and the American Child'' is really a call to action. It shows so dramatically why this bill we are debating today is important, and why we must set partisan rhetoric aside to get this legislation passed and enacted.

NATIONAL MISSILE DEFENSE ACT

Mr. COCHRAN. Mr. President, on March 17, of this year the Senate passed S. 257, the National Missile Defense Act of 1999, by a vote of 97–3. Subsequently, the House adopted as H.R. 4 a different version of the legislation, and today the House has agreed to the substance of the Senate bill. No further action is required on the bill, and it now goes to the President for his signature.

After many years of debate, Congress has passed legislation stating the national policy to be that the United States will deploy a national missile defense as soon as technologically possible.

Section 2 of the bill notes that, like all discretionary programs, national missile defense is subject to the authorization and appropriation of funds.

Section 3 states that we support the continued reductions in Russian nuclear force levels. There is no linkage between Russian nuclear force levels, or any arms control agreement, and the national missile defense deployment policy of the bill.

I urge the President to sign this bill and put to rest the concerns of many that our country would continue its vulnerability to ballistic missile attack. With the signing of this bill, a new era of commitment to missile defense will begin.

TRADE

Mr. THOMAS. Mr. President, I rise today to address an issue of critical importance to the domestic lamb industry and to producers in my home state of Wyoming. In September 1998, a coalition of individuals from all segments of the U.S. lamb industry filed a Section 201 trade petition with the U.S. International Trade Commission under laws embedded in the Trade Act of 1974 and every trade act this nation has agreed to since that time.

Our domestic industry filed this trade case in response to the surging, record-setting levels of imported lamb meat from Australia and New Zealand. These individuals, although representing different sectors of the U.S. lamb industry, collectively signed onto this legal battle because each entity has witnessed a drastic impact from lamb imports—imports that increased nearly 50 percent between 1993 and 1997 and continue at an aggressive rate still today.

Under a Section 201 petition, the International Trade Commission is required to conduct an investigation to confirm or dispel the claims asserted within the trade case. Twice the Commissioners heard arguments from both the domestic industry and the importers. Twice the Commissioners rejected the importers arguments. In both instances, the Commissioners voted unanimously—during the injury phase in February and again in March, when they recommended that the President impose some form of trade relief. The Commission's report, and the industry's trade case, now await a final determination by President Clinton.

According to the Commission's report, wholesale imported lamb cuts consistently undercut the price of identical domestic cuts. Evidence of importers underselling domestically produced lamb was found in 79 percent of the product-to-product comparisons with margins of 20 percent to 40 percent. Other comparisons have found margin disparities reaching as high as 70 percent. It is evident that our domestic industry is suffering from the flood of cheap, imported lamb that has swamped the U.S. market and forced prices below break-even levels.

Time is of the essence in this matter as President Clinton has until June 4, 1999, to render his decision on what trade relief, if any, to implement. It is important to remember that under our own trade laws, the requirement of demonstrating that imports are threatening serious injury to the domestic industry has been met. As a result, I urge the President to impose strong, effective and temporary trade relief. More importantly, I urge the President to act on behalf of our producers by seriously considering the undisputed facts outlined in the Commission's report.

EMERGENCY MEDICAL SERVICES EFFICIENCY ACT

Mr. GRAMS. Mr. President, I rise today on behalf of all those who serve their fellow citizens through their active participation in the nation's emergency care system to make my remarks on the introduction of S. 9–1–1, the ''Emergency Medical Services Act of 1999.''

Mr. President, as a Senator who is deeply concerned about the every-expanding size and scope of the federal government, I've long believed Washington is too big, too clumsy and too removed to deal effectively with many of the issues in which it already meddles. However, I also believe there's an overriding public health interest in ensuring a viable and seamless EMS system across the country. By designating this week as national EMS Week, our nation recognizes those individuals who make the EMS system work.

There's no more appropriate time to reaffirm our commitment to EMS by addressing some of the problems the system is presented with daily.

I've often said that Congress has a tendency to wait until there's a crisis before it acts, but Congress cannot wait until there's a crisis in the EMS system before we take steps to improve it. There's simply too much at stake.

