

There are some who say this is common sense; why is there any controversy? The resistance to some of this legislation has been fierce. The pharmaceutical industry has been running attack ads against my colleagues in the other body who have sponsored this legislation. Television ads, radio ads, and print ads can be intimidating. I am hopeful we can sit down at the table together.

I don't want to demonize or villainize the pharmaceutical industry. We are proud of the research and development that they do. We want them to continue doing that. We want them to continue to make a profit. This is not some sort of confiscatory plan. We want them to sit down in good faith. If not, we will proceed anyway. This issue has become too serious. It has to do with the health care integrity of our Nation.

I believe we can make progress with these two middle-of-the-road kind of bills, while at the same time working with the President who, to his great credit, has been talking about ways we can add Medicare prescription drug coverage to our health care system in this country. If we do that, we will have resolved one of the most severe problems our country faces this year.

We need to go on to broader range Medicare reforms. There are things that will have to happen with Social Security, as well. We all know that and hopefully we can reach some bipartisan resolution of those issues. In the meantime, every single day that goes by, there are South Dakota seniors and disabled individuals with high prescription drug bills, seniors from all over the country, who are skipping meals, who are not taking the drugs they should be taking, who are making terrible choices that the citizens of the world's richest democracy should not be compelled to make. It is just unconscionable that people are given these choices. We should not have to make those decisions. We should not have people showing up with acute illnesses in our emergency room where taxpayers then pick up the tab because they were not able to afford the prescription drugs they need.

There are a great many core issues we need to debate this year, from world trade issues to the scope and the nature of the Federal budget, to education and so on. However, I submit that among the very top tier of issues we need to resolve before this Congress goes home this fall, before it returns to more politics and campaigning, is to take up these two bills and to pass needed legislation to address the issue of prescription drug affordability.

I have no ego involved in the sponsorship here. We need to deal constructively now, this year, with the cost of prescription drugs, certainly for seniors, and hopefully for the entire American public. If we do that, this will have been a year well spent.

I yield the floor and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. KYL). Without objection, it is so ordered.

THE REACH INITIATIVE

Mr. BOND. Mr. President, I rise today to talk about one of the hot topics in the world of health care—health care access. Many people see this as the biggest problem in health care today.

Part of the problem, and the part that has received the most attention, is that too many Americans lack health insurance—about 44 million Americans are not covered by any type of health plan. But an equally serious part of the problem is many people's simple inability to get access to a health care provider. Even if they have insurance, a young couple with a sick child is out of luck if they cannot get in to see a pediatrician or another health care provider. And in too many urban and rural communities across the country, there just are not enough doctors to go around.

Several plans have been proposed recently on how to deal with the health care access problem. Senator Bradley has a plan. The Vice President has one. There's also a bipartisan proposal for tax credits to help people buy health insurance. All of these plans have at least three things in common:

First, they all address a worthwhile goal. I think we all want to see that people have access to good health care, even if we might disagree on how to get there.

Second, they are all very ambitious. Senator Bradley in fact is basically proposing to use close to the entire \$1 trillion surplus to provide people with health insurance.

The third thing these plans have in common—and perhaps the most important thing—is that it will be difficult or impossible for them to become law this year. Whether because of policy differences or political differences, it is just not likely that they will pass.

So last week, we launched a bipartisan effort—along with Senators HOLLINGS, COCHRAN, LINCOLN, HATCH, HUTCHINSON of Arkansas, I and other Senators—called the REACH Initiative, that does have a chance this year. There is no need to wait for an election, we can do it now.

Our proposal builds on the crucial work that organizations known as community health centers have been doing to ensure better access to health care. Health centers are private non-

profit clinics that provide primary care and preventive health care services in medically-underserved urban and rural communities across the country. Partially with the help of Federal grants, health centers provide basic care for about 11 million people every year, 4 million of whom are uninsured.

The goal of the REACH Initiative is simple—to make sure more people have access to health care. We plan to achieve this by doubling Federal funding for community health centers over a period of 5 years. We believe this will allow up to 10 million more women, children, and others in need to receive care at health centers. If we are successful with the REACH Initiative, we can practically double the number of uninsured and underinsured people cared for at health centers.

I am pleased that 12 colleagues—led by my good friend from South Carolina, Senator HOLLINGS—have joined me to introduce this resolution calling for doubled health center funding over 5 years.

The REACH Initiative basically recognizes the key contributions that community health centers have already made in addressing the health care access problems. But there is so much more that can still be one.

Now, out of all the ways we can address health care access problems, why are health centers a good solution and a worthwhile target for additional funding?

No. 1, they are building on an existing program that produces results. Too many health care proposals want to start practically from scratch, and make breathtakingly revolutionary changes. When I look at the health system and its admittedly huge problems, I sometimes think that might not be a bad idea. But it is also extremely risky. We need to remember that despite the many flaws in our health system, many people are pleased with it. We should be wary about making too radical changes that could interfere with what is right in our system. Instead, we can expand an existing part of the system that has been proven to provide cost-effective, high-quality care.

No. 2, health centers play a crucial role in health care, and are vastly underappreciated. It is amazing to me how few people know what community health centers are. After all, health centers care for close to one out of every 20 Americans, one out of every 12 rural residents, one out of every 6 low-income children, and one of every 5 babies born to low-income families.

No. 3, health centers truly target the health care access problem. By definition, health centers must be located in "medically underserved" communities—which simply means places where people have serious problems getting access to health care. So health centers attack the problem right at its

source. Unlike other health care proposals, the REACH Initiative does not create problems of "crowding out" private insurance by replacing private dollars spent on health insurance with Federal dollars. The health centers are partially funded by those patients who do have health insurance.

