Health, the Secretary of the United States Department of Health and Human Services, the President of the United States Senate, the Speaker of the House of Representatives, the members of the Michigan congressional delegation, and the President of the United States.

POM–415. A resolution adopted by the House of the General Assembly of the State of Indiana relative to reauthorization of the Ryan White CARE Act; to the Committee on Health, Education, Labor, and Pensions.

HOUSE RESOLUTION NO. 14

Whereas, In Indiana as of January 1, 2000, more than 10,000 cases of the expanding epidemic known as AIDS—Acquired Immune Deficiency Syndrome—have been reported;

Whereas, The state of Indiana created a division of HIV/STD within the state department of health to proactively address issues relating to HIV/AIDS and which now directly administers the expenditure of federal and state funds to combat the disease;

Whereas, Due to advancements in pharmaceutical therapies and an increasing focus on early intervention and treatment, the number of individuals living with HIV has grown significantly;

Whereas, For many, the progression from HIV to an AIDS diagnosis has slowed considerably as a result of these therapies;

Whereas, It is estimated that more than 6,000 residents of Indiana are currently living with HIV;

Whereas, It is estimated that an additional 1,300, or 21 percent, of Hoosiers with HIV are unaware of their condition, and hundreds more have been diagnosed with HIV but remain untreated;

Whereas, It is estimated by the Centers for Disease Control and Prevention that there are 40,000 new HIV infections in the United States each year;

Whereas, HIV/AIDS in Indiana disproportionately impacts communities of color, gay and bisexual men, women, and economically depressed and other underserved communities;

Whereas, In 1999, the rate of HIV disease among whites was 7 per 100,000, while the rate among Hispanics was 19.3 per 100,000, and the rate among African-Americans was 44 per 100,000;

Whereas, In 1999, the rate of HIV disease among white males was 13 per 1000,000, while the rate among Hispanic males was 29.9 per 100,000, and the rate among African-American males was 59.8 per 100,000;

Whereas, In 1999, the rate of HIV disease among white females was 1.3 per 100,000 while the rate among Hispanic females was 8.4 per 100,000, and the rate among African-American females was 29.8 per 100,000;

Whereas, The rate among African-American females more than doubled compared to the rate among white females from 1998 to 1999;

Whereas, As many as 16 percent of new HIV infections occur in people under age 25; one in eight HIV infections occurs in people under age 22;

Whereas, Young adults ages 20–29 represent 20 percent of reported AIDS cases but represent 38 percent of newer cases of HIV infection;

Whereas, Increasingly, some individuals have a dual diagnosis: these individuals have been diagnosed with HIV and have also been diagnosed with substances abuse or mental illness, or both;

Whereas, Substance abuse is a factor in well over 50 percent of HIV infections in some United States cities;

Whereas, Indiana looks to the federal government to assist the state in meeting the expanding health care and social service needs of people living with HIV;

Whereas, The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was first adopted by Congress in 1990;

Whereas, The Ryan White CARE Act expires September 30, 2000;

Whereas, Since its inception, the Ryan White CARE Act has ensured the delivery of vital medical care, treatment, and essential support services to thousands of Hoosiers, including medical examinations, laboratory procedures and evaluations, pharmaceuticals, dental care, case management, transportation, housing, legal assistance, benefits education and assistance, treatment education and adherence, and mental health counseling;

Whereas, In more recent years, the state has developed the Health Insurance Assistance Program (HIAP) using a portion of Ryan White CARE Act dollars to purchase comprehensive health insurance policies for hundreds of Hoosiers through the Indiana Comprehensive Health Insurance Association (ICHIA), Indiana's high risk insurance pool, at roughly one-half of the cost of providing medical and pharmaceutical services under the state's Early Intervention Program (EIP) and AIDS Drug Assistance Program (ADAP);

Whereas, Under federal law, the Ryan White CARE Act is designated as the provider of last resort; therefore, it is recognized as the critical safety net program for low income, uninsured or underinsured individuals;

Whereas, The federal budget for fiscal year 2000 contains increased funding for the Ryan White CARE Act and Indiana is expected to receive $7,813,713 beginning April 1, 2000;

