

the Congress that is entrusted to reflect both the desires of our people and it was envisioned that it is this Congress that would be the most responsive to immediate public need.

But there has arisen in recent years both a frustration with the Congress and a tendency to rely upon other institutions. Patterns emerged in the fight against tobacco and the health care crisis that have come from citizens, aggrieved parties who have relied upon the Federal courts to redress their grievances. Indeed, the same pattern is now occurring with regard to the problems of gun violence and the inability of Congress to respond to the legitimate needs of controlling these dangerous weapons in their design and in their distribution, leading citizens to, once again, rely upon the Federal courts.

I rise today because there is now a third rising frustration with the American people that is leading them to the Federal courts rather than to the Federal Congress. I am addressing the problem of lead poisoning.

Victims of lead poisoning are suing corporations that have manufactured this paint before its residential use was banned in 1978, recognizing that lead today is the leading health hazard to children in many communities around America.

Despite all of our efforts in the last 20 years to ban lead paint to protect American children, there are still estimated to be 890,000 children in America who suffer from elevated levels of lead poisoning in their blood. This lead poisoning in America's children leads to physical impairment, mental impairment, and severe behavioral problems in children. In extreme cases, this leads to comas, mental retardation, brain damage, and even death.

In 1992, the Congress made a commitment to our children. It was our collective judgment we would mandate that States test every child under 2 years of age in America, using Medicaid, to determine the level of lead poison. This mandatory screening would limit the dangers of lead to children with the highest risk of exposure. We felt confident, because 75 percent of the highest risk children were already in Federal health care programs.

There was a recognition that these children were five times more likely than other children in America to be exposed to lead and to have these potential impairments because they lived in older housing and were less likely to have access to health care. The fact of the matter is that, despite 20 years of congressional good intentions and this mandatory program through Medicaid, children in America are not being protected. A recent GAO report indicates that two-thirds of children on Medicaid have never been tested for lead. Over 400,000 children with high lead in their blood are unidentified, and these children need our help.

Just like in the tobacco cases, and now with the gun cases, citizens are frustrated. The Congress expressed good intentions. It legislated. But there is no response. Indeed, citizens now are left with the thought of having nothing happen, or to pursue their grievances in the Federal courts. The Congress has not provided an answer. That is why Senator REED and I have introduced the Children's Lead Safe Act, S. 1120.

This legislation would ensure that every Federal program which serves children at risk in our country is testing them for lead. We are not asking. We are not hoping for the best. We are requiring an answer, and that every child in a Federal program today—Head Start and WIC—be involved; ensuring that we know whether or not these children have high lead levels; recognizing that every day that goes by and that every year of development of these children leaves them at risk for brain damage, developmental problems, or even death.

Our legislation requires that WIC and Head Start centers determine if a child has been tested. It guarantees that Medicaid contracts explicitly require health care providers to adhere to Federal rules for screening and treatment. It requires that States report to the Federal Government the number of children on Medicaid who have been tested. At long last, we will require the testing, ensure there is funding for the testing, and then finally know how many children are at risk and the nature of their risk.

This legislation will also ensure that States and Federal agencies have the resources. This is not a mandate without a financial alternative. Reimbursement to WIC and Head Start will be provided for screening costs; and, indeed, we go further and create a bonus program to reward States for every child screened above 65 percent of the Medicaid population. But, indeed, screening, reimbursement for screening, and mandatory screening is only part of what Senator REED and I would provide.

Finally, we will do this: expand Medicaid coverage to include treatment for lead poisoning. If we identify a child who has an elevated lead poisoning level, that child is given immediate treatment before brain damage, paralysis, or learning disabilities become permanent.

Second, we improve information on lead poisoning so parents who live in older housing in our older cities where the risk is greatest know how to identify the dangers, change the living environment, and deal with the problem. We encourage the CDC to develop information-sharing guidelines to health departments, drug test labs, and official health programs.

These are all part of a comprehensive program to fulfill the promise that this

Congress made 20 years ago to deal honestly with the problem of lead poison: Inform parents, give health care alternatives, assure that children in programs such as WIC and Head Start actually are given the screening that they know is necessary and that they deserve.

I hope the parents and advocacy groups which are now going to the Federal courts on the well-beaten path of tobacco advocates and gun control advocates before them can now have confidence that this Congress will not wait on the sidelines in frustration, recognizing that a program we implemented 20 years ago is not working; we are now demanding and providing the resources for a mandate that, indeed, can have meaning for the life of these children and for their parents.