Whether we realize it or not, we all depend on and expect the constant readiness of emergency medical services. To ensure that readiness, we need to make efforts to secure the stability of the system. This has been my focus in drafting the EMSEA.

The most important thing we can do to maintain the vitality of the EMS system is to compel the government to reimburse for the services it says it will pay for under Medicare.

In the meetings I've had with ambulance providers, emergency medical technicians, emergency physicians, nurses, and other EMS-related personnel, their most common request is to base reimbursement on a ''prudent layperson'' standard, rather than the ultimate diagnosis reached in the emergency room.

While the Balanced Budget Act of 1997 [BBA] contained a provision basing reimbursement for emergency room services on the prudent layperson standard, I find it troubling HCFA refuses to include ambulance transportation in its regulations as a service covered by the patient protections enacted as part of Medicare Plus Choice. I also believe it is unacceptable that beneficiaries participating in fee-for-service are not granted the protections afforded to those in Medicare Plus Choice.

There has been a great debate in the Senate for the last year regarding protections for consumers against HMOs. Many of my colleagues would be startled to learn of the treatment many seniors have experienced at the hands of their own government through the Medicare fee-for-service program. The federal government would do better to lead by example rather than usurping powers from state insurance commissioners by imposing federal mandates on health insurance plans already governed by the states.

To illustrate how prevalent the problem of the federal government denying needed care to Medicare beneficiaries is, I want to share with you a case my staff worked on relating to Medicare reimbursement for ambulance services. I mentioned this case last year, but it is worth repeating. Please keep in mind that this is the fee-for-service Medicare program.

In 1994, Andrew Bernecker of Braham, Minnesota was mowing with a power scythe and tractor when he fell. The rotating blades of the scythe severely cut his upper arm. Mr. Bernecker tried to walk toward his home but was too faint from the blood loss, so he crawled the rest of the way. Afraid that his wife, who was 86 years old at the time, would panic—or worse, have a heart attack—he crawled to the pump and washed as much blood and

dirt off as he could. His wife saw him and immediately called 911 for an ambulance.

He was rushed to the hospital where Mr. Bernecker ultimately spent some time in the intensive care unit and had orthopedic surgery. A tragic story.

In response to the bills submitted to Medicare, the government sent this reply with respect to the ambulance billing: ''Medicare Regulations Provide that certain conditions must be met in order for ambulance services to be covered. Medicare pays for ambulance services only when the use of any other method of transportation would endanger your health.'' The government denied payment, claiming the ambulance wasn't medically necessary.

Apparently, Medicare believed the man's wife—who was, remember, 86 years old—should have been able to drive him to the hospital for treatment. Mr. and Mrs. Bernecker appealed, but were denied and began paying what they could afford each month for the ambulance bill.

After several years of paying $20 a month, the Berneckers finally paid off the ambulance bill. Medicare later reopened the case and reimbursed the Berneckers, but unfortunately, Mr. Bernecker is no longer with us.

I have a few more examples I'd like to share with my colleagues to assure them this is not an isolated incident. In fact, I encourage all of my colleagues to meet and speak with their EMS providers to see first-hand how the lack of consistent reimbursement policy impacts their ability to provide services. This one provision of the Emergency Medical Services Efficiency Act will bring fairness and clarity for both the beneficiary and the EMS provider trying to help those in need.

In Austin, Minnesota, a 66-year-old male was found in a shopping center parking lot slumped over the steering column of his car. The car was in drive, up against a light pole with the wheels spinning and the tread burning off the tires. An Austin policeman at the scene requested an ambulance and the driver was transported to the emergency room. Ambulance transportation reimbursement was denied based on the assumption that the driver could have used other means to get to the emergency room. Apparently, since he was already in the car, he was supposed to drive himself to the hospital despite being unresponsive.

Another case in Minnesota involved a 74-year-old male who was complaining to his family about an upset stomach when he collapsed. The frightened family began CPR and summoned an ambulance via 9–1–1. The city's fire department was the first on scene and applied an automatic external defibrillator, which advised against shock. Paramedics arrived and continued CPR en route to the emergency room. The patient ultimately died of cardiac arrest. Again, Medicare fee-for-service denied payment for the ambulance because it was deemed unnecessary.

