the RECORD.

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

S. 1151

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "Veterans Outreach Protection Act".

**SEC. 2. RESCISSION OF DEPARTMENT OF VETERANS AFFAIRS MEMORANDUM.**

(a) RESCISSION OF MEMORANDUM.—The memorandum of the Department of Veterans Affairs dated July 18, 2002, from the Deputy Under Secretary for Health for Operations

and Management with the subject "Status of VHA Enrollment and Associated Issues" is hereby rescinded. Marketing activities of Directors of health service networks (known as "Veterans Integrated Service Networks") of the Department of Veterans Affairs to enroll new veterans within their respective networks shall be carried out without regard to such memorandum.

(b) FUNDING LIMITATION.—No funds available to the Department of Veterans Affairs may be used to carry out the memorandum referred to in subsection (a) or otherwise to implement the policy contained in that memorandum.

By Mr. MCCAIN (for himself and Mr. HOLLINGS):

S. 1152. A bill to reauthorize the United States Fire Administration, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Mr. MCCAIN. Mr. President, I am pleased to be joined this morning by Senators HOLLINGS in introducing legislation to reauthorize the United States Fire Administration, USFA, for fiscal year 2004 through fiscal year 2006. This legislation would also re-establish the position of the U.S. Fire Administrator, which would serve in the new Department of Homeland Security.

USFA's mission is to reduce the loss of life and property because of fire and related emergencies. Each year, fire injures and kills more Americans than all other natural disasters combined. Death rates by fire in the United States are among the highest in the industrialized world.

The U.S. Fire Administration utilizes a number of tools to fulfill its mission. USFA's National Fire Data Center administers a national system for collecting, analyzing, and disseminating data and information on fire and other emergency incidents to state and local governments and the fire community. The National Fire Academy, NFA, is the premiere training academy for fire services. It is estimated that since 1975, over 1.4 million firefighters and other first-responders have benefitted from NFA training classes in emergency management, fire prevention, and anti-terrorism. USFA also engages in research, testing, and evaluation activities with public and private entities to promote and improve fire and life safety. Finally, USFA administers the popular Assistance to Firefighters Grant Program, which provides competitive grants to local fire departments for training, wellness and fitness programs, vehicles, firefighting equipment, and fire prevention.

The U.S. Fire Administrator plays an important role in our nation's fire control policy and homeland security initiatives by serving as the point-of-contact for the fire services. This position was eliminated in last year's legislation that established the Department of Homeland Security. On April 30, 2003, the Senate Committee on Commerce, Science, and Transportation heard testimony from many of the major fire service organizations regarding the importance of the U.S. Fire

Administrator position, and the need for the Administrator to serve as a representative of the fire services within the Department of Homeland Security. This legislation would re-establish this position.

Firefighting remains one of the most dangerous professions in the United States. We rely on firefighters to aid us in fires, accidents, and natural disasters. However, we have also witnessed the role that firefighters play as the first responders on the scene of any possible terrorist attack. It is important that we pass this legislation to ensure that the Federal government continues its appropriate role in helping our fire services adapt to this new challenge.

I urge my colleagues to support this legislation, and look forward to working with them to ensure timely passage of this legislation. I also ask unanimous consent that the text of the bill be printed in the RECORD.

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

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

#### SECTION 1. SHORT TITLE.

This Act may be cited as the "United States Fire Administration Reauthorization Act of 2003".

#### SEC. 2. RE-ESTABLISHMENT OF POSITION OF UNITED STATES FIRE ADMINISTRATOR.

Section 1513 of the Homeland Security Act of 2002 does not apply to the position or office of Administrator of the United States Fire Administration, who shall continue to be appointed and compensated as provided by section 5(b) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2204(b)) after the functions vested by law in the Federal Emergency Management Agency have been transferred to the Directorate of Emergency Preparedness and Response in accordance with section 503 of the Homeland Security Act of 2002.

#### SEC. 3. AUTHORIZATION OF APPROPRIATIONS.

Section 17(g)(1) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2216(g)(1)) is amended to read as follows: "(1) Except as otherwise specifically provided with respect to the payment of claims under section 11 of this Act, there are authorized to be appropriated to carry out the purposes of this Act—

- “(A) \$52,000,000 for fiscal year 2004;
- “(B) \$53,560,000 for fiscal year 2005; and
- “(C) \$55,166,800 for fiscal year 2006.”.

By Mr. SPECTER (for himself and Mr. BOND):

S. 1153. A bill to amend title 38, United States Code, to permit medicare-eligible veterans to receive an out-patient medication benefit, to provide that certain veterans who receive such benefit are not otherwise eligible for medical care and services from the Department of Veterans Affairs, and for other purposes; to the Committee on Veterans' Affairs.

Mr. SPECTER. Mr. President, I have sought recognition to explain the provisions of the "Veterans Prescription Drugs Assistance Act of 2003," a bill that I have introduced today to assist Medicare-eligible veterans struggling

with the costs of prescription medications.

I fully understand that Congress, and the President, are working very hard on legislation to take on the larger issue of providing a prescription drug benefit for all American seniors. I applaud that effort, and I will continue to work with my colleagues to see that Congress enacts legislation to help all seniors who struggle with the ever-increasing costs of necessary medications. But in the meantime, as Chairman of the Committee on Veterans Affairs, I offer legislation to allow Medicare-eligible veterans to obtain prescription drugs from the Department of Veterans Affairs, VA, at the significantly discounted costs that VA, as a high-volume purchaser of prescription medications, is able to secure in the marketplace.

Earlier this year, VA Secretary Anthony J. Principi was forced to limit access to VA care by suspending new enrollments of non-service-disabled middle and higher income veterans who were not enrolled for care as of January 17, 2003. The Secretary was forced to do so because the number of patients provided care by VA has more than doubled in just five years. And as a result, VA's medical care system has been overwhelmed and, as a consequence, VA has been unable to provide timely access to healthcare for all veterans who have sought it and appointment waiting times have grown to alarming levels. But in almost every news story that followed the Secretary's difficult decision, it was noted that many of the new enrollees who had overwhelmed VA's capacity to provide care were Medicare-eligible veterans who were able to get Medicare-financed care elsewhere—but who were seeking access to the relatively generous prescription drug program provided to veterans under VA care.

Currently, VA provides enrolled patients with prescription medications for \$7.00 for each 30-day supply. But to get such prescriptions, the veteran must obtain the full range of medical care from VA. This fact, coupled with the Secretary's decision to close enrollment, means that veterans who are now—or who will be—eligible for Medicare who had not enrolled for VA care prior to January 17, 2003, will be unable to access VA's generous prescription drug benefits. This legislation would provide some relief for those veterans. In addition, I anticipate that it may induce some VA-enrolled Medicare-eligible veterans—those who were happy with their Medicare-financed care but who enrolled for VA care to gain access to VA-supplied drugs—to return to non-VA care with knowledge that they will be able to get their non-VA prescriptions filled through VA. Enactment of this provision, then, would reduce—not exacerbate—VA patient backlog numbers.

The premise of this legislation is straightforward: VA fills and distributes more than 100 million prescrip-

tions each year for its 4.5 million veteran-patients. As a result, it has significant purchasing power—power which, coupled with VA's formulary program, allows it to negotiate very favorable prices for prescription drugs. According to the National Association of Chain Drug Stores, the average "cash cost" of a prescription in 2001 was \$40.22. The average VA per-prescription cost in 2001 was \$22.87—almost 50 percent less. The average per-prescription price paid by VA this year is up to just under \$25—a slower growth rate than the 6.7 percent annual growth experienced in the population at large since 2001.

My purpose is to afford Medicare-eligible veterans access to such discounts. I do not propose that VA be directed to supply drugs to all Medicare-eligible veterans at VA expense, or even with a partial VA subsidy. VA has stated that such a mandate would divert VA funding—which, clearly, is already stretched to the limit—away from VA priority patients: the service-connected, the poor, and those with special needs. I accept VA's statement of concern; I accept and I insist—that scarce funding be directed, first, to meet the needs of priority patients. This legislation, therefore, requires that VA recover the costs of drugs it supplies under this program from veterans who bring their prescriptions from outside doctors to VA.

I do not propose to tell VA in this bill how to recover these costs. VA is better positioned than I to make such judgments. Thus, my legislation provides flexibility to VA to design and test payment mechanisms to best accomplish cost recovery while still easing veterans' access to the drugs they need. It might be that enrollment fees, a copayment structure, or a simple "cost-plus"—for administrative expenses pricing format—or some combination of those mechanisms—works best. And it might be that different approaches work best in different regions of the country. I intend for the VA to experiment with different pricing structures to determine what works best. But I also intend that veterans get a break on prescription drug pricing.

Those who would benefit from this program are World War II and Korean War veterans who answered their country's call over 50 years ago. As they age, many desperately need relief from high drug prices. My purpose is not to disparage the drug companies; their discoveries have truly been marvels. But that is precious little comfort to a Medicare participant who, whatever the drug's overall utility might be, cannot afford both the drug and food or shelter or heat. Many such persons reside in the Commonwealth of Pennsylvania where, just last month, a genuine titan in the industrial history of the United States, Bethlehem Steel, ceased to exist. Many retired steelworkers who are also veterans—and who never needed VA because of company-paid

benefits—have lost their health insurance coverage and, with it, prescription drug benefits. These people need a break. This bill could provide it.

The premise of this legislation is simple: veteran access to VA market-driven discounts. Yet, the assistance it could provide might be profound. I do hope that Congress will find a way to provide prescription drug benefits to all seniors. But for now, I urge my colleagues to support this bill so that the problem might be solved—or at least reduced—for seniors who served. They deserve it, and we should do it.

I ask unanimous consent that the text of this bill be printed in the RECORD.

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

S. 1153

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the “Veterans Prescription Drugs Assistance Act”.

**SEC. 2. ELIGIBILITY OF MEDICARE-ELIGIBLE VETERANS FOR OUT-PATIENT MEDICATION BENEFIT.**

(a) RESTATEMENT OF CURRENT LAW ON DRUGS AND MEDICATIONS AND PROVISION OF OUT-PATIENT MEDICATION BENEFIT.—Chapter 17 of title 38, United States Code, is amended by inserting after section 1710B the following new section:

**“§ 1710C. Drugs and medications; vaccines**

“(a)(1) The Secretary shall furnish to each veteran who is receiving additional compensation or allowance under chapter 11 of this title, or increased pension as a veteran of a period of war, by reason of being permanently housebound or in need of regular aid and attendance, such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of any illness or injury suffered by such veteran.

“(2) The Secretary shall continue to furnish such drugs and medicines ordered under paragraph (1) to any such veteran in need of regular aid and attendance whose pension payments have been discontinued solely because such veteran’s annual income is greater than the applicable maximum annual income limitation, but only so long as such veteran’s annual income does not exceed such maximum annual income limitation by more than \$1,000.

“(b)(1) Any medicare-eligible veteran may elect to be furnished by the Secretary, on an out-patient basis, such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of any illness or injury suffered by such veteran.

“(2) In this subsection, the term ‘medicare-eligible veteran’ means any veteran who—

“(A) is entitled to or enrolled in hospital insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); or

“(B) is enrolled in the supplementary medical insurance program under part B of such title (42 U.S.C. 1395j et seq.).

“(3) The Secretary shall furnish to any veteran who makes an election under paragraph (1), on an out-patient basis, such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of any illness or injury suffered by such veteran.

“(4)(A) Notwithstanding any other provision of law and except as provided in sub-

paragraph (B), a veteran who makes an election under paragraph (1) shall not be eligible for care and services under this chapter during the year covered by the election.

“(B) Subparagraph (A) shall not apply with respect to any veteran who has a compensable service-connected disability.

“(5) The furnishing of drugs and medicines under this subsection shall be subject to the provisions of section 1722A(b) of this title.

“(6)(A) An election under paragraph (1) shall be for a calendar year, and shall be irrevocable for the year covered by such election. An election may be renewed.

“(B) The Secretary shall prescribe the form, manner, and timing of an election.