Whereas, Funding under Title II of the Ray White CARE Act pays for care, treatment, and social services, over 80 percent of which are for life extending and life saving pharmaceuticals under the state's AIDS Drug Assistance Program (ADAP), and for comprehensive health insurance policies under the state's Health Insurance Assistance Program (HIAP);

Whereas, Title III of the Ryan White CARE Act provides funding to public and private nonprofit entities in Indiana for outpatient early intervention and primary care services;

Whereas, The goal of the Ryan White CARE Act Special Projects of National Significance (SPNS) Program (Part F) is to advance knowledge about the care and treatment of persons living with HIV/AIDS by providing time limited grants to assess models for delivering health and support services; SPNS projects have supported the development of innovative service models for HIV care to provide legal, health, and social services to communities of color, youth, hard to reach populations, and those with dual diagnoses in Indiana; and

Whereas, The Midwest AIDS Training and Education Centers (MATEC) is funded as part of Part F of the Ryan White CARE Act; in Indiana, MATEC trains clinical health care providers, provides consultation and technical assistance, and disseminates current information for the effective management of HIV disease: Therefore,

Be it resolved by the House of Representatives of the General Assembly of the State of Indiana:

Section 1. That the Indiana General Assembly affirms its support of the Ryan White CARE Act and urges the Congress of the United States to expeditiously reauthorize the Act in order to ensure that the expanding medical care and support service needs of the individuals living with HIV are met.

Section 2. That the Principal Clerk of the House of Representatives transmit copies of this resolution to the President and Vice President of the United States, the Senate Majority and Minority Leaders, the Speaker of the House of Representatives and the House Minority Leader, the Chairpersons and Ranking Minority Members of the Senate Health, Education, Labor and Pensions, Appropriations, and Budget Committees, the Chairpersons and Ranking Minority Members of the House Commerce, Appropriations, and Budget Committees, and to the members of the Indiana Congressional delegation.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first time and second time by unanimous consent, and referred as indicated:

By Mr. WARNER (for himself, Mr. LOTT, Mr. LEVIN, Mr. DASCHLE, Mr. HUTCHINSON, Mr. CLELAND, Mr. THURMOND, Mr. KENNEDY, Mr. INHOFE, Mr. SANTORUM, Ms. SNOWE, Mr. ROBERTS, Mr. ALLARD, Mrs. HUTCHISON, Mr. LIEBERMAN, Ms. LANDRIEU, Mr. REED, Mr. CRAPO, Mr. INOUYE, Mrs. LINCOLN, and Mr. KERRY):

S. 2087. A bill to amend title 10, United States Code, to improve access to benefits under the TRICARE program; to extend and improve certain demonstration programs under the Defense Health Program; and for other purposes; to the Committee on Armed Services.

By Mr. CLELAND:

S. 2088. A bill to amend the Clean Air Act and titles 23 and 49, United States Code, to provide for continued authorization of funding of transportation projects after a lapse in transportation conformity; to the Committee on Environment and Public Works.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. WARNER (for himself, Mr. LOTT, Mr. LEVIN, Mr. DASCHLE, Mr. HUTCHINSON, Mr. CLELAND, Mr. THURMOND, Mr. KENNEDY, Mr. INHOFE, Mr. SANTORUM, Ms. SNOWE, Mr. ROBERTS, Mr. ALLARD, Mrs. HUTCHISON, Mr. LIEBERMAN, Ms. LANDRIEU, Mr. REED, Mr. CRAPO, Mr. INOUYE, Mrs. LINCOLN, and Mr. KERRY):

S. 2087. A bill to amend title 10, United States Code, to improve access to benefits under the TRICARE program; to extend and improve certain demonstration programs under the Defense Health Program; and for other purposes; to the Committee on Armed Services.

THE MILITARY HEALTH CARE IMPROVEMENTS ACT OF 2000

Mr. WARNER. Mr. President, I am introducing this bill with the complete support and, indeed, the leadership of our distinguished majority leader, the Senator from Mississippi, Mr. LOTT.