Finally, Mr. President, a 74-year-old female complained of flu-like symptoms. Her family checked on her and found she was acting confused and strange. They summoned emergency medical services. Paramedics arrived to find the woman awake but confused as to time and events. They discovered she had a history of cardiac disease and diabetes. The paramedics tested her blood-sugar level and found it below 40. For those of you unfamiliar with diabetes, a blood sugar level below 70 is dangerous and could lead to seizure. But once again, Medicare denied payment.

Mr. President, I have a stack of actual run tickets from EMS providers in Minnesota, with names and other identifiers deleted, all demonstrating what a problem this is for Medicare beneficiaries and EMS providers. Again, I urge all of my colleagues to meet with their EMS providers and ask how these denials affect them.

Title II of the Emergency Medical Services Efficiency Act creates a Federal Commission on Emergency Medical Services which will make recommendations and provide input on how federal regulatory actions affect all types of EMS providers.

EMS needs a seat at the table when health care and other regulatory policy is made. Few things are more frustrating for ambulance services than trying to navigate and comply with the tangled mess of laws and regulations from the federal level on down, only to receive either a reimbursement that doesn't cover the costs of providing the service or a flat denial of payment.

Mr. President, I came across this chart two years ago which demonstrates how a Medicare claim moves from submittal to payment, denial, or write-off by the ambulance provider. Look at this chart and tell me how a rural ambulance provider who depends on volunteers has the manpower or expertise to navigate this mess. And, in the event it is navigated successfully, ambulance services are regularly reimbursed at a level that doesn't even cover their costs.

Mr. President, I have heard complaints from many individuals about the cost of ambulance care. In fact, some within this very body criticize ambulance providers for the high prices they charge for their services. While I do not doubt there are cases of abuse, I know for a fact an overwhelming majority of EMTs, Paramedics, Emergency Nurses and EMS providers are trying to provide the best possible care for their patients at a reasonable price.

Let's talk about how much it costs to run just one ambulance. There's the cost of the dispatcher who remains on the line to give pre-arrival assistance. The ambulance itself, which costs from $85,000 to $100,000. The radios, beepers, and cellular telephones used to communicate between the dispatcher, ambulance, and hospital. The supplies and equipment in the ambulance, including everything from defibrillators to bandages. The two Emergency Medical Technicians or Paramedics who both drive the ambulance and provide care to the patient. The vehicle repair, maintenance, and insurance costs. The liability insurance for the paramedics. And the list goes on.

Yes, the costs can be high, but it's clear to me that, with the uncertainty ambulance providers face out in the field each day, they need to be prepared for very type of injury or condition. Mr. President, that's expensive.

I'm convinced those who complain about the high costs of emergency care would be the first to complain if the ambulance that arrived to care for them in an emergency didn't have the life-saving equipment needed for treatment.

Let's be honest with ourselves: we want the quickest and best service when we face an emergency—and that costs money.

Mr. President, many of our political debates in Washington center around how to better prepare for the 21st century. I've always supported research and efforts to expand the limits of technology and continue to believe technological innovations and advances in biomedical and basic scientific research hold tremendous promise.

Under the new EMSEA, federal grant programs will be clarified to ensure EMS agencies are eligible for programs that relate to highway safety, rural development, and tele-health technology.

Emergency Medical Services have come a long way since the first ambulance services began in Cleveland and New York City during the 1860s.

Indeed, the scientific and technological advances have created a new practice of medicine in two short decades, and have dramatically improved the prospects of surviving serious trauma. There's reason to believe further advances will have equally meaningful results.

Innovations like tele-health technology may soon allow EMTs, nurses, and paramedics to perform more sophisticated procedures under a physician's supervision via real-time, ambulance-mounted monitors and cameras networked to emergency departments in specific service areas. By not considering EMS agencies for federal grant dollars, we may cause significant delays in the application of current technologies. That would be a mistake.