“(7) Before permitting a veteran to make an election under paragraph (1), the Secretary shall provide the veteran such educational materials and other information on the furnishing and receipt of drugs and medicines under this subsection as the Secretary considers appropriate to inform the veteran of the benefits and costs of being furnished drugs and medicines under this subsection, including materials and information on the consequences of making an election under paragraph (1) and on the fees, copayments, or other amounts required under section 1722A(b) of this title for drugs and medicines furnished under this subsection.

“(c)(1) In order to assist the Secretary of Health and Human Services in carrying out national immunization programs under other provisions of law, the Secretary may authorize the administration of immunizations to eligible veterans who voluntarily request such immunizations in connection with the provision of care for a disability under this chapter in any Department health care facility.

“(2) Any immunization under paragraph (1) shall be made using vaccine furnished by the Secretary of Health and Human Services at no cost to the Department. For such purpose, notwithstanding any other provision of law, the Secretary of Health and Human Services may provide such vaccine to the Department at no cost.

“(3) Section 7316 of this title shall apply to claims alleging negligence or malpractice on the part of Department personnel granted immunity under such section.”.

(b) COPAYMENT REQUIREMENTS.—

(1) IN GENERAL.—Section 1722A of such title is amended—

(A) in subsection (a)(1), by inserting “(other than a veteran covered by subsection (b))” after “require a veteran”;

(B) by redesignating subsections (b), (c), and (d), as subsections (c), (d), and (e), respectively;

(C) by inserting after subsection (a) the following new subsection (b):

“(b)(1) In the case of a veteran who is furnished medications on an out-patient basis under section 1710C(b) of this title, the Secretary shall require the veteran to pay, at the election of the Secretary, one or more of the following:

“(A) An annual enrollment fee in an amount determined appropriate by the Secretary.

“(B) A copayment for each 30-day supply of such medications in an amount determined appropriate by the Secretary.

“(C) An amount equal to the cost to the Secretary of such medications, as determined by the Secretary.

“(2)(A) In determining the amounts to be paid by a veteran under paragraph (1), and the basis of payment under one or more subparagraphs of that paragraph, the Secretary shall ensure that the total amount paid by veterans for medications under that paragraph in a year is not less than the costs of the Department in furnishing medications to veterans under section 1710C(b) of this title

during that year, including the cost of purchasing and furnishing medications, and other costs of administering that section.

“(B) The Secretary shall take appropriate actions to ensure, to the maximum extent practicable, that amounts paid by veterans under paragraph (1) in a year are equal to the costs of the Department referred to in subparagraph (A) in that year.

“(3) In determining amounts under paragraph (1), the Secretary may take into account the following:

“(A) Whether or not the medications furnished are generic medications or brand name medications.

“(B) Whether or not the medications are furnished by mail.

“(C) Whether or not the medications furnished are listed on the National Prescription Drug Formulary of the Department.

“(D) Any other matters the Secretary considers appropriate.

“(4) The Secretary may from time to time adjust any amount determined by the Secretary under paragraph (1), as previously adjusted under this paragraph, in order to meet the purpose specified in paragraph (2).”; and

(D) in subsection (d), as so redesignated—

(i) by striking “subsection (a)” and inserting “subsections (a) and (b)”; and

(ii) by striking “subsection (b)” and inserting “subsection (c)”.

(2) DEPOSIT OF COLLECTIONS IN MEDICAL CARE COLLECTIONS FUND.—Paragraph (4) of section 1729A(b) of such title is amended to read as follows:

“(4) Subsection (a) or (b) of section 1722A of this title.”.

(c) CONFORMING AMENDMENTS.—(1) Section 1707 of such title is amended by adding at the end the following new subsection:

“(c) Notwithstanding any other provision of law, a veteran who makes an election authorized by section 1710C(b) of this title (other than a veteran covered by paragraph (4)(B) of that section) shall not, for the period of such election, be eligible for care and services under this chapter, except as provided in that section.”.

(2) Section 1712 of such title is amended by striking subsections (d) and (e).

(d) CLERICAL AMENDMENTS.—(1) The heading for section 1712 of such title is amended to read as follows:

**“§ 1712. Dental care”.**

(2) The table of sections at the beginning of chapter 17 of such title is amended—

(A) by inserting after the item relating to section 1710B the following new item:

“1710C. Drugs and medications; vaccines.”; and

(B) by striking the item relating to section 1712 and inserting the following new item:

“1712. Dental care.”.

Mr. BOND. Mr. President, I rise today to express my strong support for the Veterans Prescription Drugs Assistance Act of 2003. As an original co-sponsor, I am pleased to join my colleague, the Chairman of the Veterans Affairs Committee, Senator SPECTER in introducing this important legislation that addresses the medical care needs of Medicare-eligible veterans. I applaud Senator SPECTER for his leadership on this important issue.

For several years, many veterans have not been able to receive timely health care from the Department of Veterans Affairs due to the long waiting lines created by the huge demand for prescription drugs. Under current policy, veterans are required to see a VA doctor before receiving their medication even when they have already

had a prescription written by a privately licensed physician. This policy has not only contributed to the long waiting lines, but it has denied care to service-connected and lower income veterans. It is a moral imperative that we correct this problem and I believe that this legislation is a step in the right direction.

As Chair of the VA-HUD and Independent Agencies Appropriations Subcommittee, my top priority is ensuring that the VA has adequate funding to provide accessible and quality care for our Nation's veterans. Unfortunately, despite record funding increases over the past few years, veterans must still wait for several months to see a VA doctor.

This past January, VA Secretary Principi had to take the unfortunate but necessary step of closing new enrollments to middle and higher income veterans who do not have service-connected disabilities. Many of these so-called Priority 8 veterans have Medicare insurance but do not have a prescription drug benefit. I recognize that the Congress and the President are trying to address the prescription drug issue for all American seniors and I will continue to fight to ensure that a Medicare prescription drug bill is enacted. Nevertheless, I believe that we need to raise awareness of the tragedy that many veterans suffer today to ensure that no matter what occurs during this session of Congress, they are not left behind.

This bill contains a number of important provisions but I highlight one particular measure. As I mentioned earlier, current policy requires veterans to see a VA doctor before having their prescription filled, even if they have had already seen a private doctor. This legislation allows eligible veterans to fill their prescriptions at the VA without having to see a VA doctor. This not only greatly streamlines the process and time for veterans to receive much-needed medications, but it also provides relief to the waiting lines so that our higher priority veterans can receive timely care. In other words, this legislation is a win-win for all veterans.

This legislation may not be perfect but it is important to begin a dialogue on the prescription drug needs of our nation's veterans. I welcome my colleagues' comments and comments from the Administration. I believe that we can resolve this matter this year. I thank my colleagues for their attention to this matter and I look forward to working with all of you over the next several weeks.

By Ms. SNOWE (for herself, Mr. BOND, and Mr. BURNS):

S. 1154. A bill to provide for the reauthorization of programs administered by the Small Business Administration that assist small business concerns owned and controlled by women; and for other purposes; to the Committee on Small Business and Entrepreneurship.

Ms. SNOWE. Mr. President, I rise to introduce the "Women's Small Business Programs Improvement Act of 2003" in recognition of the critical potential that women entrepreneurs hold for the Nation's economic welfare. I am pleased to be joined by Senators BOND and BURNS in offering this important legislation.

Today, women own nearly a third of the Nation's small businesses—totaling nearly 7 million women-owned enterprises that contribute approximately \$1.2 trillion to be economy annually. That number, however, does not include jointly owned businesses in which women play a major role but hold less than fifty percent of the ownership rights. So, the actual number of women with significant roles in business goes well beyond 7 million—and they are growing rapidly.

These figures reflect the successes that women entrepreneurs are having despite facing the same challenges for the past twenty years—access to business assistance, access to capital, and access to Federal Government contract opportunities. The "glass ceiling" in corporate America that led many women to start a small business has been transformed into a another obstacle—"a glass doorway"—between women who want to start and grow businesses and the lending and Federal contract markets these women entrepreneurs seek to enter. Overcoming these obstacles requires that women are provided the business assistance tools they need, which we can ensure through the programs and services established within the Small Business Administration, SBA, specifically for women.

As the new Chair of the Committee on Small Business, I have been carefully examining the SBA's programs with a particular focus on the agency's initiatives that are intended to foster women-owned businesses. During the past year, witnesses and participants of the Committee's hearings and roundtables clearly identified the concerns of women business owners: the lack of business assistance programs for existing small businesses; scarcity of financial resources for start-up or expansion; limited opportunities for Federal Government contracts; and the need for specific research on women's business ownership.

In addition, we heard concerns from the Women's Business Centers and their advocates about the Women's Business Centers Sustainability Grants Program, which sunsets in 2003. These centers have been extraordinarily successful in providing assistance to women in all walks of life—those who once received public assistance but now operate businesses and create jobs; women transitioning from employee to small business employer; and establish women-business owners who create and manufacture products for sale at home and abroad. The Centers nurture women entrepreneurs through business and financial planning and help with

critical issues like securing funding for startup and expansion. Despite these successes, however, funding questions have long plagued the program.

Adding to the information gained from its official activities, the Committee staff also conducted a review of all SBA funded and sponsored activities for women entrepreneurs, held discussions with women business leaders, and obtained information in the process of preparing for the reauthorization of SBA Non-Credit Programs.

Our findings support specific changes to ensure that the SBA will be more accountable in its delivery of programs and services through the Office of Women's Business Ownership. Specifically, based on the need and the impressive record of the Women's Business Centers, there is strong support for making the program permanent, provided that the SBA streamlines the grants administration processes. Improvements in the focus and operations for the National Women's Business Council and the Women's Interagency Committee on Women's Business Enterprise would also enhance their missions and ability to serve women entrepreneurs.

The bill I introduce today is designed to address these issues and improve the programs and services that the SBA delivers across the nation for women business owners through the Office of Women's Business Ownership, the Women's Business Centers Program, the National Women's Business Council, and the Interagency Committee on Women's Business Enterprise. The key elements of the bill's improvements will provide direction, consolidation and integration of existing programs that have been previously created to offer opportunities for women through their entrepreneurial endeavors.

The "Women's Small Business Programs Improvement Act of 2003" would improve the entrepreneurial environment for women seeking assistance and opportunity through Federal Government sponsored programs. A key to the success of this bill is the integration of all internal and external SBA programs and partnerships. The provisions in this bill are timely and in response to the many concerns of women business owners that I have received from my constituents in Maine and from across the country through the Small Business Committee.

Additionally, the bill makes the Women's Business Center a permanent program for existing eligible Centers so that women can depend on the experienced services of small business long-term counseling and small business education and training. The Centers have proven to be a great value the communities they serve so we must ensure that their programs and services continue to be available.

The "Women's Small Business Programs Improvement Act of 2003" ensure that women entrepreneurs at all stages of business ownership get the assistance they need so that success

through business growth is more easily obtained. And it achieves that goal, not by establish costly new initiatives, but by building on successful establish programs within the SBA and improving their delivery for the benefit of current and future women entrepreneurs.

As the Small Business Committee continues its work on legislation to reauthorize the SBA, we will be addressing all of the agency's programs. I look forward to working with my colleagues in the Senate to ensure that the provisions of this bill are included so the growth of women owned business in America can reach its full potential.

I ask unanimous consent that the text of the bill and a section-by-section analysis be printed into the RECORD.

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

S. 1154

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

#### SECTION 1. SHORT TITLE.

This Act may be cited as the "Women's Small Business Programs Improvement Act of 2003".

#### SEC. 2. OFFICE OF WOMEN'S BUSINESS OWNERSHIP.

Section 29(g) of the Small Business Act (15 U.S.C. 656(g)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (B)(i), by striking "in the areas of—

"(I) starting and operating"; and inserting the following:

"to solve problems concerning operations, manufacturing, technology, finance, international trade, and other disciplines required for—

"(I) starting, operating, and growing";

(B) in subparagraph (C), by inserting "the National Women's Business Council, and the Association of Women's Business Centers" before the period at the end; and

(2) by adding at the end the following:

"(3) PROGRAMS AND SERVICES FOR WOMEN-OWNED SMALL BUSINESSES.—The Assistant Administrator, in consultation with the Association of Women's Business Centers, the National Women's Business Council, and the Interagency Committee on Women's Business Enterprise, shall develop programs and services for women-owned businesses (as defined in section 408 of the Women's Business Ownership Act of 1988 (15 U.S.C. 631 note)) that provide goods or services in the areas of—

"(A) manufacturing;

"(B) technology;

"(C) professional services;

"(D) travel and tourism;

"(E) international trade; and

"(F) Federal Government contract business development.