No. 4, they are relatively cheap. Health centers can provide primary and preventive care for one person for less than \$1 per day—about \$350 per year. That's just about the best value you will ever see in health care. Even better, health centers are able to leverage each grant dollar from the Federal Government into additional funding from other sources—meaning they can effectively turn one grant dollar into several dollars that can be used to address health care problems. With an extra billion dollars a year—the goal of the REACH Initiative in its fifth year—health centers could be caring for an additional 10 million people.

No. 5, this initiative is not a government takeover of health care. Admittedly, our plan calls for more government spending. This is of course true for most plans that try to deal with health access problems. But this new funding would not go to create a huge new bureaucracy. Instead, the REACH Initiative would invest additional funds into private organizations that have consistently proven themselves to be efficient, high-quality, and cost-effective health care providers.

To me, all of these reasons point to one logical conclusion—a need for drastically increased funding for health centers. Health centers are already helping millions of Americans get health care. But they can still help millions more—pregnant women, children, and anyone else who desperately needs care.

Simply put, we must reach the goal of the REACH initiative—doubled funding for health care centers within 5 years—and we can and should make it happen.

Let me close with what this means in human terms.

The REACH initiative will help make sure that a young woman who has just found out she is pregnant but does not have health insurance has a place to get prenatal care so she does not risk her health and the baby's health by waiting until late in the pregnancy.

The REACH initiative will help make sure that a 6-year-old boy who is living in a deep rural Missouri community, a community that otherwise would not have any health care providers at all, has a place to get regular checkups so he can stay healthy at home and in school.

The REACH initiative will help make sure a young couple without anyplace to go will be able to get their infant daughter immunized to protect her from a variety of dreaded diseases.

The REACH initiative will make sure Americans like Denise Hall, a Wash-

ington, DC, resident, and her children have a place to get needed care. Denise joined us for our announcement last week and talked about her reliance on health care centers. The REACH initiative will make sure she and her children have a place to get needed care. Denise, at our press conference kicking off the REACH initiative, said she is an out-of-work mother of two who is working to improve her job skills so she can rejoin the workforce. But for the moment, she and her children simply have nowhere to go for health care needs other than a local community health center.

These Americans, and millions like them, are the reasons why we must make the REACH initiative—doubled funding for community health centers—become a reality. I invite my colleagues to join me and 12 others who cosponsored this resolution, and 29 distinguished health care organizations, in support of the REACH initiative. If we work together, we can make a difference and serve those who are in the greatest need of access to health care and who, without community health centers, will not have that access.

I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. THOMAS. Mr. President, what is the current status of business?

The PRESIDING OFFICER. The Senator from Wyoming is notified that under the previous order, time until 2 p.m. is under the control of the Senator from Wyoming or his designee.

EXCESSIVE REGULATION BY THE CLINTON ADMINISTRATION

Mr. THOMAS. Mr. President, we have seen in the last several months, and I suspect we will continue to see from now until the end of this administration, a considerable effort to implement programs that bypass the Congress, programs that, indeed, bypass public input into those programs.

We have seen a great many Executive orders regarding regulations that have had limited, if any, public input. We have seen the use of the Antiquities Act and a number of other activities of this kind.

It is important that we remember the constitutional requirements of this Government, that there is a division within Government. That is what the legislative, executive, and judicial branches were designed to do, and they were purposely put in place to ensure that none of the three branches developed a domineering position and became a czar of the Government.

It is terribly important we take a look at this in Congress; that we ensure, to the extent we can, that this does not happen; that there is, indeed, as we move forward with various programs—whether they be regulatory, whether they be legislative—an opportunity for people to participate.

The current regulatory system encompasses more than 50 Federal agencies, more than 126,000 workers, and annual spending of more than \$14 billion in the area regulations.

From April 1, 1996, until March 31, 1999, Federal agencies issued nearly 13,000 final rules. Of these, 188 were major final rules that each carried an annual cost of more than \$100 million in our Nation's economy.

The paperwork burden of these Federal regulations is approaching \$190 billion annually. A recent study by the American Enterprise Institute concluded that all EPA rules promulgated between mid-1982 and mid-1996 under environmental statutes such as Superfund, the Clean Water Act, Toxic Substances Control Act, and the Federal Insecticide, Fungicide and Rodenticide Act, have had negative net benefits; that is, they hurt more than they helped.

When these regulations come into place, we hear that there is going to be a partnership, a partnership between the communities, a partnership between the State, a partnership with the Federal Government. Unfortunately, it has been our experience, particularly in the area of public lands, the partnership is a little one sided, a one-horse, one-dog arrangement, not an equal partnership.

One example is the clean water action plan, an Executive order establishing 111 key actions designed to improve the Nation's remaining water impairment problems. Everyone wants to do that. Imagine putting into place in one move 111 different regulatory actions, done without the NEPA process, without the process of input, without the process of having public discussion.

The administration has requested roughly \$2 billion annually since 1998 for implementation. It has been an interesting process, particularly with EPA and the Committee on Environment and Public Works, which is taking a strong look at this and, in one instance, declared this agency had gone beyond its statutory authority.

One of the difficulties is, first of all, the nonpoint source idea which was never authorized in the Clean Water Act. It was only point sources which were authorized.

What is happening now is they have moved toward an implementation of the plan that is designed more to control the land use than, in fact, to control nonpoint source water.

The Environmental Protection Agency structured the plan around data that the GAO, the Government auditing organization, has criticized. In 1999, GAO cautioned the methodology used in determining both impairment levels and impacts from nonpoint source was underfunded and, consequently, results were very possibly inaccurate.

Specifically, GAO highlighted concerns relating to how the agency identified waters polluted by nonpoint