I urge our colleagues to recognize the advantages of S. 1120. I hope Members join with Senator REED and me in offering this worthwhile and important program to deal with lead poison.

I yield the floor.

The PRESIDING OFFICER (Mr. GORTON). The Senator from Rhode Island.

Mr. REED. Mr. President, I am pleased today to join my colleague from New Jersey, Senator TORRICELLI, to discuss the issue of childhood lead poisoning and discuss the legislation we introduced.

Over the last 20 years, the United States has made significant progress in reducing lead exposure, particularly among our children. We have enacted bans on lead-based paint, lead solder in food cans, and the deleading of gasoline. As a result, blood lead levels in the United States have decreased by 80 percent. That is good news.

However, what is not good news is the fact that there are an estimated nearly 1 million preschoolers who have excessive lead in their blood, making lead poisoning one of the leading childhood environmental diseases, if not the most significant environmental disease that affects children today.

Today, lead-based paint in housing is the major source of this exposure to our children. It has been estimated that approximately half of America's housing stock, roughly 64 million units, contain some lead-based paint. Twenty million of these homes contain lead-based paint in a hazardous condition—paint which is peeling, cracked, or chipped.

Children typically get exposed to this, and young children particularly, while playing on floors that have minute particles of lead, from opening and closing windows, particularly old windows, because of the paint in the runners which crack when the window is opened or closed. Thousands of particles of lead are set off in the atmosphere, and children ingest these particles.

Children also ingest lead in backyards in older neighborhoods where

cars were worked on 20 years before but in the ground there are still significant quantities of lead.

This is particularly a problem in my home State of Rhode Island, because we have a rather old housing stock; 43.7 percent of our houses and homes were built before 1950 when lead paint was ubiquitous; it was used everywhere. HUD estimates that 80 percent of pre-1950 homes used lead paint. There are only five States that have a higher percentage of older homes—those built before 1950—than Rhode Island. In Rhode Island this is a significant problem.

Nationally we have found that 1 in 11 children has elevated blood levels. In Rhode Island it is one in five. Nationally this is still a problem. This is not just an issue that pertains to the Northeast or to some parts of the country. It cuts across every sector of this great Nation.

Another example from the Rhode Island experience: In 1998, 15,000 Rhode Island children entering kindergarten had their blood levels screened; 3,000 of these children had elevated lead in their blood systems. That is an unacceptable percentage. We would like to see zero elevated lead levels but certainly not 3,000 out of 15,000.

The impact is unfairly borne by minority children, low-income children. African American children are five times more likely than white children to contract lead poisoning. In Rhode Island, 14 percent of white children screened in 1998 had elevated lead levels, 36 percent of African American children, and 29 percent of Hispanic children. This is an environmental disease that is correlated highly with low income. Poor housing unduly affects minority children throughout the country.

We also know that exposure to lead leads to health problems for children. It also has a profound impact on their educational development, because lead will attack the central nervous system and upset cognitive functions. It is a pernicious disease which will lead to impairment of educational ability and intellectual ability.

One of the ironies of our program is that we spend very little relative to lead problems, but we are spending millions and millions and millions on special education. In fact, there is not one of my colleagues who has not heard his or her local school superintendent or the Governor say: We have to support special education; we have to reduce these costs. We can if we have a health care system that reacts and screens for lead in children.

These lead-affected children are more likely, because of educational complications, to drop out of school. In fact, it has been estimated that they are seven times more likely to drop out of school if they have elevated blood lead levels. We continue to pay for special education through dropouts,

through young people who do not have the skills to participate fully in our economy.

It is our responsibility to do something. As my colleague, Senator TORRICELLI, mentioned, we have in the past instructed all the Federal health care programs to screen children and to treat children, but we have not been able to measure up to the task we have given them. We have not been able to effectively screen all the children. Certainly we haven't been able to treat all these children.

We do have solutions: First, we have to make parents more aware, and also we have to insist upon comprehensive screening and treatment for children who are at risk.

In January 1999, the General Accounting Office reported that children in federally funded health care programs such as Medicaid, WIC programs, and the Health Centers Program are five times more likely to have elevated blood levels than children who are not in these programs. The report also found—this is substantiated by what Senator TORRICELLI said and underscores the need for action now—that despite longstanding Federal requirements over 20 years, two-thirds of the children in these programs, more than 400,000, have never been screened at all, even though it is our policy that they all should be screened—400,000 children.