"(4) TRAINING.—The Administration shall provide sufficient training for business ownership representatives and technical representatives within the district offices of the Administration to enable these staffs to carry out their responsibilities under this section."

#### SEC. 3. WOMEN'S BUSINESS CENTER PROGRAM.

(a) WOMEN'S BUSINESS CENTER GRANTS PROGRAM.—Section 29 of the Small Business Act (15 U.S.C. 656) is amended by striking subsection (b) through (f) and inserting the following:

"(b) GRANTS AUTHORIZED.—

"(1) IN GENERAL.—The Administration is authorized to award grants, to be known as

'Women's Business Center Grants', to private nonprofit organizations to conduct 3-year projects for the benefit of small business concerns owned and controlled by women. At the end of the initial 3-year grant period, and every 3 years thereafter, the grant recipient may apply to renew the grant in accordance with this subsection and subsection (e)(2).

"(2) CONTRACT AUTHORITY.—

"(A) IN GENERAL.—The Administration may enter into annual contracts with grant recipients under this subsection to perform the services described under paragraph (3) only to the extent and in the amount provided by appropriated funds.

"(B) TERMINATION.—If any grant recipient under this subsection does not fulfill its contractual obligations during the 3-year period of the grant, the Administration may terminate the grant.

"(3) USE OF FUNDS.—Grants awarded under paragraph (1) shall be used to provide—

"(A) financial assistance, including training and counseling in how to apply for and secure business credit and investment capital, preparing and presenting financial statements, and managing cash flow and other financial operations of a business concern;

"(B) management assistance, including training and counseling in how to plan, organize, staff, direct, and control each major activity and function of a small business concern; and

"(C) marketing assistance, including training and counseling in identifying and segmenting domestic and international market opportunities, preparing and executing marketing plans, developing pricing strategies, locating contract opportunities, negotiating contracts, and utilizing varying public relations and advertising techniques.

"(4) MATCHING REQUIREMENT.—

"(A) WOMEN'S BUSINESS CENTER GRANTS.—As a condition of receiving financial assistance under this section, the grant recipient shall agree to obtain, after its application has been approved and notice of award has been issued, cash contributions from non-Federal sources as follows:

"(i) In the first and second years, 1 non-Federal dollar for each 2 Federal dollars provided under the grant.

"(ii) In the third year, 1 non-Federal dollar for each Federal dollar provided under the grant.

"(iii) In each renewal period, 1 non-Federal dollar for each Federal dollar provided under the grant.

"(B) FORM OF NON-FEDERAL CONTRIBUTIONS.—Not more than ½ of the non-Federal sector matching assistance may be in the form of in-kind contributions that are budget line items only, including office equipment and office space.

"(C) FAILURE TO OBTAIN NON-FEDERAL FUNDING.—If any grant recipient fails to obtain the required non-Federal contribution during any project, it shall not be eligible thereafter for advance disbursements pursuant to subparagraph (D) during the remainder of that project, or for any other project for which it is or may be funded by the Administration. Before approving assistance to the grant recipient for any other projects, the Administration shall specifically determine whether the Administration believes that the grant recipient will be able to obtain the requisite non-Federal funding and enter a written finding setting forth the reasons for making such determination.

"(D) FORM OF FEDERAL CONTRIBUTIONS.—The financial assistance authorized pursuant to this section may be made by grant, contract, or cooperative agreement and may contain such provision, as necessary, to provide for payments in lump sum or installments, and in advance or by way of reim-

bursement. The Administration may disburse up to 25 percent of each year's Federal share awarded to a grant recipient after notice of the award has been issued and before the non-Federal sector matching funds are obtained.

"(5) APPLICATION SUBMISSION.—Each organization desiring a grant under this subsection, shall submit to the Administration an application that contains—

"(A) a certification that the applicant—

"(i) is a private nonprofit organization;

"(ii) employs an executive director or program manager to manage the center; and

"(iii) as a condition of receiving a grant under this subsection, agrees—

"(I) to receive a site visit as part of the final selection process;

"(II) to undergo an annual programmatic and financial examination; and

"(III) to the maximum extent practicable, to remedy any problems identified pursuant to the site visit or examination under subclauses (I) and (II);

"(B) information demonstrating that the applicant has the ability and resources to meet the needs of the market to be served by the women's business center site for which a grant is sought, including the ability to comply with the matching requirement under paragraph (4);

"(C) information relating to assistance provided by the women's business center site for which a grant is sought in the area in which the site is located, including—

"(i) the number of individuals assisted;

"(ii) the number of hours of counseling, training, and workshops provided; and

"(iii) the number of startup business concerns created;

"(D) information demonstrating the effective experience of the applicant in—

"(i) conducting financial, management, and marketing assistance programs, as described under paragraph (3), which are designed to teach or upgrade the business skills of women who are business owners or potential business owners;

"(ii) providing training and services to a representative number of women who are both socially and economically disadvantaged; and

"(iii) using resource partners of the Administration and other entities, such as universities;

"(E) a 3-year plan that projects the ability of the women's business center site for which a grant is sought—

"(i) to serve women business owners or potential owners in the future by improving training and counseling activities; and

"(ii) to provide training and services to a representative number of women who are both socially and economically disadvantaged; and

"(F) any additional information that the Administration may reasonably require.

"(6) REVIEW AND APPROVAL OF APPLICATIONS.—

"(A) IN GENERAL.—The Administration shall—

"(i) review each application submitted under paragraph (5) based on the information provided in such paragraph and the criteria set forth under subparagraph (B); and

"(ii) as part of the final selection process, conduct a site visit at each women's business center for which a grant is sought.

"(B) SELECTION CRITERIA.—

"(i) IN GENERAL.—The Administration shall evaluate and rank applicants in accordance with predetermined selection criteria that shall be stated in terms of relative importance. Such criteria and their relative importance shall be made publicly available and stated in each solicitation for applications made by the Administration.

“(ii) REQUIRED CRITERIA.—The selection criteria under clause (i) shall include—

“(I) the experience of the applicant in conducting programs or ongoing efforts designed to impart or upgrade the business skills of women business owners or potential owners;

“(II) the ability of the applicant to commence a project within a minimum amount of time;

“(III) the ability of the applicant to provide training and services to a representative number of women who are both socially and economically disadvantaged; and

“(IV) the location for the women’s business center site proposed by the applicant.

“(C) RECORD RETENTION.—The Administration shall maintain a copy of each application submitted under this subsection for not less than 7 years.

“(7) DATA COLLECTION.—Consistent with the annual report to Congress under subsection (g), each women’s business center site that is awarded a grant shall, to the maximum extent practicable, collect information relating to—

“(A) the number of individuals assisted;

“(B) the number of hours of counseling and training provided and workshops conducted;

“(C) the number of startup business concerns formed;

“(D) any available gross receipts of assisted concerns; and

“(E) the number of jobs created, maintained, or lost at assisted concerns.

“(8) SAVINGS PROVISION.—Notwithstanding any other provision of law, a contract or cooperative agreement, in effect on the date of enactment of the Women’s Small Business Programs Improvement Act of 2003, that awards a sustainability grant to a Women’s Business Center, shall remain in full force and effect under the terms, and for the duration, of such contract or agreement.

“(c) ASSOCIATION OF WOMEN’S BUSINESS CENTERS.—

“(1) RECOGNITION.—The Administration shall recognize the existence and activities of an association formed by the Women’s Business Centers to address matters of common concern.

“(2) CONSULTATION.—The Administration shall consult with the association described under paragraph (1) to develop—

“(A) a request for proposal to deliver assistance under this section;

“(B) a training program for the staff of the Women’s Business Centers; and

“(C) policies and procedures for governing the general operations and administration of the Women’s Business Center Program.”.

(b) CONFORMING AMENDMENTS.—Section 29 of the Small Business Act (15 U.S.C. 656) is amended—

(1) by redesignating subsections (g), (h), (i), (j), and (k) as subsections (d), (e), (f), (g), and (h), respectively.

(2) in subsection (e)(2), as redesignated by paragraph (1), by striking “to award a contract (as a sustainability grant) under subsection (l) or”;

(3) in subsection (h), as redesignated by paragraph (1)—

(A) by amending paragraph (1) to read as follows:

“(1) IN GENERAL.—There are authorized to be appropriated to carry out the provisions of this section, to remain available until expended—

“(A) \$14,500,000 for fiscal year 2004;

“(B) \$16,000,000 for fiscal year 2005; and

“(C) \$17,500,000 for fiscal year 2006.”; and

(B) by striking paragraph (4); and

(4) by striking subsection (l).

**SEC. 4. NATIONAL WOMEN’S BUSINESS COUNCIL.**

(a) COSPONSORSHIP AUTHORITY.—Section 406 of the Women’s Business Ownership Act of 1988 (15 U.S.C. 631 note) is amended by adding at the end the following:

“(e) COSPONSORSHIP AUTHORITY.—The Council is authorized to enter into cosponsorship agreements with public and private entities to carry out its duties under this section.”.

(b) MEMBERSHIP.—Section 407 of the Women’s Business Ownership Act of 1988 (15 U.S.C. 631 note) is amended by adding at the end the following:

“(j) REPRESENTATION OF MEMBER ORGANIZATIONS.—Notwithstanding subsection (b), a national women’s business organization or small business that is represented on the Council may replace its representative member on the Council at any time during the service term to which that member was appointed.”.

(c) ESTABLISHMENT OF COMMITTEES.—The Women’s Business Ownership Act of 1988 (15 U.S.C. 631 note) is amended by inserting after section 407, the following new section:

**“SEC. 408. COMMITTEES.**

“(a) ESTABLISHMENT.—There are established within the Council—

“(1) the Committee on Manufacturing, Technology, and Professional Services;

“(2) the Committee on Travel, Tourism, and International Trade; and

“(3) the Committee on Federal Procurement and Contracting.

“(b) DUTIES.—The Committees established under subsection (a) shall perform such duties as the chairperson shall direct.”.

(d) REPOSITORY FOR HISTORICAL DOCUMENTS.—Section 409 of the Women’s Business Ownership Act of 1988 (15 U.S.C. 631 note) is amended by adding at the end the following:

“(c) REPOSITORY FOR HISTORICAL DOCUMENTS.—The Council shall establish a repository for historical documents relating to women’s ownership of small businesses in the United States.”.

(e) AUTHORIZATION OF APPROPRIATIONS.—Section 410(a) of the Women’s Business Ownership Act of 1988 (15 U.S.C. 631 note) is amended by striking “2001 through 2003, of which \$550,000” and inserting “2004 through 2006, of which 30 percent”.

**SEC. 5. INTERAGENCY COMMITTEE ON WOMEN’S BUSINESS ENTERPRISE.**

(a) CHAIRPERSON.—Section 403(b) of the Women’s Business Ownership Act of 1988 (15 U.S.C. 631 note) is amended—

(1) by striking “Not later” and inserting the following:

“(1) IN GENERAL.—Not later”; and

(2) by adding at the end the following:

“(2) VACANCY.—In the event that a chairperson is not appointed under paragraph (1), the Deputy Administrator of the Small Business Administration shall serve as acting chairperson of the Interagency Committee until a chairperson is appointed under paragraph (1).”.

(b) POLICY ADVISORY GROUP.—Section 401 of the Women’s Business Ownership Act of 1988 (15 U.S.C. 631 note) is amended—

(1) by striking “There” and inserting the following:

“(a) IN GENERAL.—There”; and

(2) by adding at the end the following:

“(b) POLICY ADVISORY GROUP.—

“(1) ESTABLISHMENT.—There is established within the Interagency Committee a Policy Advisory Group to assist the chairperson in developing policies and programs under this Act.