The Senate will recall that Senator LOTT was one of the principal persons who enabled the pay and other benefits bill that was passed by the Senate, and indeed adopted by the President, to be introduced last year. He has exhibited leadership on this subject throughout. He is a former member of our committee, a very valued member. He has kept quite active on matters relating to not only personnel but the whole aspect of our national defense. I pay a special tribute to him and also to the

other members of our committee. Indeed, it is a bipartisan effort at this time in every respect to present to the Senate this piece of legislation.

I see the distinguished chairman of the Personnel Subcommittee of the Senate Armed Services Committee who will follow me in addressing this issue.

Mr. President, I will be chairing a committee meeting of the Armed Services Committee on the subjects of Kosovo and China, two very troublesome situations in the world today, so I am briefly going to make a few statements and then ask unanimous consent the remainder of my statement be printed in the RECORD.

I rise to introduce a very critical piece of legislation entitled ''The Military Medical Improvement Act of 2000.'' This legislation represents an important and much needed first step. I wish to carefully underline this is a first step. It is a beginning in addressing the many needed requirements to fulfill the commitments of the United States of America through the years—beginning in World War II—to the men and women who have proudly worn the uniform of our Armed Forces. It relates, of course, to the military medical care system, which serves not only those on active duty but their dependents and, indeed, those who have retired.

I am particularly privileged to have had the opportunity to serve with, and to continue to work on behalf of, the men and women of the Armed Forces for over a half century. I was privileged to have brief tours of active duty in World War II and Korea. Indeed, I myself was a beneficiary of this care system. I did not remain in service long enough to get the entitlements that come with retirement, but nevertheless I know firsthand the value and superb medical treatment that is offered to the men and women of the Armed Forces.

What we are trying to ensure is that the same treatment and care is spread throughout the system. A particular part of this legislation is to go beyond the President's request and includes laying a larger foundation, a larger beginning series of steps, for those in the retired community.

All of us, when we proudly raised our hand and took the oath of office as military persons, were given certain assurances that we would be cared for not only while on active duty but for those who went on in a career—a career, I stress—type of situation, that they would get that care along with their families for the balance of their lives. That is the important thing that I address today.

These men and women depend, at various times in our Nation's history, on the Congress. I repeat that—not necessarily criticism to the Commander in Chief, the President—it is not a political observation; it is simply a fact that the Congress, at various times in our history, has had to step forward on its own initiative to provide the fulfillment of the commitments that have been made to the men and women of the Armed Forces.

This is one of those instances. The President put forth in his package those measures which he believed began to address this problem. Now we come along, as a coequal branch of this Government, and lay before first the Senate and, indeed, the House will soon take it up similarly, our own proposals as to how to add to the President's package so as to, in particular, have a bigger foundation, a greater beginning, to care for those men and women of the Armed Forces, particularly in their period of retirement.

Mr. President, as I said, I rise today to introduce a very critical piece of legislation, the Military Medical Improvement Act of 2000. This legislation represents an important and much needed first step—a beginning—in addressing the many complaints and concerns with the military medical care system.

I am particularly privileged to have had the opportunity to serve with, and to continue to work on behalf of, the men and women of the armed forces for over a half century. These men and women depend, at various times in our Nation's history, on the Congress to keep the commitments that were made when they took the oath of office to serve their nation. In most cases our nation committed to provide health care—for life—for military members, their families, and retirees and their families.

Quality military health care has been a lifelong priority for me. I was dependent on the military health care system with brief tours as an active duty sailor and U.S. Marine, and later, responsible for its oversight as Secretary of the Navy. Today, I, along with the Majority Leader, Senator LOTT, Senators DASCHLE, LEVIN, as well as others, propose legislation to meet our commitment to the brave men and women who have so honorably served their country, through a full career and those now serving, by taking initial steps to fulfill the obligation to provide them with quality health care.

Last year, the Congress adopted significant enhancements to pay and benefits for our military members and their families. Already, we are seeing the positive impact of last year's legislative actions on recruiting and retention.

We must not stop there. Health care remains to be addressed and is a significant component of our military benefit package, as well as a commitment our Nation made to our service members and their families.

Meeting our health care promise to our service members and their families is not only a commitment and a moral obligation but it is also in our interest. Today it is a key factor in recruiting and retention. Delivery of quality health care and the assurance that the government meets its obligations are key factors in the morale and retention of our troops.