Our legislation, the Children's Lead Safe Act, will ensure that all preschool children who are enrolled in Federal health care programs who are most at risk for lead poisoning are screened and receive appropriate followup care. We know that early detection of lead exposure is critical to the success and the health of that child.

We also know that unless you screen the child, you will not know if that child requires extensive follow-on care. If we do the screening, as for years we have said we must, we will go a long way toward taking the first step in reducing this problem, finding out who is exposed, and getting those children into appropriate care.

We want to ensure there are clear and consistent standards for the screening, that we don't have a hodgepodge of different standards, that we have a program that is sensitive to the latest scientific information.

In addition to comprehensive screening, we are also going to insist on clear and consistent standards that will be applied by every health care provider who is screening these children.

Another aspect of the legislation is to have a management system in place that follows these children.

As an aside, I had an interesting conversation just a few weeks ago with a physician from Los Angeles who is an expert in asthma, which is another environmental childhood disease of significance. He has created a special program with a mobile laboratory which

goes to each school. One of the key factors for the success of his program is that not only does he treat the child, but there is an elaborate information system to follow the course of that child. In fact, what he found is that without this elaborate followup, this information system that can monitor the results and the progress of children, initial treatment is seldom effective.

If we begin to insist upon comprehensive screening, as we have said we wanted for 20 years, if we go ahead and require that there be universal screening standards that are applied everywhere, if we have a system of information that will follow these children and ensure that they get the care, and ultimately we provide the resources for the care, we can go a long, long way to do what we have wanted to do for decades, to ensure that every child in America is not exposed to lead and, if they are, they are treated properly and effectively.

If we do these things, the payoff is going to be dramatic. We are going to have healthier children. We are going to have children who are more able and willing to learn. We will, I hope, reduce the dropout rate because, I remind my colleagues again, a child with elevated lead blood levels is seven times more likely to drop out.

In sum, we are going to be able to spare children from a disease which is entirely avoidable. That is why we are so enthusiastic about the legislation we are proposing. Both Senator TORRICELLI and I believe this is a sensible, efficient way to do what we all want to do. We also believe in the long run—and I know this is said about so much legislation, but this certainly must be the case—this will be saving not only the children but will be saving dollars in special education and in dropout prevention.

In many ways we are paying right now for a problem that not only could be addressed but effectively resolved. So I encourage all my colleagues to join us to ensure our legislation becomes law and that an unnecessary disease affecting children, the No. 1 environmental disease affecting children in this country, can be eradicated and will go the way of many other childhood diseases because we took action.

Mr. President, I yield the floor.

Ms. COLLINS addressed the Chair.

The PRESIDING OFFICER. Under the previous order, the Senator from Illinois is to be recognized.

Mr. DURBIN. Mr. President, I ask unanimous consent that order be changed and Senator COLLINS now be recognized for 10 minutes and I follow her with 10 minutes, Senator DORGAN will follow me, and we will see if there is any remaining time in morning business beyond that.

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

circumstances, the Senator from Maine is recognized.

Ms. COLLINS. Mr. President, I thank my colleague from Illinois for his courtesy.

(The remarks of Ms. COLLINS and Mr. DURBIN pertaining to the introduction of S. 1231 are located in today's RECORD under "Statements on Introduced Bills and Joint Resolutions.")

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, is there time remaining under Senator COLLINS' 10-minute allocation?

The PRESIDING OFFICER. There is no time.

Mr. DURBIN. I ask unanimous consent to be allocated 5 additional minutes, for a total of 15 minutes, and then Senator DORGAN for 10 minutes.

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

PATIENTS' BILL OF RIGHTS

Mr. DURBIN. Mr. President, it is interesting. Prior to my speech, the Senator from New Jersey and the Senator from Rhode Island talked about lead poisoning and public health. The Senator from Maine has discussed Medicare, and now I want to discuss the Patients' Bill of Rights. There have been three speeches in a row on health care. It sounds like a pretty important issue to me.

Frankly, for many Americans, it is the most important issue. But the sad reality is that the Senate spends a lot of time on speeches when it comes to health care and almost no time when it comes to debating legislation to make things better.

If you are watching this proceeding or are within the sound of my voice and you can say in the last year I had a problem in my family with health insurance coverage or I know someone in my family who did, do not believe you are in the minority. In fact, almost 50 percent of Americans say they have had problems with their managed care health insurance.

What kind of problems? Coverage. If there is a problem, a medical problem, will the managed care policy cover it with the care that is necessary, or do you have to go out and hire a lawyer?