“(2) MEMBERSHIP.—The Policy Advisory Group shall be composed of—

“(A) 1 representative from the Small Business Administration;

“(B) 1 representative from the Department of Commerce;

“(C) 1 representative from the Department of Labor;

“(D) 1 representative from the Department of Defense;

“(E) 1 representative from the Association of Women’s Business Centers; and

“(F) 2 representatives from the National Women’s Business Council.”.

(c) ESTABLISHMENT OF SUBCOMMITTEES.—Section 401 of the Women’s Business Ownership Act of 1988 (15 U.S.C. 631 note), as amended by subsection (b), is further amended by adding at the end the following:

“(c) SUBCOMMITTEES.—

“(1) ESTABLISHMENT.—There are established within the Interagency Committee—

“(A) the Subcommittee on Manufacturing, Technology, and Professional Services;

“(B) the Subcommittee on Travel, Tourism, and International Trade; and

“(C) the Subcommittee on Federal Procurement and Contracting.

“(2) DUTIES.—The Subcommittees established under paragraph (1) shall perform such duties as the chairperson shall direct.”.

**SEC. 6. ANNUAL MANAGEMENT REPORT.**

Section 29(g)(1) of the Small Business Act, as amended by this Act, is further amended by striking “The Administration” and inserting “Not later than November 1st of each year, the Administration”.

**SEC. 7. EFFECTIVE DATE.**

This Act, and the amendments made by this Act, shall take effect on October 1, 2003.

THE WOMEN’S SMALL BUSINESS PROGRAMS IMPROVEMENT ACT OF 2003—EXPLANATION OF PROVISIONS

I. SBA OFFICE OF WOMEN’S BUSINESS OWNERSHIP

This section of the bill reflects the Committee’s recognition of the achievements and challenges of women small business owners. The hearings and reauthorization roundtables, held during 2003, provided the opportunity to identify the Small Business Administration (SBA) non-credit programs that most interest or concern women advocates and business owners.

Hearing witnesses and Roundtables participants identified the following concerns held by women business owners:

The concern for the Women’s Business Center Program’s sustainability grants pilot program that fund centers beyond the maximum 5-year funding periods;

The need to expand the SBA non-credit programs (Entrepreneurial Development and Government Contracting);

The need for current research on women-owned small businesses;

The lack of progress for women to gain access to start-up and expansion capital, and

The limited opportunities available to women-owned small businesses for Federal government contracts.

In followup meetings and discussions, women business advocates and leaders indicated their interests in positive changes for the SBA sponsored programs through the Women’s Business Centers program, the National Women’s Business Council, and the Interagency Committee on Women’s Business Enterprise. The SBA Office of Women’s Business Ownership is in a position to take the “real world problems” faced by women on a day-to-day basis and work with all of its partners and public and private resources to expand its menu of programs and services.

The bill will direct the SBA Office of Women’s Business Ownership to develop and make available new programs and services for established women owned businesses—adding to the SBA menu of small business start-up programs.

The new programs and services for women would assist women-owned small business solve problems concerning business operations, manufacturing, technology, finance, Federal government contracting and international trade and other disciplines required for starting, operating, and growing small

business in changing economies. New programs would be based on recommendations by the National Women's Business Council, the Women's Business Centers, and the Interagency Committee on Women's Business Enterprise, these programs and services would be developed by the SBA in partnership with its funded resource partners and private sector cosponsors.

The bill will direct the SBA to provide training for District Office Women Business Ownership Representatives (existing staff who carry out marketing and outreach activities) and District Office of Technical Representatives (existing staff who carry out grant programmatic and financial oversight) and to provide resources for the District Offices to carry out their responsibilities in support of women's business ownership programs.

The bill will direct the SBA to submit a report on data collections on women's programs and services to the Congress no later than November 1st of each year.

The bill will direct the SBA to work with the Association of Women's Business Centers, the National Women's Business Council and the Interagency Committee on Women Business Enterprise to develop marketing and outreach programs, as well as procurement training programs, on Federal government contracting and business development opportunities.

#### II. WOMEN'S BUSINESS CENTER PROGRAM

The Women's Business Center Program, established in 1988, provides long-term training and counseling to encourage small business ownership through nonprofit organizations. The competitive grant award programs is administered through the SBA Headquarters Office of Women's Business Ownership (OWBO) Grants Management Division, with oversight designated to the SBA District Office Technical Representative. The Women's Business Center program has been well received by the recipient users and the program has been a tremendous marketing and outreach tool for the SBA in recent years. The SBA estimated in Fiscal Year 2002, the Women's Business Center program had an approximate return of \$161 for every \$1 invested in the program.

The bill makes the Women's Business Centers a permanent grant program with renewal options, replacing the Pilot Sustainability Grants Program. The Pilot program sunsets in 2003.

Existing Women's Business Centers will be eligible to submit proposals every 3 years. The program improvements are modeled after the SBDC grant program and several provisions contained in the Sustainability Grant Program. Eligibility and evaluation criteria will be established that encourages existing productive Centers to continue to participate in the program.

The bill recognizes the Association of Women's Business Centers (AWBCs) and directs the SBA Office of Women's Business Ownership to partner with the Association in developing and administering the programs delivered through the Centers (modeled after the SBA's current partnership with the Association of Small Business Development Centers with regard to the Small Business Development Center program).

The bill directs the SBA to streamline the reporting requirements of the Centers recognizing the limited grant award and limited human resources within the Centers.

#### III. INTERAGENCY COMMITTEE ON WOMEN'S BUSINESS ENTERPRISE

The Interagency Committee on Women's Business Enterprise was created in 1977, as an interagency task force. By Executive Order 112138, in May 1979, the name was changed to the Interagency Council. In 1988,

the Women's Business Ownership Act (Public Law 100-533) replaced the Interagency Council with a joint public-private sector National Women's Business Council. The SBA Reauthorization and Amendment Act of 1997 (Public Law 103-403) revised the Council's structure, returning to all public-sector participants to comprise an expanded Interagency Committee on Women's Business Enterprise.

Under current law, there is no authorization for appropriations to support the activities on the Interagency Committee. Nor are there clear directives on the operations and interaction of the Federal agency and department representatives. The Federal agencies and departments represented on the Interagency Committee allocate existing personnel and resources to support participation on the Interagency Committee. The Interagency Committee is required to submit, through SBA, an annual report to the President and Congress, but there is no record of such annual reports being prepared or delivered for the past three years.

In addition, the President has not appointed a Chairperson to carry out the mission of the Interagency Committee, and therefore, it is inactive.

The bill will direct that the SBA Deputy Administrator temporarily fulfill the needs of the Interagency Committee Chair if vacant until the President makes an appointment. When the Interagency Committee is active and a Chair is in place, the SBA Office of Women's Business Ownership serves as Co-Chair. This action will provide for the continuity of activities and avoid the periods of time of inactivity.

The bill will direct the Interagency Committee to conduct three official meetings each year:

In October to plan upcoming fiscal year activities;

In February to track year-to-date agency contracting goals; and

In August to evaluate fiscal year progress and begin the report process.

The bill creates a Policy Advisory Group consisting of representatives from the SBA, the Department of Commerce, the Department of Labor, the Department of Defense, Association of Women's Business Centers, and two individuals and two organizations that are members of the National Women's Business Council. Creating the Policy Advisory Group will return the Interagency to a mix of public/private members to provide the energy and direction so badly needed to revive the intent of the Interagency Committee.

The bill will create three subcommittees:

Subcommittee on Manufacturing, Technology and Professional Services;

Subcommittee on Travel and International Trade; and

Subcommittee on Procurement and Federal Contracting.

These subcommittees will create the opportunity for smaller groups to work on specific issues. Each subcommittee will meet once a quarter and report their minutes to the National Women's Business Council, the SBA Office of Women's Business Ownership, and the SBA Contract Assistance for Women Business Ownership Office. In addition to the Policy Advisory Group members, all Federal departments and agencies may participate as well.

#### IV. NATIONAL WOMEN'S BUSINESS COUNCIL

The National Women's Business Council was created by the Women's Business Ownership Act of 1988 to serve as an advisory body because the Interagency Committee had been criticized for inactivity. By separating the Council from the Interagency Committee (1994 Act), the Council was able to focus on

its mission. The 1997 Reauthorization Act provided for improved reporting duties and Council appointments.

The 1988 Act required the Council to conduct studies on issues relating to women-owned businesses, including the award of Federal prime contracts to women-owned businesses and access to credit and investment capital by women entrepreneurs. In general, the National Women's Business Council's statutory mandate is broad and lacks an integration with other women's business ownership programs.

Although the Council has not received its authorized level of \$1 million in funding, it has been required to designate \$550,000 of its appropriated funding to research studies. The level of funding for Fiscal Year 2003 was \$750,000. The Administration has proposed a change in the amount that can be spent on research studies—from a set amount of dollars allocated to a 55 percentage of appropriated funds.

The bill supports full funding for the National Women's Business Council and full authority for the Chairperson to conduct the Council's activities. In addition, the bill establishes an allocation of appropriated funds for research.

The change will provide the opportunity for the Council to engage in activities, conferences and the development of programs and services, at the direction of the Chairperson, and be more pro-active in the years 2004 through 2006.

The bill creates three Sub-committees on the Council (which parallel the new subcommittees that the bill establishes for the Interagency Committee on Women's Business Enterprise):

Subcommittee on Manufacturing, Technology and Professional Services;

Subcommittee on Travel and International Trade; and

Subcommittee on Procurement and Federal Contracting.

These subcommittees will create the opportunity for smaller groups to work on specific issues and interact with the Interagency Committee on Women's Business Enterprise and the SBA Office of Women's Business Ownership. Recognizing that the membership of the Council includes very active business owners and leaders, rather than establish official meetings for the Committees, the participants may participate via conference calls or video conferencing.

The bill will provide the Council with cosponsorship authority. The SBA advised the Council in 2003 that the Council did not have sufficient authority to engage in cosponsored activities (such conferences, training activities, and materials). The inability to engage in cosponsored activities would seriously impede the works of the Council in the future. It is through cosponsored activities, partially funded by the private-sector or other government agencies, that the Council is able to conduct research as well as produce activities for women-owned small businesses.

The bill will clarify the membership representation. At present, there is a problem with the interpretation of Council membership as applied to an organization, business or individual. Clarification language is needed to allow an organization or business to change the names of individuals representing the organization or business on the Council without interruption.

The bill directs the Council to establish a repository, at the direction of the Chairperson, of information and research on women's entrepreneurship.

By Mr. GRASSLEY:

S. 1155. A bill to repeal section 801 of the Revenue Act of 1916; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, today I am introducing a bill to bring the United States into compliance with its obligations under the World Trade Organization.

The basic thrust of the bill is simple—it repeals section 801 of the Revenue Act of 1916 which the WTO Appellate Body found to be inconsistent with our responsibilities under Article VI of the GATT 1994 and the WTO Antidumping Agreement. Repealing section 801 will therefore bring the United States into conformity with its WTO obligations.

Section 801, which has been referred to as the Antidumping Act of 1916, allows private parties to sue importers of dumped imports in U.S. district courts, and also establishes criminal liability for importing dumped goods. While the provision is seldom used, there are several recent court cases pending in the United States where litigants have sued under the Antidumping Act of 1916.

I am introducing this legislation because I believe it is important that the United States comply with its WTO obligations. While we may not agree with each and every decision that comes out of the WTO, we should not pick and choose which decisions we will comply with. The bottom line is that the United States benefits greatly from a rules-based world trading system. We have had considerable success in bringing down foreign import barriers, and this has resulted in increased trade, economic growth, and more jobs right here in the United States. When we comply with adverse decisions we only strengthen our position in other cases where we challenge the impermissible import restraints of our trading partners, such as the *de facto* biotechnology moratorium adopted by the European Union, which continues to hurt farmers in Iowa and is now under challenge before the WTO. I want other countries to comply when we win, so I think it is important to comply when we lose.

I would also like to point out an important aspect of the bill I am introducing. The bill brings us into compliance with our WTO obligations, but it does not apply retroactively. I think retroactive application of repeal would be wrong in this case for a number of reasons.