I would like to acknowledge the efforts of Secretary Cohen, Chairman Shelton, and the Joint Chiefs in highlighting the many problems in meeting the health care commitment to our military retirees and implementing a user-friendly medical program for all. The legislation I am introducing today includes the initiatives for active duty family members included in the President's budget request for fiscal year 2001. However, these initiatives do not go far enough. The President's request stops short in addressing any initiatives for our military retirees. Military retiree healthcare needs cannot wait longer.

I am well aware of the promises of lifetime health care made to those service members with whom I served. There is ample evidence that when young men and women joined the Armed Forces, they were promised health care for themselves and their families, for the rest of their lives in return for career commitments. Often this was in writing. Now, upon reaching age 65, they are finding that this commitment is often not fulfilled.

My desire is to return a sense of fairness to the military health care system by providing beneficiaries, including Medicare-eligible military retirees, access to health care. Under the current system, military retirees lose entitlement to military medical care at age 65 and must rely on Medicare for their healthcare needs.

In addition, base closure and realignment actions have had a significant impact on both active duty members and retirees by reducing the medical infrastructure of our Armed Forces. Our military's hospital network has decreased by approximately 30 percent since the mid-eighties, while the military beneficiary population has grown and aged.

Those who have so honorably served their country believed they could depend on health care provided by local base hospitals. The Department of Defense capacity has become limited. We must find other ways to meet our health care commitment.

For our active duty members and their families, implementation of TRICARE, the Department of Defense's managed care program, has created its own set of challenges for the Department of Defense. As General Shelton stated before the Senate Armed Services Committee on February 8, ''the program is not user friendly'' and ''we need to get it right and I know we will''.

The first section of the bill I am introducing today provides for health care delivery to the over-65, Medicare eligible retired military population. Over the past 2 years, Congress directed implementation of several demonstration programs, for over-65 military retirees, including Medicare subvention, the Federal Employee Health Benefits Program, and a Medicare insurance supplement or ''medi-gap'' type policy.

One of these programs is due to expire this year, some have just started, and other are due to start this spring. This legislation extends the demonstration programs to allow for continuity of care and assessment by the Department of Defense and the Congress to determine the most appropriate long term health care solutions for these beneficiaries.

In addition, the bill allows for the expansion of the ''Medicare subvention'' or TRICARE Senior Prime Program to major medical centers throughout the country, where the Department of Defense is reimbursed for care provided to Medicare eligible beneficiaries through agreement between the Secretary of Defense and Health Care Financing Administration. This authority will permit TRICARE Senior Prime to grow in these areas in which the program appears to be more promising.

Additionally, due to the low response to the Federal Employees Health Benefit Program demonstration so far, the Secretary of Defense will be authorized to expand the number of sites at which this option is offered. We want to allow a full and open evaluation of this program.

The second section of this bill recognizes and meets a major healthcare need or our older military retirees by providing a pharmacy benefit, which Medicare does not provide. The legislation expands the Department of Defense's mail order program to allow participation by all beneficiaries, including the over 65 population. Military retirees over the age of 65 would be asked to pay a modest deductible of $150 per year to participate in this new benefit. This responds to their urgent need for pharmaceuticals for our retirees—especially for those suffering from chronic long-term conditions such as diabetes and heart disease.

This bill recognizes the need to quickly implement improvements to the Department of Defense's managed care program, TRICARE, especially for active duty personnel and their family members. Chairman Shelton, and the Service Chiefs, have been extremely vocal in his desire to create equity in the TRICARE program for active duty personnel and their families. The Department has recognized that improvements in this area are crucial to recruiting and retention and have included two provisions in the President's budget request.

Those provisions which are incorporated in this bill, include expanding the TRICARE Prime Remote benefit to family members of those active duty personnel stationed in remote locations and elimination of co-pays for TRICARE Prime family member who use care outside of the military medical facilities.

Defense Authorization Acts over the past several years have included various legislative direction pertaining to improving access, availability and scheduling of appointments, claims filing and payment, and a single nationwide enrollment program. This bill reinforces the previous actions of the Congress and requires the Secretary of Defense to accelerate implementation of these improvements to the TRICARE program by October 2001.