In August of 1996, the National Highway Traffic and Safety Administration and the Health Resources and Services Administration, Maternal and Child Health Bureau issued a report, ''Emergency Medical Services: Agenda for the Future.'' The report outlined specific

ways EMS can be improved, and one of the stated goals was the authorization of a ''lead federal agency.''

After consultation with those in the EMS field throughout the country, I believe the most appropriate action is to take our time and get it right by conducting a study to determine which current or new office would best coordinate federal EMS efforts.

Those are the major provisions of the legislation I introduce today.

Mr. President, in 1995, there were approximately 100 million visits to emergency departments across this nation. Roughly 20 percent of those visits started with a call for an ambulance. Each one of those calls is important, especially to those seeking assistance and to the responding EMS personnel. While EMS represents a small portion of health care spending overall, it is critically important. It serves as the access point for the sickest among us and it would be tragic for Congress to deny its role in improving the system.

Over the past several years, I've been privileged to get to know the men and women who dedicate their talents to serving others in an emergency.

The nation owes a great deal to the EMS personnel who have dedicated themselves to their profession because they care about people and want to help those who are suffering. Nobody gets rich as a professional paramedic, and there's no monetary compensation at all as a volunteer. The field of emergency medical services presents many challenges—but offers the reward of knowing you helped someone in need of assistance.

Every year, the American Ambulance Association recognizes EMS personnel across the country for their contributions to the profession, and bestows upon them the Stars of Life Award.

This year, 94 individuals have been chosen by their peers to be honored for demonstrating exceptional kindness and selflessness in performing their duties.

Mr. President, Minnesota suffered a tremendous loss this year. On January 14, while extricating a victim of an automobile accident, two EMTs were hit by a car. Brenda HagE, an EMT and Registered Nurse, was transported in traumatic arrest to a nearby hospital where she was pronounced dead. Ms. HagE is survived by her husband Darby and two children.

I ask that the Senate observe a moment of silence for Ms. HagE and all EMS personnel who have died in the line of duty.

Mr. President, I've talked with many professional EMTs, paramedics, and emergency nurses, and most tell me they wouldn't think of doing anything else for their chosen career. Similarly, volunteer EMS personnel tell me of the indescribable satisfaction they feel when they help those in their community get the care they need.

So, in honoring them during this National EMS Week, I can think of no better way to recognize their service than through legislation that will help them help others.

I ask my colleagues to support them by supporting S. 9–1–1, the ''Emergency Medical Services Act.''

Mr. President, I ask unanimous consent that the names of the 1999 American Ambulance Association Stars of Life honorees be printed in the RECORD.

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

1999 STARS OF LIFE

AZ—Theresa J. Pareja, Rural/Metro Fire Department;

AR—Rae Meyer, Rural/Metro Ambulance and John C. Warren, Columbia County Ambulance Service;

CA—Marti Aho-Fazio, American Medical Response—Sonoma Division, Dean B. Anderson, American Medical Response—Sonoma Division, Chris S. Babler, Rural/Metro Ambulance, Carlos Flores, American Medical Response, May Anne Godfrey-Jones, Hall Ambulance Service, Inc., Randy Kappe, American Medical Response, Frank Minitello, American Medical Response, and Penny Vest, Hall Ambulance Service, Inc.;

CO—Doug Jones, American Medical Response;

CT—Todd Beaton, American Medical Response, Michael Case, Hunter's Ambulance Service, and John M. Gopoian, Hunter's Ambulance Service;

FL—Clara DeSue, Rural/Metro Ambulance, Leroy Funderburk, American Medical Response—West Florida, Andrea Hays, Rural/Metro Ambulance, and Keith A. Lund, American Medical Response;

GA—Deborah Lighton, American Medical Response—Georgia and Kelly J. Potts, Mid Georgia Ambulance Service;

IL—Carolyn Gray, Consolidated Medical Transport, Inc., James Gray, Consolidated Medical Transport, Inc. and Cristen Miller MEDIC EMS;

IA—Paul Andorf, MEDIC EMS, Dennis L. Cosby, Lee County EMS Ambulance, Inc., and Danny Eversmeyer, Henry County Health Center EMS;