First, the U.S. Supreme Court has held that under the constitutional due process standard, retroactive application of economic legislation is acceptable only where it is justified by a rational legislative purpose. To my knowledge, no one has yet articulated any reason, let alone a rational legislative purpose, for depriving litigants in U.S. courts of the opportunity for final adjudication of their disputes in this case. In fact, the Appellate Body Ruling itself does not call for a retroactive repeal of section 801 in order for the United States to conform to its WTO obligations. It seems to me that no rational legislative purpose is served by

retroactive repeal of section 801 when the Appellate Body Report does not ask for retroactive repeal and the Administration has not explained why retroactive repeal is necessary.

The Supreme Court has also held that the justification for prospective application of legislation may not suffice for retroactive application of the same legislation. The justification for repeal of section 801 is to conform to our WTO obligations; again, if WTO compliance does not call for retroactive repeal, then the justification for repealing section 801 should not extend to a retroactive repeal of this provision.

Second, the administration and Congress have consistently taken the position that retroactive repeal is not necessary to ensure compliance with our WTO obligations in all cases, particularly in cases dealing with U.S. trade remedy laws. The Joint Report of the Committee of Finance, Committee on Agriculture, Nutrition, and Forestry, Committee on Government Affairs of the U.S. Senate which accompanied the legislation implementing the Uruguay Round Agreements Act explicitly noted that compliance with WTO panels in trade remedy cases applied prospectively only. The Joint Report continued that prospective application "is consistent with the general principle in the GATT, and in the future WTO, that panel decisions do not have retroactive effect."

This principle is fully consistent with the text of the WTO agreement itself. Article 19.1 of the Dispute Settlement Understanding states only that "{w}here a panel or the Appellate Body concludes that a measure is inconsistent with a covered agreement, it shall recommend that the Member concerned bring the measure into conformity with that Agreement. In addition to its recommendations, the panel or Appellate Body may suggest ways in which the Member concerned could implement the recommendations." Thus, the text of the WTO calls only for "bringing the measure into conformity" and not retroactive application of an Appellate Body decision.

To my knowledge, this is the position which has consistently been taken by the U.S. Government and the WTO Appellate Body. In fact, with the exception of one aberrant decision by a panel in the case of Australian Automotive Leather, WTO panels and the Appellate Body have continued to adhere to the general principle that retroactive compliance measures are inappropriate.

The panel ruling in Australian Automotive Leather is instructive. The WTO Dispute Settlement Body adopted a panel report that recommended the Australian recipient of a subsidy pay back the entire amount of the \$30 million Australian dollar subsidy it had received. This recommendation went far beyond what the United States asked for. The United States sought only the return of the prospective value of the subsidy that the Aus-

tralian automotive leather company had received. The United States argued that repayment of the entire subsidy was inappropriate and ultimately settled the dispute with Australia in a deal that required the automotive leather company to pay back \$7.2 million Australian dollars to the Government of Australia, which reflected the prospective value of the subsidy. Thus, both U.S. law and U.S. trade policy conform to the general principle that compliance measures should be prospective in nature.

Finally, I believe that as a general matter, attempts at retroactive compliance with WTO rulings can make for bad trade policy. The intent of the rules-based trading system established under the WTO is to bring Members into compliance so that going forward international trade can be conducted on a level playing field. There is just no telling where efforts at retroactive compliance may lead. While in this instance the retroactive repeal of section 801 may seem clear-cut to some, it could set a dangerous precedent for future cases. Imagine if the WTO Appellate Body required or the U.S. Government advocated for retroactive application of a measure repealing the Extraterritorial Income Act/Foreign Sales Corporation tax regime. The result would be ludicrous.

Rather than foster the establishment of a level playing field, efforts at retroactive compliance may well distort markets to an extent even greater than the underlying measure that was found to be WTO inconsistent. We need to carefully consider whether retroactive repeal of a statutory provision is appropriate. I believe that considerations of judicial precedent, legislative intent, established practice under the GATT and the WTO, as well as good trade policy, all mitigate against the retroactive repeal of section 801.

I call upon my colleagues to support this bill repealing section 801. Passing the bill will bring us into compliance with our WTO obligations, demonstrate our continued commitment to the rules-based trading system, and strengthen our position in future cases where we prove successful in challenging impermissible import restraints erected by our trading partners.

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

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

S. 1155

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

**SECTION 1. REPEAL OF ANTIDUMPING PROVISION OF REVENUE ACT OF 1916.**

(a) REPEAL.—Section 801 of the Act entitled "An Act to increase the revenue, and for other purposes", approved September 8, 1916 (15 U.S.C. 72), is repealed.

(b) EFFECT OF REPEAL.—The repeal made by subsection (a) shall not affect any action under section 801 of the Act referred to in

subsection (a) that was commenced before the date of the enactment of this Act and is pending on such date.

By Mr. SPECTER:

S. 1156. A bill to amend title 38, United States Code, to improve and enhance the provision of long-term health care for veterans by the Department of Veterans Affairs, to enhance and improve authorities relating to the administration of personnel of the Department of Veterans Affairs, and for other purposes; to the Committee on Veterans' Affairs.

Mr. SPECTER. Mr. President, I have sought recognition to explain briefly the provisions of the "Department of Veterans Affairs Long-Term Care and Personnel Authorities Enhancement Act of 2003," a bill that I have introduced today.

Title I of the bill would extend through calendar year 2008 authorities that now specify that the Department of Veterans Affairs, VA, will provide to veterans enrolled for VA medical care outpatient-based long-term care services, such as Adult Day Health Care, Home Health Aide assistance, Non-Institutional Respite Care, and Home-based Primary Care. These services provide alternatives to institutional care and, in many cases, they obviate the need for institutional care by allowing veterans to remain in their own homes with care-giving assistance provided by VA.

In addition, this bill would lower, from 70 percent to 50 percent, the threshold level of service-connected disability that would qualify a veteran for highest-priority for institutional care should he or she need it. VA currently provides highest-priority access to hospital and outpatient clinic-based care to veterans who have suffered a service-connected disability rated by VA as 50 percent disabling or higher. Highest-priority access to inpatient-based long-term care services, however, is only granted by law to veterans who are 70 percent or more disabled, unless such care is needed specifically to treat a less-disabling service-connected disability. When this provision of law was enacted in 1999, Congress set the threshold for priority access to nursing home care at 70 percent, rather than at 50 percent, due primarily to concerns that a lower threshold—which was actively considered—might cause VA to be faced with an unforeseen level of demand that could not be met. Since then, however, VA has reported that "there was only a small increase in the numbers of veterans 70 percent service-connected or greater who were estimated to need nursing home care but who actually received that care from VA." In light of that, I see no compelling reason to continue distinguishing between nursing home care and all other types of care that are made available to 50 percent or higher service-connected veterans on a highest-priority basis. This bill would provide, in effect, that hospital care, outpatient clinic-based care, and nursing home

care will equally be made available to all such enrolled veterans.

Title I of the bill would also make technical changes to VA authority to contract for nursing home and adult day health care services by allowing VA to enter into agreements with providers under standards similar to those allowed by Medicare. According to VA, these changes will allow a greater number of smaller community-based providers to contract with VA by reducing the regulatory burdens placed upon them as a condition to contracting eligibility.

Title II of the bill authorizes major construction for long-term care facilities in Beckley, WV and Lebanon, PA. Each of these states has a substantial elderly population and each is need of expansion to their VA long-term care programs.

Title III of the bill would change current law to allow VA to more easily hire and retain certain clinical staff members. Under current law, VA hires many clinical professionals, such as physicians and nurses, under streamlined authorities set forth in title 38 of U.S. Code. But other key clinical professionals, such as clinical social workers, psychologists, and pharmacists, may only be hired through the standard "civil service" authorities specified in Title 5, U.S. Code. Further, members of such professions may only be paid and promoted in accordance with the standard civil service General Schedule, GS, pay scale. The process of hiring staff under these procedures is arduous and lengthy, consuming three months or more and placing VA at great competitive disadvantage in securing the services of best qualified candidates. This bill would convert many of these positions into "hybrid Title 38" status and permit VA greatly increased hiring and promotion flexibility, and compensation at special, locally-based, pay scales. Such clinicians, however, would retain their standard civil service grievance, vacation, and discipline protections.

Title III of the bill also contains provisions to correct a long-standing inequity relating to retirement benefits for certain part-time VA nurses; to expand a successful pilot program allowing for contract-physician disability compensation medical examinations; and to afford certain wage-grade canteen workers an opportunity to compete favorably for VA employment.

I urge my colleagues to support this legislation.

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

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

S. 1156

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

#### SECTION 1. SHORT TITLE.

This Act may be cited as the "Department of Veterans Affairs Long-Term Care and Per-

sonnel Authorities Enhancement Act of 2003".

#### TITLE I—EXTENSION AND ENHANCEMENT OF AUTHORITIES

##### SEC. 101. EXTENSION AND MODIFICATION OF CERTAIN HEALTH CARE AUTHORITIES.

(a) TREATMENT OF NONINSTITUTIONAL EXTENDED CARE SERVICES AS MEDICAL SERVICES.—Section 1701(a)(10)(A) of title 38, United States Code, is amended by striking "December 31, 2003" and inserting "December 31, 2008".

(b) REQUIRED NURSING HOME CARE.—(1) Subsection (a) of section 1710A of such title is amended by striking "70 percent" and inserting "50 percent".

(2) Subsection (c) of such section is amended by striking "December 31, 2003" and inserting "December 31, 2008".

##### SEC. 102. ENHANCED AGREEMENT AUTHORITY FOR PROVISION OF NURSING HOME CARE AND ADULT DAY HEALTH CARE IN NON-DEPARTMENT OF VETERANS AFFAIRS FACILITIES.

Section 1720 of title 38, United States Code, is amended—

(1) in subsection (c)—

(A) by designating the existing text as paragraph (2); and

(B) by inserting before paragraph (2), as so designated, the following new paragraph (1):

"(1) In furnishing nursing home care or adult day health care under this section, the Secretary may enter into agreements for furnishing such care utilizing such authorities relating to agreements for the provision of services under section 1866 of the Social Security Act (42 U.S.C. 1395cc) that the Secretary considers appropriate."; and

(2) in subsection (f)(1)(B), by inserting "or agreement" after "contract" each place it appears.

#### TITLE II—CONSTRUCTION AUTHORIZATION

##### SEC. 201. AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS.

The Secretary of Veterans Affairs may carry out the following major medical facility projects, with each project to be carried out in an amount not to exceed the amount specified for that project:

(1) Construction of a long-term care facility in Lebanon, Pennsylvania, \$14,500,000.

(2) Construction of a long-term care facility in Beckley, West Virginia, \$20,000,000.

##### SEC. 202. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated for the Secretary of Veterans Affairs for fiscal year 2004 for the Construction, Major Projects, account, a total of \$34,500,000 for the projects authorized in paragraphs (1) and (2) of section 201.

(b) LIMITATION.—The projects authorized in section 201 may only be carried out using—

(1) funds appropriated for fiscal year 2004 pursuant to the authorization of appropriations in subsection (a);

(2) funds appropriated for Construction, Major Projects, for a fiscal year before fiscal year 2004 that remain available for obligation; and

(3) funds appropriated for Construction, Major Projects, for fiscal year 2004 for a category of activity not specific to a project.

#### TITLE III—PERSONNEL

##### SEC. 301. MODIFICATION OF AUTHORITIES ON APPOINTMENTS OF PERSONNEL IN THE VETERANS HEALTH ADMINISTRATION.

(a) POSITIONS TREATABLE AS HYBRID STATUS POSITIONS.—Section 7401 of title 38, United States Code, is amended—

(1) in paragraph (2), by striking "Psychologists" and all that follows through "other scientific" and inserting "Other scientific"; and

(2) by striking paragraph (3) and inserting the following new paragraph (3):

“(3) Audiologists, speech pathologists, and audiologist-speech pathologists, biomedical engineers, certified or registered respiratory therapists, dietitians, licensed physical therapists, licensed practical or vocational nurses, medical instrument technicians, medical records administrators or specialists, medical records technicians, medical technologists, nuclear medicine technologists, occupational therapists, occupational therapy assistants, orthotist-prosthetists, pharmacists, pharmacy technicians, physical therapy assistants, prosthetic representatives, psychologists, diagnostic radiologic technicians, therapeutic radiologic technicians, social workers, and personnel in such other positions as the Secretary designates (subject to section 7403(f)(4) of this title) for purposes of this paragraph as necessary for the medical care of veterans.”.