In this time of decreasing resources, increasing costs and increasing demand for health care services, cooperation among the federal agencies is critical. The Department of Defense and the Department of Veterans Affairs have a long standing, cooperative, and productive relationship. This legislation authorizes additional initiatives between DOD and the VA in the area of patient safety, reducing medical errors and pharmaceutical safety.

Finally, much discussion has taken place about how to finance the military health care program over the long term. Specifically, the Joint Chiefs have suggested the accrual financing of military retiree health care might be the most appropriate option. This legislation directs the Department of Defense to conduct two studies to assess the feasibility and desirability of financing the military health care program for military retirees on an accrual basis.

Our men and women in uniform have answered the call of their country without hesitation or equivocation. Commitments were made to them in return for their service. We must fulfill those commitments. This legislation begins, I repeat begins, the process of satisfying the health care needs of all beneficiaries in a more comprehensive, uniform and fair manner. I urge my colleagues to support this legislation.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, I commend Chairman WARNER, the distinguished Senator from Virginia, for his outstanding leadership on this critically important issue. I am glad to join the majority leader, along with Chairman WARNER, and Senators LEVIN and CLELAND, in the introduction of this legislation.

Mr. WARNER. Mr. President, I thank my colleague.

I am confident we will have a majority of the Senate eventually as cosponsors on this legislation. Indeed, there are other Senators who may have ideas of their own, so we will work this piece of legislation. It may be passed as a freestanding bill. It may well be that this legislation will be incorporated in the annual authorization. That is a decision that the distinguished majority leader, myself, and others will make, together with the chairman of the Personnel Subcommittee in the course of the coming months.

I thank the Senator.

Mr. HUTCHINSON. It is, indeed, encouraging that this issue has been given such a high priority by the leadership of the Senate and that we have a bill—whether it passes freestanding or whether it is incorporated in the authorization bill—that is eminently doable this year. I think that is one of the hallmarks. There are others that have grander schemes of what can be done, but this is very achievable this year.

Mr. WARNER. Mr. President, will the Senator yield?

Mr. HUTCHINSON. Yes.

Mr. WARNER. I am not certain that the Senator mentioned Senator DASCHLE as a cosponsor.

Mr. HUTCHINSON. I think that underscores, once again, the bipartisan nature of this legislation. I appreciate the Senator pointing out that omission.

Like the rest of our country's health care system, the military health care delivery system is in great need of reform. Over the years, I have met with and heard from countless veterans, military retirees, and their families, who have informed me of the many and varied problems of every aspect of the military medical care system—including access to proper care, dissatisfaction with the current TriCare program, loss of coverage at age 65 when they become eligible for Medicare, and, especially, availability of needed pharmaceutical drugs.

Last month, in fact, I had the privilege of leading a congressional delegation overseas to visit U.S. service men and women serving in Japan and South Korea. The most common complaints I heard, aside from the high OPTEMPO that keeps families apart, were complaints about the military health care system and how it treats dependents. Too many had trouble scheduling appointments for dependents, and too many had trouble being reimbursed for the cost of care provided to their loved ones.

This is unacceptable. The men and women who choose to wear America's uniform have too many other important things to worry about than dependable health care for themselves and their families. Millions of Americans made the sacrifice to defend our country with the understanding that health care would be available to them upon retirement if they served at least 20 years. Unfortunately, for too many military retirees this commitment has simply not been honored.

Since the establishment of CHAMPUS, and its successor, TriCare, we have seen that the idea of space-available health care at military treatment facilities for military retirees is simply not adequate.

With base closures, military downsizing, and reduced services at military treatment facilities, it is nearly impossible for military retirees to access quality health care without having to travel hundreds of miles.

It should come as no surprise that problems with military medicine are often cited by troops as a key reason for leaving the force. In fact, a GAO study found that access to medical and dental care in retirement was the No. 5 career dissatisfier among active-duty officers in retention-critical specialties.

One of the critical challenges now is how best to reconfigure military health care delivery systems so that it might continue to meet its military readiness and peacetime obligations at a time when our base and force structure is continually changing.