On the question of emergency room access, if you belong to a managed care plan, they might tell you, incidentally, you are supposed to go to St. John's Hospital and not Memorial Medical Center and you find yourself in a predicament where Memorial Medical Center is closer to your home in an emergency situation, you better check your policy. You might have just done something, by going to the wrong hospital, in the view of that insurance company, that is going to cost you and your family some money. That should be changed.

Basically, an individual in a family situation who has a medical necessity,

a kid who has fallen down with a broken arm or something very serious should not have to fumble through the glove compartment to figure out which hospital to go to for emergency care. That is something we need to address.

The Patients' Bill of Rights proposed by the Democratic side is an attempt to try to address obvious inadequacies when it comes to health insurance and health care in America. I have given a couple of examples—coverage under a health insurance policy and the question of which emergency room you can use. There are many others.

For instance, most people believe when they sit down in the doctor's office, the doctor is being honest with them, the doctor is telling the truth, the doctor is giving his or her best medical judgment. In fact, that relationship and that conversation is really so honored in law, that in a courtroom it is considered a confidential relationship—the doctor-patient relationship. Yet, what has happened is there is another party in the room, although invisible. That other party is a bureaucrat from an insurance company. Many doctors, when they lean over the table and say, you know, I think this is what your son needs, or this is what your wife will need, are not giving you their best medical advice. They are telling you what the health insurance company will pay for and what it will not pay for.

One of the things we address in the Patients' Bill of Rights is ending this physician gag rule. Please, in America, allow doctors to practice medicine. Do not let clerks and insurance companies make crucial medical decisions.

The Illinois State Medical Society invited me several years ago to accompany a local doctor in Springfield, IL, to a hospital and spend a day making rounds. I was a little nervous about it because, frankly, I do not have any business in a hospital room unless I am being treated. But they invited me, and it turned out that most of the patients were happy to see a politician wandering around with their doctors.

But the thing that was an eye-opener at St. John's Hospital in Springfield was when the doctor I was accompanying decided he wanted to keep a patient in the hospital over the weekend. The lady was in her sixties. She had been diagnosed with a brain tumor that was causing her dizziness. She lived alone.

The doctor said: I'm afraid that if she went home over the weekend before the Monday surgery to remove the tumor, she might fall down and hurt herself. We would have to postpone the surgery. I want to keep her in the hospital so we can take care of her and watch her, and then on Monday perform the surgery.

I am a layman, but that sounded perfectly reasonable.

Before he could make that decision, though, he had to get on the phone and

call a clerk at an insurance company in Omaha, NE. You know what the clerk said? "No. Send her home. Tell her to come back Monday morning for the brain surgery."

This doctor could not believe it. He stood at this nurse's station, on that same floor, arguing with that clerk for half an hour. Finally, he slammed the phone down and said: I'm keeping this woman in the hospital. We'll appeal this later on.

What that doctor faced is repeated every day all across America where people who are sitting with these books of insurance regulations are making the decisions—the life-and-death decisions—that we count on when we take ourselves or our family in for medical care.

This has to come to an end. It has to change. We have to say, basically, that health insurance in this country is not going to be driven just by the bottom line in reducing costs, but by the top line of quality medical care; we are not going to take health care away from the professionals and give it to the insurance bureaucrats.

There is legislation pending before the Senate which engages this debate, which says this, the greatest deliberative body in America, is going to come down and debate, once and for all, how to make it right for American families. That bill is mired down in the process and cannot be brought to this floor. As a result, we stand before you today—and I know Senator DORGAN is going to address this as well—in frustration.

What is it we are doing here that is more important than making sure health insurance and health care in America is of the highest quality? We spent 5 days, 5 legislative days, debating the protection of computer companies. Well, it is an interesting challenge in terms of liability and their protection. Can't we spend 5 hours debating whether or not 150 million American families have health insurance protection? Isn't that worth our time and our debate?

Oh, there are differences of opinion here. I see things one way and some on the other side may see it another, but that is what the legislative process is about. Yet, we cannot seem to bring it to the floor so that we can have an honest debate to help America's families.

The other day I called on the Senate majority leader, the Republican leader, TRENT LOTT, to call up this bill before the Fourth of July. We have the bill out there. We know what the issues are. Let's have the debate. Yet, he was not sure he could. I hope he changes his mind. I hope those who were listening to this speech, and others, will decide that it is worth calling their Senators and their Congressmen and telling them: Yes, do something about health insurance.

Incidentally, in the case I mentioned earlier, where that insurance company