KS—Tom Collins, Metropolitan Ambulance Services Trust and Bill D. Witmer, American Medical Response;

LA—Pattie Desoto, Med Express Ambulance Service, Inc., Michael Noel, Priority Mobile Health, John Richard, Med Express Ambulance Service, Inc., Scott Saunier, Acadian Ambulance & Air Med Services, and Pete Thomas, Priority Mobile Health;

MD—Lily Puletti, Rural/Metro Ambulance and Michael Zeiler, Rural/Metro Ambulance;

MA—Daniel Doucette, Lyons Ambulance Service, Leonard Gallego, American Medical Response, Mark Lennon, Action Ambulance Service, Inc. and Edward McLaughlin, Lyons Ambulance Service;

MI—Steve Champagne, Huron Valley Ambulance, Edgar ''Butch'' R. Dusette Jr., Medstar Ambulance, Mary Elsen, Medstar Ambulance, Steven J. Frisbie, LifeCare Ambulance Service, Richard Landis, American Medical Response, Tony L. Sorensen, LIFE EMS, and Norma Weaver, Huron Valley Ambulance;

MN—Barbara Erickson, Life Link III and Jesse Simkins, Gold Cross Ambulance;

MS—Carlos J. Redmon, American Medical Response (South Mississippi);

MO—Michelle D. Endicott, Newton County Ambulance District and Lynette Lindholm, Metropolitan Ambulance Services Trust;

NH—David Deacon, Rockingham Regional Ambulance, Inc., Jason Preston, Rockingham Regional Ambulance Inc., Joseph Simone, Action Ambulance Service, Inc., Joanna Umenhoffer, Rockingham Regional Ambulance, Inc., and Roland Vaillancourt, Rockingham Regional Ambulance, Inc.;

NJ—Laurie Rovan, Med Alert Ambulance and Roberta Winters, Rural/Metro Corp.;

NM—LeeAnn J. Phillips, American Medical Response;

NY—Susan Bull, Rural/Metro Medical Services, Nicholas Cecci, Rural/Metro Medical Services Southern Tier, Daniel Connors, Rural/Metro Medical Services, Scott Crewell, Rural/Metro Medical Services—Intermountain, Frank D'Ambra, Rural/Metro Corp., Doug Einsfeld, American Medical Response—Long Island, Kevin Jones, Rural/Metro Medical Services—Intermountain, Patty Palmeri, Rural/Metro Corp., Carl Sharak, Rural/Metro, Samuel Stetter, Rural/Metro Medical Services Southern Tier, and Jean Zambrano, Rural/Metro Medical Services;

NC—Chris Murdock, Mecklenburg EMS Agency, Corinne Rust, Mecklenburg EMS Agency, and John Sepski, Mecklenburg EMS Agency;

OH—Duane J. Wolf, Stofcheck Ambulance Service, Inc. and Eric Wrask, Rural/Metro;

OR—Larry B. Hornaday, Metro West Ambulance, Tony D. Mooney, Pacific West Ambulance, and Mark C. Webster, American Medical Response—Oregon;

PA—Jerry Munley, Rural/Metro Medical Services;

SD—Travis H. Spier, Rural/Metro Medical Services—South Dakota;

TN—Brian C. Qualls, Rural/Metro and Rodney B. Ward, Rural/Metro—Memphis;

TX—Robert Moya, American Medical Response, Luis Salazar, Life Ambulance Service, and Mike Sebastian, Life Ambulance Service;

UT—Monica Masterson, Gold Cross Services and Robert Torgerson, Gold Cross Services;

VT—John G. Potter, Regional Ambulance Service, Inc.;

VA—Beverly Leigh, American Medical Response—Richmond;

WA—Jack N. Erickson, Olympic Ambulance, Gary D. McVay, American Medical Response—Washington, Aaron J. Schmidt, Olympic Ambulance Service, and Rand P. Whitney, Rural/Metro Ambulance.

MESSAGES FROM THE PRESIDENT

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

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

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

MESSAGES FROM THE HOUSE

At 6:09 p.m., a message from the House of Representatives, delivered by Mr. Hanrahan, one of its reading clerks, announced that the House has