Let me briefly give a summary of legislative provisions in the bill that we are introducing.

Section A deals with our over-65 retirees. It extends the demonstration programs that have been in place. It allows expansion of ''Medicare subvention,'' which is critically important as a funding stream for military retiree health care. It allows expansion of the Federal Employee Health Benefits Program Demonstration—a program that I believe will still work, though there have been too few enrolled in it. We need to adequately publicize it, adequately promote it, and allow it to be expanded. This bill does that.

It expands the National Mail Order Pharmacy Program to all beneficiaries, including Medicare-eligible beneficiaries, with only a $150 deductible. Addressing of the needs of retirees for pharmaceuticals is probably the most critical part of the entire bill and will provide great relief for our military retirees in the area of prescription drugs.

It directs modification to DOD's implementation of a legislatively directed pharmacy pilot program by reducing participation fees and alternative payment methods.

Section C deals with TriCare Prime. It makes improvements to the TriCare program, especially for active duty and their family members. It requires expansion of TriCare Prime Remote for active-duty family members of those members in remote locations. We hear many complaints from those who are serving in remote locations, and who are not near military hospitals, and this would allow expansion of that Prime Remote for those important service members.

It eliminates copays for TriCare Prime for active-duty family members, a very important provision. It directs improvement in business practices used in administering provision of health care services through the TriCare program to include access, availability, and scheduling of appointments; claims filing, processing, and payment; and national enrollment. It continues and caps previous provisions related to custodial care.

Section D provides for further collaboration between the DOD and the VA in the cooperative programs that exist in the areas of patient safety and pharmaceutical safety. All of these are critically important provisions, and there are other provisions that are going to help our military health care situation.

As we know, retirees especially have had problems with access to health care. These over-65 retirees and their families are seeing a critical problem develop. These beneficiaries believe—and rightly so—that a lifetime commitment was made and that lifetime commitment is not being honored. Service members thought they were assured free lifetime health care. This was promised by recruiters in recruiting materials as late as the 1990s. We must honor that promise to our retirees.

Our active-duty service men and women find that access to care is very often difficult. Young families find it especially difficult to navigate the often cumbersome process of getting their young children to the care they need. Implementation of the managed care program appears inconsistent across the country. Families don't know what to expect when they move to different regions of the country because administration of the program appears to be handled differently at different locations.

We must show these active-duty service men and women that we care. We can do that by the passage of this bill. I look forward to working with my colleagues on both sides of the aisle to see this legislation enacted. This is a very doable, very achievable first step in improving our military health care provision for our service men and women.

I thank the Chair for his willingness to serve a little extra today so I could make my comments regarding what I think is very important legislation.

I yield the floor.

Mr. CLELAND. Mr. President, I am pleased to introduce this military health care initiative—the Military Health Care Improvements Act of 2000.

I am here today because the military health care system saved my life.

Many distinguished members have preceded me in attempting to address this issue of ensuring that our military members and their families are properly cared for.

As I have stated many times—and devoted untold hours of thought, meetings, and considerations to—military health care is the issue for those who have served and for those who are serving, and especially those who will serve in the military.

From my first day in the Senate, I have considered no issue more important in the maintenance of our military forces than the military health care system. I have addressed this issue in prior legislation.

As I arrived in Washington, the Tricare system of military health care was taking hold in my State with poor performance I might add. Of course, much has been improved because of this body and the Congress as a whole responding to our constituents, and ensuring we live up to our obligations to our military members.

In any scholar's opinion, our Nation's rise as a national power has been dependent on our military power—military power is the enabler to economic power and well being of any country.

The underpinning to our military power has always been and always will be our military service members. In fact, Time magazine recently voted the American GI as the Person of the 20th Century.

We have obligations to these brave souls and their families who serve selflessly and proudly.

I believe that among many other quality of issues, the most important of these obligations is quality military health care. Service members serve with distinction, in places unknown, without question to orders, and without expectations. It is up to this Congress to act on legislation, and to provide the most comprehensive health care for those members—past, present, and future.