(b) REPORT ON PROPOSAL TO DESIGNATE ADDITIONAL POSITIONS AS HYBRID STATUS POSITIONS.—Section 7403(f) of such title is amended by adding at the end the following new paragraph:

“(4) Not later than 45 days before the date on which the Secretary proposes to designate a position as a position necessary for the medical care of veterans for which appointment may be made under section 7401(3) of this title, the Secretary shall submit to the Committees on Veterans’ Affairs of the Senate and the House of Representatives a report on the proposed designation.”.

(c) TEMPORARY, PART-TIME, AND WITHOUT COMPENSATION APPOINTMENTS.—Section 7405 of such title is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking subparagraphs (B) and (C) and inserting the following new subparagraphs:

“(B) Positions listed in section 7401(3) of this title.

“(C) Librarians.”; and

(B) in paragraph (2), by striking subparagraph (B) and inserting the following new subparagraph (B):

“(B) Positions listed in section 7401(3) of this title.”; and

(2) in subsection (c)(1), by striking “section 7401(1)” and inserting “paragraphs (1) and (3) of section 7401”.

(d) AUTHORITY FOR ADDITIONAL PAY FOR CERTAIN HEALTH CARE PROFESSIONALS.—Section 7454(b)(1) of such title is amended by striking “certified or registered” and all that follows through “occupational therapists,” and inserting “individuals in positions listed in section 7401(3) of this title.”.

**SEC. 302. COVERAGE OF EMPLOYEES OF VETERANS’ CANTEEN SERVICE UNDER ADDITIONAL EMPLOYMENT LAWS.**

Section 7802(5) is amended by inserting before the semicolon the following: “. Employees and personnel under this clause may be considered for appointment in Department positions in the competitive service in the same manner that Department employees in the competitive service are considered for transfer to such positions. An employee or individual appointed as personnel under this clause who is appointed to a Department position under the authority of the preceding sentence shall be treated as having a career appointment in such position once such employee or individual meets the three-year requirement for career tenure (with any previous period of employment or appointment in the Service being counted toward satisfaction of such requirement)”.

**SEC. 303. EFFECTIVE DATE OF MODIFICATION OF TREATMENT FOR RETIREMENT ANNUITY PURPOSES OF CERTAIN PART-TIME SERVICE OF CERTAIN DEPARTMENT OF VETERANS AFFAIRS HEALTH-CARE PROFESSIONALS.**

(a) EFFECTIVE DATE.—The effective date of the amendment made by section 132 of the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (Public Law 107-135; 115 Stat. 2454) shall be as follows:

(1) January 23, 2002, in the case of health care professionals referred to in subsection (c) of section 7426 of title 38, United States Code (as so amended), who retire on or after that date.

(2) The date of the enactment of this Act, in the case of health care professionals referred to in such subsection (c) who retired before January 23, 2002, but after April 7, 1986.

(b) RECOMPUTATION OF ANNUITY.—The Office of Personnel Management shall recompute the annuity of each health-care professional described in the first sentence of subsection (c) of section 7426 of title 38, United States Code (as so amended), who retired before January 23, 2002, but after April 7, 1986, in order to take into account the amendment made by section 132 of the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001. Such recomputation shall be effective only with respect to annuities paid after the date of the enactment of this Act, and shall apply beginning the first day of the first month beginning after the date of the enactment of this Act.

**SEC. 304. PERMANENT AUTHORITY FOR USE OF CONTRACT PHYSICIANS FOR DISABILITY EXAMINATIONS.**

(a) PERMANENT AUTHORITY.—Section 504 of the Veterans’ Benefits Improvements Act of 1996 (Public Law 104-275; 110 Stat. 3341; 38 U.S.C. 5101 note) is amended—

(1) in subsection (a), by striking “may conduct a pilot program” and all that follows through “may be made by” and inserting “may carry out examinations with respect to the medical disability of applicants for benefits under the laws administered by the Secretary through”; and

(2) in subsection (c), by striking “the pilot program under”.

(b) REPEAL OF LIMITATION AND OBSOLETE AUTHORITY.—That section is further amended—

(1) by striking subsections (b) and (d); and

(2) by redesignating subsection (c), as amended by subsection (a) of this section, as subsection (b).

(c) CONFORMING AMENDMENT.—The heading for that section is amended to read as follows:

**“SEC. 504. AUTHORITY FOR USE OF CONTRACT PHYSICIANS FOR DISABILITY EXAMINATIONS.”.**

By Mr. BROWNBACK (for himself, Mr. DODD, Mr. STEVENS, Mr. AKAKA, Mr. ALLARD, Mr. ALLEN, Mr. BIDEN, Mrs. BOXER, Mr. CAMPBELL, Mr. CHAFEE, Mrs. CLINTON, Ms. COLLINS, Mr. CORNYN, Mr. CORZINE, Mr. DASCHLE, Mr. DEWINE, Mrs. DOLE, Mr. DURBIN, Mr. EDWARDS, Mr. FRIST, Mr. GRAHAM of Florida, Mr. GRAHAM of South Carolina, Mr. GRASSLEY, Mr. HOLLINGS, Mrs. HUTCHISON, Mr. JEFFORDS, Mr. KENNEDY, Mr. KERRY, Ms. LANDRIEU, Mr. LAUTENBERG, Mr. LEVIN, Mr. LIEBERMAN, Mrs. LINCOLN, Mr.

LOTT, Ms. MIKULSKI, Mr. MILLER, Mr. NELSON of Nebraska, Mr. NELSON of Florida, Mr. PRYOR, Mr. REID, Mr. SANTORUM, Mr. SCHUMER, Mr. SMITH, Ms. STABENOW, Mr. CRAIG, and Mr. LEAHY):

S. 1157. A bill to establish within the Smithsonian Institution the National Museum of African American History and Culture, and for other purposes; to the Committee on Rules and Administration.

Mr. BROWNBACK. Mr. President, over 200 years ago, there was a dream that was America for a group of individuals who were brought to our shores in shackles. A dream so powerful that compelled a race of people to fight for the liberty of others when they were in bondage themselves. A dream that not only served as a catalyst for physical liberation in the African-American community but removed societal shackles from our culture and enabled us to realize the ideals set before us in the constitution—that all men are created equal under God.

Today, we celebrate this magnificent history. A history of people’s quest for freedom that shaped this Nation into a symbol of freedom and democracy around the world. I am proud to stand here today with my colleagues and introduce once again to this body a bill that will create the National Museum of African American History and Culture.

I would specifically like to thank Senator DODD, who is committed to honoring this history and has worked hard to get us to this point today. I look forward to working with him on this bill.

I would also like to thank Senator TED STEVENS for his leadership and commitment to this project as well. It means a great deal to have his support and I am grateful.

Senator SANTORUM has always been a supporter of this legislation and has given unwavering enthusiasm to this project since the 107th Congress. I look forward to working with him as well to finally complete this museum.

And I am grateful to all of the original cosponsors of this bill—this is fantastic.

Mr. President, the national Museum of African American History and Culture Presidential Commission—signed into law by President Bush, stated that the time is now. Indeed the time is now to honor this incredible history that has shaped this great Nation.

I thank the Presidential Commission for their hard work and effort in recommending to Congress that we should build this museum and that there is sufficient interest in the philanthropic community to financially support this museum and that there are sufficient artifacts to fill this museum.

So many Americans will be able to share in the celebration of this museum—a uniquely American museum one that we can celebrate. I remember when I met with the dean of the Afro-

American studies at Howard University.

He told me of a story about his grandfather who finished a bowl the day the Emancipation Proclamation was authorized.

His grandfather decided to keep the bowl because it no longer was the property of a slave master but the man who made it—his grandfather.

Mr. President, the dean has this bowl in his home—an incredible piece of history and I am sure there are many more pieces out there waiting for a home—a national home.

Today, we are not just introducing a bill, we are completing a piece of American history by introducing the National Museum of African American History and Culture, which will create a museum to honor African-American contributions to this Nation—which is an extraordinary story of sacrifice and triumph.

This bill will create this museum within the Smithsonian Institution—America's premier museum complex. We have worked very hard with the Smithsonian Institution to craft a bill that will compliment their programs—and indeed we have done just that.

This bill is very similar to the American Indian Museum, slated to open next year. And I know that the Smithsonian Institution will create another national treasure one that tells the story of African-Americans in this country—a proud history, a rich history.

This bill charges the board of regents of the Smithsonian Institution along with the Council of the National Museum to plan, build and construct a museum dedicated to celebrating nationally African-American history—which is American history.

In addition, this bill charges the Board of Regents with choosing a site on or adjacent to the national mall for the location of the museum.

Additionally, the bill establishes an education and program liaison section designed to work with educational institutions and museums across the country in order to promote African-American history.

Finally, the bill sets forth a Federal-private partnership for funding the museum and authorizes \$17 million for the first year in order to begin implementation of the museum council, which will be comprised from a mixture of leading African-Americans from the museum, historical, and business communities.

Mr. President, it has been well over 70 years since the first commission was formed to seek ways to honor nationally the contributions of African-Americans.

It has always been my hope that this museum will not only showcase nationally the accomplishments of African-Americans—which are great—but will also serve as a catalyst for racial reconciliation for our Nation. Indeed we have triumphed over our difficulties in this area, but we must continue to do more.

I do not pretend that this museum is a panacea for racial reconciliation. It is, however, a productive step in recognizing the important contributions and the debt all Americans owe to African-Americans.

Dr. Martin Luther King, Jr. once expressed his desire for this Nation, "that the dark clouds of [misconceptions] will soon pass away and the deep fog of misunderstanding will be lifted from our fear-drenched communities and in some not too distant tomorrow the radiant stars of love and brotherhood will shine over our great nation with all their scintillating beauty." We are one step closer today—God bless.

Mr. President, I ask unanimous consent that the bill be printed in the RECORD after my remarks.

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

S. 1156

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "National Museum of African American History and Culture Act".

**SEC. 2. FINDINGS.**

Congress finds that—

(1) since its founding, the United States has grown into a symbol of democracy and freedom around the world, and the legacy of African Americans is rooted in the very fabric of the democracy and freedom of the United States;

(2) there exists no national museum within the Smithsonian Institution located on the National Mall that—

(A) is devoted to the documentation of African American life, art, history, and culture; and

(B) encompasses, on a national level—

(i) the period of slavery;

(ii) the era of reconstruction;

(iii) the Harlem renaissance;

(iv) the civil rights movement; and

(v) other periods associated with African American life, art, history, and culture; and

(3) a National Museum of African American History and Culture would be dedicated to the collection, preservation, research, and exhibition of African American historical and cultural material reflecting the breadth and depth of the experiences of individuals of African descent living in the United States.

**SEC. 3. DEFINITIONS.**

In this Act:

(1) **BOARD OF REGENTS.**—The term "Board of Regents" means the Board of Regents of the Smithsonian Institution.

(2) **COUNCIL.**—The term "Council" means the National Museum of African American History and Culture Council established by section 5.

(3) **MUSEUM.**—The term "Museum" means the National Museum of African American History and Culture established by section 4.

(4) **SECRETARY.**—The term "Secretary" means the Secretary of the Smithsonian Institution.

**SEC. 4. ESTABLISHMENT OF MUSEUM.**

(a) **ESTABLISHMENT.**—There is established within the Smithsonian Institution a museum to be known as the "National Museum of African American History and Culture".

(b) **PURPOSE.**—The purpose of the Museum shall be to provide for—

(1) the collection, study, and establishment of programs relating to African American

life, art, history, and culture that encompass—

(A) the period of slavery;

(B) the era of reconstruction;

(C) the Harlem renaissance;

(D) the civil rights movement; and

(E) other periods of the African American diaspora;

(2) the creation and maintenance of permanent and temporary exhibits documenting the history of slavery in America and African American life, art, history, and culture during the periods referred to in paragraph (1);

(3) the collection and study of artifacts and documents relating to African American life, art, history, and culture; and

(4) collaboration between the Museum and other museums, historically black colleges and universities, historical societies, educational institutions, and other organizations that promote the study or appreciation of African American life, art, history, or culture, including collaboration concerning—

(A) development of cooperative programs and exhibitions;

(B) identification, management, and care of collections; and

(C) training of museum professionals.