I urge my colleagues to support this bill with conviction. Why? Because it is more than the right thing to do—it must be done, if we are to fill the ranks of our services, and if we are to live up to the obligations of all those brave soldiers, sailors, marines, and airmen that have given their lives for this country so that we could enjoy this country's bounty.

Our legislation would cover several main health care issues for military personnel, their families, and military retirees, such as: expanding health care coverage for Medicare Eligible Retirees by extending the demonstration projects already underway to 2005, expanding the Tricare Senior Prime demonstration, and expanding the Federal Employees Health Care Benefits Program (FEHP), demonstration for Medicare eligibles, that is also currently underway; expanding the military pharmacy programs by expanding the national mail order pharmacy program to Medicare-eligible beneficiaries, reducing enrollment fees for the pharmacy pilot program and implementing deductibles and quarterly/monthly payment schedules; eliminating copays for Tricare Prime and expanding the Tricare remote program and improve Tricare business practices; and grandfather those participating the Department of Defense home health care demonstration program; and additionally, encourage the Department of Defense and Veterans Administration Cooperative Programs already underway to address patient safety and pharmaceutical safety, two key issues in health care today. Several other legislative initiatives have been introduced this year to address health care for the military—active duty and retirees.

In the coming weeks, the Personnel Subcommittee of the Senate Armed Services Committee, which Senator HUTCHINSON heads and of which I am pleased to be the ranking Democrat, will address each bill that comes to us on the subject of military health care reform in the hopes of finding the right combination of each of these bills to formulate the best final product for the committee's markup. I look forward to receiving testimony on each measure, and I look forward to working with Senator HUTCHINSON on these important health care initiatives. Since his appointment to the Senate Armed

Services Committee, I have truly enjoyed a wonderful working relationship with him, and I am sure that will continue. I appreciate his support and his interest in the issue of service men and women and their health care.

I have also been encouraged by the bipartisan support our measure has received, and I am happy to be working with the chairman of the Armed Services Committee, Chairman WARNER, Ranking Member LEVIN, Majority Leader LOTT, and Minority Leader DASCHLE on addressing this critical issue. This legislation continues our work on addressing health care for retirees and the active components. I am excited at the possibility of passage of this comprehensive legislation.

By Mr. CLELAND:

S. 2088. A bill to amend the Clean Air Act and titles 23 and 49, United States Code, to provide for continued authorization of funding of transportation projects after a lapse in transportation conformity; to the Committee on Environment and Public Works.

THE ROAD BACK TO CLEAN AIR ACT

• Mr. CLELAND. Mr. President, I am pleased to rise today to introduce the ''Road Back to Clean Air Act''. Georgia has one of the fastest growth rates in the nation, specifically in the Metropolitan Atlanta area. Although this growth is welcomed and encouraged as an economic boom for the region, two of the results created by this growth have been traffic congestion and air pollution. Unfortunately, as we embark into a new millennium with all of its great possibilities, what is most noted about Metro Atlanta is the severe transportation problems of the region. A recent survey found that Atlanta had the very worst traffic congestion of any Southern city, and Metro Atlanta drivers have the longest average vehicle miles traveled in the nation—an average of 34 miles per day. All of this costs our economy $1.5 billion a year in wasted time and fuel. And, this congestion has been accompanied by significant environmental problems.

To make matters even worse for the State and Metro Atlanta, the ability of the area to correct this problem is complicated and constrained for two reasons. First, Metro Atlanta is designated a ''serious'' non-attainment area under the Clean Air Act. Second, Metro Atlanta has been in a conformity lapse since January 17, 1998. Each of these designations restricts the ability of the Metro area to implement new transportation projects, thus hindering the economic growth and quality of life in the region.

In addition, in March of last year, the D.C. District Court of Appeals effectively ruled that Metro Atlanta's 61 ''grand-fathered'' transportation projects were illegal because they were not in conformity with clean air requirements, thus calling into question some $1 billion worth of such construction projects. Fortunately, on June 21, 1999, an out-of-court settlement was reached in Atlanta relating to a similar lawsuit filed by The Georgia Conservancy, the Sierra Club, and Georgians for Transportation Choices. These groups indicated that they did not file the suit to kill road projects, but rather to bring attention to the need for regional planning, air quality improvement, and transportation alternatives. The settlement allowed 17 of the 61 road projects to move forward while declaring the remaining 44 ineligible.

I must express my sincerest appreciation to Transportation Secretary Slater whose personal intervention and commitment made this settlement agreement possible. This was very positive news which has allowed Metro Atlanta to finally begin to move forward with its 17 approved projects and to redirect its surplus funds toward transportation alternatives which will help reduce traffic congestion and improve air quality. In fact, as a result of the settlement, Atlanta is soon expected to submit its Regional Transportation Plan (RTP) which not only embodies a new focus on more regional planning and transportation alternatives, but also includes most, if not all, of the grand-fathered projects which were halted. The difference here of course is that these grand-fathered projects are now incorporated into a more comprehensive long-range transportation plan which takes into account Atlanta's clean air problems. This is a win-win situation for Metro Atlanta.

However, this is a serious, serious problem and is in large measure a product of the very economic success which has made, year after year, Metro Atlanta one of the fastest growing areas of the country. Because the problem has been building over many years, the planners in Metro Atlanta understand that a solution will not occur overnight. However, Atlanta's experience has highlighted the need for providing local planners with additional flexibility during a conformity lapse. It is this experience that has led me to introduce the Road Back to Clean Air Act.

The purpose of the Road Back to Clean Air Act is to assist metropolitan areas, such as Atlanta, which are facing severe transportation problems that are complicated by time-consuming, inflexible constraints.

First, the Road Back to Clean Air Act codifies the Environmental Protection Agency (EPA) and U.S. Department of Transportation (DOT) guidance put forward as a result of the D.C. District Court decision. The Atlanta situation has demonstrated that these guidelines can allow transportation projects to move forward while ensuring that local residents are protected from the negative health effects of dirty air.

Second, the bill provides local planners with additional flexibility to obtain federal funding for beneficial transportation projects during a conformity lapse. Among other projects which could move forward during such a lapse would be public transit and high occupancy vehicle lanes.

The main benefit of this legislation is that it provides transportation planners in cities across the country with additional flexibility in meeting their transportation goals while preserving the health benefits of clean air. Additionally, it has the endorsement of numerous environmental groups, including the plaintiffs in the D.C. District Court case. Therefore, costly litigation that can only delay Atlanta's, and other areas, good faith efforts to alleviate traffic congestion and improve air quality will be avoided should this legislation be enacted into law.

Beyond Atlanta, other metropolitan areas in the United States are currently or will in the future face the constraints of non-conformity and non-attainment as they attempt to develop and implement their transportation plans. I believe the Road Back to Clean Air Act will provide these cities with the flexibility to move forward with vital transportation projects while at the same time maintaining the integrity of the Clean Air Act.

I thank my colleagues for their attention and I urge your co-sponsorship of this important legislation.•

ADDITIONAL COSPONSORS

S. 279

At the request of Mr. MACK, his name was added as a cosponsor of S. 279, a bill to amend title II of the Social Security Act to eliminate the earnings test for individuals who have attained retirement age.

S. 353

At the request of Mr. GRASSLEY, the name of the Senator from North Carolina (Mr. HELMS) was added as a cosponsor of S. 353, a bill to provide for class action reform, and for other purposes.

S. 424

At the request of Mr. COVERDELL, the names of the Senator from Utah (Mr. HATCH) and the Senator from Mississippi (Mr. LOTT) were added as cosponsors of S. 424, a bill to preserve and protect the free choice of individuals and employees to form, join, or assist labor organizations, or to refrain from such activities.

S. 512

At the request of Mr. GORTON, the name of the Senator from South Dakota (Mr. DASCHLE) was added as a cosponsor of S. 512, a bill to amend the Public Health Service Act to provide for the expansion, intensification, and coordination of the activities of the Department of Health and Human Services with respect to research on autism.

S. 542

At the request of Mr. ABRAHAM, the names of the Senator from Virginia (Mr. WARNER) and the Senator from Minnesota (Mr. GRAMS) were added as cosponsors of S. 542, a bill to amend the Internal Revenue Code of 1986 to expand the deduction for computer donations to schools and allow a tax credit for donated computers.