**SEC. 5. COUNCIL.**

(a) **ESTABLISHMENT.**—There is established within the Smithsonian Institution a council to be known as the "National Museum of African American History and Culture Council".

(b) **DUTIES.**—

(1) **IN GENERAL.**—The Council shall—

(A) make recommendations to the Board of Regents concerning the planning, design, and construction of the Museum;

(B) advise and assist the Board of Regents on all matters relating to the administration, operation, maintenance, and preservation of the Museum;

(C) recommend annual operating budgets for the Museum to the Board of Regents;

(D) report annually to the Board of Regents on the acquisition, disposition, and display of objects relating to African American life, art, history, and culture; and

(E) adopt bylaws for the operation of the Council.

(2) **PRINCIPAL RESPONSIBILITIES.**—The Council, subject to the general policies of the Board of Regents, shall have sole authority to—

(A) purchase, accept, borrow, and otherwise acquire artifacts and other property for addition to the collections of the Museum;

(B) loan, exchange, sell, and otherwise dispose of any part of the collections of the Museum, but only if the funds generated by that disposition are used for—

(i) additions to the collections of the Museum; or

(ii) programs carried out under section 7(a); and

(C) specify criteria with respect to the use of the collections and resources of the Museum, including policies on programming, education, exhibitions, and research with respect to—

(i) the life, art, history, and culture of African Americans;

(ii) the role of African Americans in the history of the United States from the period of slavery to the present; and

(iii) the contributions of African Americans to society.

(3) **OTHER RESPONSIBILITIES.**—The Council, subject to the general policies of the Board of Regents, shall have authority—

(A) to provide for preservation, restoration, and maintenance of the collections of the Museum; and

(B) to solicit, accept, use, and dispose of gifts, bequests, and devises of services and

property, both real and personal, for the purpose of aiding and facilitating the work of the Museum.

(c) COMPOSITION AND APPOINTMENT.—

(1) IN GENERAL.—The Council shall be composed of 19 voting members as provided under paragraph (2).

(2) VOTING MEMBERS.—The Council shall include the following voting members:

(A) The Secretary of the Smithsonian Institution.

(B) 1 member of the Board of Regents, appointed by the Board of Regents.

(C) 17 individuals appointed by the Board of Regents—

(i) taking into consideration individuals recommended by organizations and entities that are committed to the advancement of knowledge of African American life, art, history, and culture; and

(ii) taking into consideration individuals recommended by the other members of the Council.

(3) INITIAL APPOINTMENTS.—The Board of Regents shall make initial appointments to the Council under paragraph (2) not later than 180 days after the date of enactment of this Act.

(4) SPECIAL RULE FOR CERTAIN MEMBERS.—Of the total number of members of the Council appointed under subparagraph (C) of paragraph (2), not fewer than 9 shall be of African-American descent.

(d) TERMS.—

(1) IN GENERAL.—Except as provided in this subsection, each appointed member of the Council shall be appointed for a term of 6 years.

(2) INITIAL APPOINTEES.—As designated by the Board of Regents at the time of appointment, of the voting members first appointed under subparagraph (C) of subsection (c)(2)—

(A) 6 members shall be appointed for a term of 2 years;

(B) 6 members shall be appointed for a term of 4 years; and

(C) 5 members shall be appointed for a term of 6 years.

(3) REAPPOINTMENT.—A member of the Council may be reappointed, except that no individual may serve on the Council for a total of more than 2 terms.

(4) VACANCIES.—

(A) IN GENERAL.—A vacancy on the Council—

(i) shall not affect the powers of the Council; and

(ii) shall be filled in the same manner as the original appointment was made.

(B) TERM.—Any member of the Council appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed for the remainder of that term.

(e) COMPENSATION.—

(1) IN GENERAL.—Except as provided in paragraph (2), a member of the Council shall serve without pay.

(2) TRAVEL EXPENSES.—A member of the Council shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Council.

(f) CHAIRPERSON.—By a majority vote of its voting members, the Council shall elect a chairperson from its members.

(g) MEETINGS.—

(1) IN GENERAL.—The Council shall meet at the call of the chairperson or on the written request of a majority of the voting members of the Council, but not fewer than twice each year.

(2) INITIAL MEETINGS.—During the 1-year period beginning on the date of the first

meeting of the Council, the Council shall meet not fewer than 4 times for the purpose of carrying out the duties of the Council under this Act.

(h) QUORUM.—A majority of the voting members of the Council holding office shall constitute a quorum for the purpose of conducting business, but a lesser number may receive information on behalf of the Council.

(i) VOLUNTARY SERVICES.—Notwithstanding section 1342 of title 31, United States Code, the chairperson of the Council may accept for the Council voluntary services provided by a member of the Council.

**SEC. 6. DIRECTOR AND STAFF OF THE MUSEUM.**

(a) DIRECTOR.—

(1) IN GENERAL.—The Museum shall have a Director who shall be appointed by the Secretary, taking into consideration individuals recommended by the Council.

(2) DUTIES.—The Director shall manage the Museum subject to the policies of the Board of Regents.

(b) STAFF.—The Secretary may appoint 2 additional employees to serve under the Director, except that such additional employees may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

(c) PAY.—The employees appointed by the Secretary under subsection (b) may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates.

**SEC. 7. OFFICE OF EDUCATION AND LIAISON PROGRAMS.**

(a) IN GENERAL.—

(1) ESTABLISHMENT.—There is established within the Museum the Office of Education and Liaison Programs.

(2) FUNCTIONS.—The Office of Education and Liaison Programs shall—

(A) carry out educational programs relating to African American life, art, history, and culture, including—

(i) programs using digital, electronic, and interactive technologies; and

(ii) programs carried out in collaboration with elementary schools, secondary schools, and postsecondary schools; and

(B) consult with the Director of the Institute of Museum and Library Services concerning the grant and scholarship programs carried out under subsection (b).

(b) GRANT AND SCHOLARSHIP PROGRAMS.—

(1) IN GENERAL.—In consultation with the Council and the Office of Education and Liaison Programs, the Director of the Institute of Museum and Library Services shall establish—

(A) a grant program with the purpose of improving operations, care of collections, and development of professional management at African American museums;

(B) a grant program with the purpose of providing internship and fellowship opportunities at African American museums;

(C) a scholarship program with the purpose of assisting individuals who are pursuing careers or carrying out studies in the arts, humanities, and sciences in the study of African American life, art, history, and culture;

(D) in cooperation with other museums, historical societies, and educational institutions, a grant program with the purpose of promoting the understanding of modern-day practices of slavery throughout the world; and

(E) a grant program under which an African-American museum (including a non-profit education organization the primary mission of which is to promote the study of African-American diaspora) may use the funds provided under the grant to increase an endowment fund established by the mu-

seum (or organization) as of May 1, 2003, for the purposes of—

(i) enhancing educational programming; and

(ii) maintaining and operating traveling educational exhibits.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Director of the Institute of Museum and Library Services to carry out this subsection—

(A) \$15,000,000 for fiscal year 2004; and

(B) such sums as are necessary for each fiscal year thereafter.

**SEC. 8. BUILDING FOR THE NATIONAL MUSEUM OF AFRICAN AMERICAN HISTORY AND CULTURE.**

(a) IN GENERAL.—

(1) LOCATION.—

(A) IN GENERAL.—Not later than 18 months after the date of the enactment of this Act, the Board of Regents shall designate a site for the Museum.

(B) SITES FOR CONSIDERATION.—In designating a site under subparagraph (A), the Board of Regents shall select from among the following sites in the District of Columbia:

(i) The area bounded by Constitution Avenue, Pennsylvania Avenue, and 1st and 3rd Streets, Northwest.

(ii) The Arts and Industries Building of the Smithsonian Institution, located on the National Mall at 900 Jefferson Drive, Southwest, Washington, District of Columbia.

(iii) The area bounded by Constitution Avenue, Madison Drive, and 14th and 15th Streets, Northwest.

(iv) The site known as the "Liberty Loan site", located on 14th Street Southwest at the foot of the 14th Street Bridge.

(C) AVAILABILITY OF SITE.—

(i) IN GENERAL.—A site described in subparagraph (B) shall remain available until the date on which the Board of Regents designates a site for the Museum under subparagraph (A)(i).

(ii) TRANSFER TO SMITHSONIAN INSTITUTION.—Except with respect to a site described in clause (i) or (ii) of subparagraph (B), if the site designated for the Museum is in an area that is under the administrative jurisdiction of a Federal agency, as soon as practicable after the date on which the designation is made, the head of the Federal agency shall transfer to the Smithsonian Institution administrative jurisdiction over the area.

(D) CONSULTATION.—The Board of Regents shall carry out its duties under this paragraph in consultation with—

(i) the Chair of the National Capital Planning Commission;

(ii) the Chair of the Commission on Fine Arts;

(iii) the Chair and Vice Chair of the Presidential Commission referred to in section 10;

(iv) the Chair of the Building and Site Subcommittee of the Presidential Commission referred to in section 10; and

(v) the Chairman and Ranking Member of each of—

(I) the Committee on Rules and Administration of the Senate;

(II) the Committee on House Administration of the House of Representatives;

(III) the Committee on Transportation and Infrastructure of the House of Representatives;

(IV) the Committee on Appropriations of the House of Representatives; and

(V) the Committee on Appropriations of the Senate.

(2) CONSIDERATION.—The Board of Regents shall take into consideration the recommendations of the Council concerning the planning, design, and construction of the Museum.

(3) CONSTRUCTION OF BUILDING.—The Board of Regents, in consultation with the Council, may plan, design, and construct a building for the Museum, which shall be located at the site designated by the Board of Regents under this paragraph.

(b) COST SHARING.—The Board of Regents shall pay—

(1) 50 percent of the costs of carrying out this section from Federal funds; and

(2) 50 percent of the costs of carrying out this section from non-Federal sources.

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

#### SEC. 9. CONGRESSIONAL BUDGET ACT COMPLIANCE.

Authority under this Act to enter into contracts or to make payments shall be effective in any fiscal year only to the extent provided in advance in an appropriations Act, except as provided under section 11(b).

#### SEC. 10. CONSIDERATION OF RECOMMENDATIONS OF PRESIDENTIAL COMMISSION.

In carrying out their duties under this Act, the Council and the Board of Regents shall take into consideration the reports and plans submitted by the National Museum of African American History and Culture Plan for Action Presidential Commission under the National Museum of African American History and Culture Plan for Action Presidential Commission Act of 2001 (Public Law 107-106).

#### SEC. 11. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to the Smithsonian Institution to carry out this Act, other than sections 7(b) and 8—

(1) \$17,000,000 for fiscal year 2004; and

(2) such sums as are necessary for each fiscal year thereafter.

(b) AVAILABILITY.—Amounts made available under subsection (a) shall remain available until expended.

Mr. DODD. Mr. President, I rise to join with my colleague, Senator BROWNBACK, in introducing legislation to create a National Museum of African American History and Culture within the Smithsonian Institution.

This legislation will help ensure that the compelling stories and invaluable contributions of African-Americans to our national fabric will no longer be ignored, but shared with all Americans, indeed, all peoples of the world.

Senator BROWNBACK introduced similar legislation in the last Congress, and I was pleased to be an original cosponsor of that bill. During my tenure as chairman of the Senate Rules Committee, I was pleased to work with my colleagues to pass legislation to establish the Presidential Commission on the National Museum of African American History and Culture Action Plan.

That Presidential Commission spent a year traveling across the nation, and at more than 50 meetings, heard the voices of African-Americans calling for a national place to tell their individual and collective stories. This long overdue legislation will provide such a place.

In their report issued last month, the Presidential Commission identified a mission statement for the proposed museum that states, in part:

The museum will give voice to the centrality of the African American experience

and will make it possible for all people to understand the depth, complexity, and promise of the American experience.

It is that very goal of completing the American story of our quest for freedom and truth by publicly incorporating the experience and contributions of African Americans—that is the essence of this legislation. This museum offers the promise and hope that all Americans can come to understand the full story of how this nation was formed.

Since 1929, efforts have been made to recognize the contributions and unique history of Americans of African descent. This museum offers an historic opportunity to document, preserve, and educate this history for generations to come. It is past time that we publicly acknowledge and incorporate the African American experience into our collective identity and this museum will provide the appropriate means for accomplishing that goal.

In brief, within 18 months of enactment, the Smithsonian Board of Regents will choose a site for this museum from among four sites listed in the bill. The bill directs that, prior to the selection, the Board of Regents will consult with the National Capital Planning Commission, the chairman of the Presidential Commission, Congressional oversight committees, and others.

In the meantime, the Smithsonian Board of Regents will appoint a 19 member council, comprised of leaders within the African-American community and others, to advise the regents on the development, design and construction of the museum. The museum will include exhibits and programs relating to all aspects of African American life, art, history, and culture from the time of slavery through present day.

The museum will also provide leadership to other museums and will collaborate with historically black colleges and universities and educational organizations to ensure the integrity of the exhibits and programming and to broaden the reach of its story and mission.

I am honored to be the lead Democratic sponsor of this legislation, and I look forward to working with my colleagues on the Rules Committee to seeing this bill enacted this year.

By Mr. BINGAMAN (for himself,  
Mr. DASCHLE, Mrs. BOXER, and  
Mrs. LINCOLN):

S. 1159. A bill to provide for programs and activities to improve the health of Hispanic individuals, and for other purposes; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, today, I am introducing a bill with Senators DASCHLE, BOXER, and LINCOLN that will be jointly introduced by Representatives CIRO RODRIGUEZ, HILDA SOLIS, and others in the House of Representatives entitled the "Hispanic Health Improvement Act of 2003." This bill addresses the tremendous health

disparities that confront the Hispanic community in our Nation.

Even if you know the statistics, they remain shocking. Over one-third, a 35 percent of Hispanic adults lack health insurance. Despite that passage of the Children's Health Insurance Program, 27 percent of Latino children remain uninsured, which is sharp comparison to 9 percent of white, 18 percent of black and 17 percent of Asian/Pacific Islander children.

In testimony before the Senate Health, Education, Labor and Pensions Committee on September 23, 2002, on Hispanic health issues, Dr. Glenn Flores, chair of the Latin Consortium of the American Academy of Pediatrics Center for Child Health Research, added: "Among uninsured poor children in the U.S., Latinos outnumber all other racial/ethnic groups, including whites: there are 1 million poor, uninsured Latino children, compared with 766,000 white, and 533,000 African-American poor, uninsured children. Although 1999 marked the first time in many years that the proportion of uninsured Latino children actually decreased (from 30 percent to 27 percent), recent national data suggest that outreach efforts to enroll Latino children have largely been unsuccessful. A Kaiser Commission report found that only 26 percent of parents of eligible uninsured children said that they had ever talked to someone or received information about Medicaid enrollment, and 46 percent of Spanish-speaking parents were unsuccessful at enrolling their uninsured children in Medicaid because materials were unavailable in Spanish."

In order to address the lack of health care coverage, the legislation would expand CHIP to cover pregnant women and parents of children enrolled in CHIP. The legislation provides \$50 million in grants to community-based groups to improve outreach and enrollment of children in Medicaid and CHIP with the grants targeted to Hispanic communities.

In addition, the bill eliminates a number of enrollment barriers within Medicaid.

And finally, it provides States the option to enroll legal immigrant pregnant women and children in Medicaid or CHIP. This comes from legislation introduced by Senator GRAHAM earlier in this Congress.

In addition to poor coverage rates, according to the Centers for Disease Control and Prevention, or CDC, the Hispanic population has morbidity and mortality rates that more often than not exceed that of any other ethnic groups. For example, age-adjusted mortality rates for diabetes are over 50 percent higher among Hispanic persons than non-Hispanic whites. HIV infection rates are over 3 times those of non-Hispanic whites. Tuberculosis rates among Latino children are 13 times that of whites.

The legislation addresses these problems in a number of ways. In the area

of access and affordability, our bill requires an annual report to Congress on how federal programs are responding to improve the health status of Hispanic individuals with respect to diabetes, cancer, asthma, HIV infection, AIDS, substance abuse, and mental health. The bill provides \$100 million for targeted diabetes prevention, education, school-based programs, and screening activities in the Hispanic community.

In addition, the legislation specifically addresses the problems facing communities along the U.S.-Mexico border, a 2,000-mile stretch of land that contains 11 million people, 5 of the 7 poorest metropolitan statistical areas in the country, and disease rates in some areas that are extraordinary. If the region were a state, the border would rank 1st in the number of uninsured, last in terms of per capita income, and 1st in a number of diseases.

As Dr. Francisco Cigarroa, president of the University of Texas Health Sciences Center at San Antonio, noted in testimony at the hearing last year on Hispanic health, "Germs respect no INS regulations. We truly must work with our neighbors to the South if we are to avoid a major influx of new conditions and diseases. It can be seen so clearly on a map. Just as there are 'rivers of commerce' there are 'rivers of infectious disease' and though they may start at the Border, they are eventually seen all the way to the northern Border that we share with Canada."

In response, the bill provides \$200 million to border communities to improve health services and infrastructure along the U.S.-Mexico border.

The numbers I have cited thus far indicate what we do know. Almost as much of a concern is what we do not know with respect to the status of Hispanic health in this Nation. According to one study, only 22 percent of all articles published in major medical journals included non-English-speaking patients.

The bill provides funding to do additional research and work on reducing health disparities in this Nation. The various provisions include efforts to improve the recruitment and retention of Hispanic health professionals and programs that support training health professionals who can provide culturally competent and linguistically appropriate care. With respect to training more minority health professionals, Dr. Cigarroa said at last year's hearing, "We should do this because it is the smart thing to do. If we fail to take steps to address the gap between the health of the majority population and the health of the Nation's rapidly growing minority populations, we are on a court leading to a collision. We are far too great a nation to allow this to happen."

Representative CIRO RODRIGUEZ, chairman of the Congressional Hispanic Caucus, and I, have worked together on this legislation to respond to the challenge before us with regard to coverage, access, and health disparities

in the last Congress and have reintroduced the bill with the hope to move it forward this year.

Before closing, it should be noted that while the legislation puts forth a number of initiatives to address what are disproportionately Hispanic problems, each section of the bill, including those to reduce the number of uninsured and to improve access to care, would improve the overall health of our entire Nation regardless of race or ethnicity.

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

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

(The bill was not available at time of printing.)

#### SUBMITTED RESOLUTIONS

#### SENATE RESOLUTION 154—EX- PRESSING THE SUPPORT OF THE SENATE OF UNITED STATES EF- FORTS IN THE WORLD TRADE ORGANIZATION TO END THE UN- WARRANTED MORATORIUM IM- POSED BY THE EUROPEAN UNION ON THE APPROVAL OF AGRICULTURAL BIOTECHNOLOGY PRODUCTS

Mr. TALENT (for himself, Mrs. LINCOLN, Mr. BOND, Mr. LUGAR, Mr. BAUCUS, Mr. BUNNING, and Mr. ROBERTS) submitted the following resolution; which was considered and agreed to:

S. RES. 154

Whereas agricultural biotechnology is subject to the strictest Federal review in the United States, based on sound science, by the Department of Agriculture, the Environmental Protection Agency, and the Food and Drug Administration prior to planting and human consumption;

Whereas agricultural biotechnology has made considerable contributions to the protection of the environment by creating an environment more hospitable to wildlife and reducing the application of pesticides by 46,000,000 pounds in 2001 alone;

Whereas agricultural biotechnology holds tremendous promise for greatly increasing the world's supply of nutritious and wholesome foods which will improve the quality of life and health in the developing world;

Whereas there is objective and experience-based consensus in the international scientific community, including the National Academy of Sciences, the American Medical Association, the Royal Society of London, the French Academy of Medicine, the French Academy of Sciences, the Brazilian Academy of Sciences, the Chinese Academy of Sciences, the Indian National Science Academy, and the Mexican Academy of Science, that agricultural biotechnology is safe;

Whereas policy decisions regarding agricultural biotechnology in the European Union are being driven by politics and not by sound science;

Whereas since the late 1990s, the European Union has pursued policies that shelter its markets from competition by opposing the use of agricultural biotechnology;

Whereas agricultural biotechnology policies of the European Union have frustrated the development of modern scientific tools

and plant technology that could expand the production of indigenous food products by addressing problems related to local pests, weather conditions, and vitamin deficiencies;

Whereas since its implementation in October 1998, the moratorium has blocked more than \$300,000,000 annually in United States corn exports to countries in the European Union;

Whereas the European Union's unjustified moratorium on agricultural biotechnology approvals has ramifications far beyond the United States and Europe, forcing a slowdown in the adoption and acceptance of beneficial biotechnology to the detriment of farmers and consumers around the world, and especially to starving people in the developing world;

Whereas in the fall of 2002, famine-stricken African countries rejected healthy, wholesome, United States humanitarian offers of food aid because of ill-informed health and environmental concerns and fears that future exports to Europe would be jeopardized; and

Whereas the 5-year moratorium on the approval of new agricultural biotechnology products entering the European market is not science based, effectively prohibits most United States corn exports to Europe, violates European Union law, and clearly breaches the rules of the World Trade Organization: Now, therefore, be it

*Resolved*, That the Senate supports and applauds the efforts of the Administration on behalf of the Nation's farmers challenging the long-standing, unwarranted moratorium imposed by the European Union on the approval of agricultural biotechnology products and encourages the President to continue to press this issue at the G-8 Summit in Evian, France, on June 1 through 3, 2003.

#### SENATE RESOLUTION 155—PRO- TECTING SOCIAL SECURITY BENEFICIARIES FROM COLA CUTS

Mr. SPECTER (for himself, Ms. COLLINS, Mr. AKAKA, Mr. ALEXANDER, Mr. ALLARD, Mr. ALLEN, Mr. BAUCUS, Mr. BAYH, Mr. BENNETT, Mr. BIDEN, Mr. BINGAMAN, Mr. BOND, Mrs. BOXER, Mr. BREAUX, Mr. BROWNBACK, Mr. BUNNING, Mr. BURNS, Mr. BYRD, Mr. CAMPBELL, Ms. CANTWELL, Mr. CARPER, Mr. CHAFEE, Mr. CHAMBLISS, Mrs. CLINTON, Mr. COCHRAN, Mr. COLEMAN, Mr. CONRAD, Mr. CORNYN, Mr. CORZINE, Mr. CRAIG, Mr. CRAPO, Mr. DASCHLE, Mr. DAYTON, Mr. DEWINE, Mr. DODD, Mrs. DOLE, Mr. DOMENICI, Mr. DORGAN, Mr. DURBIN, Mr. EDWARDS, Mr. ENSIGN, Mr. ENZI, Mr. FEINGOLD, Mrs. FEINSTEIN, Mr. FITZGERALD, Mr. FRIST, Mr. GRAHAM of Florida, Mr. GRAHAM of South Carolina, Mr. GRASSLEY, Mr. GREGG, Mr. HAGEL, Mr. HARKIN, Mr. HATCH, Mr. HOLLINGS, Mrs. HUTCHISON, Mr. INHOFE, Mr. INOUE, Mr. JEFFORDS, Mr. JOHNSON, Mr. KENNEDY, Mr. KERRY, Mr. KOHL, Mr. KYL, Ms. LANDRIEU, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mr. LIEBERMAN, Mrs. LINCOLN, Mr. LOTT, Mr. LUGAR, Mr. MCCAIN, Mr. MCCONNELL, Ms. MIKULSKI, Mr. MILLER, Ms. MURKOWSKI, Mrs. MURRAY, Mr. NELSON of Florida, Mr. NELSON of Nebraska, Mr. NICKLES, Mr. PRYOR, Mr. REED, Mr. REID, Mr. ROBERTS, Mr. ROCKEFELLER, Mr. SANTORUM, Mr. SARBANES, Mr. SCHUMER, Mr. SESSIONS, Mr.