just pure malarkey. This is just another smokescreen.

Circuit judges. They say: Well, it's a circuit court. There's an election coming up. We might win it, so we want to save that position so we can get one of our Republican friends in there.

Well, again, in 1992, circuit nominees, we had nine: six were acted on in July and August, two in September, and one in October. Yet in the year 2000, we had one acted on this summer, and we are in the closing days of October. No action.

So, again, it is not fair. It is not right. It is not becoming of the dignity and the constitutional role of the Senate to advise and consent on these judges.

Thirty-three women out of 148 circuit judges; 22 percent—I guess my friends on the other side think that is fine. I do not think it is fine.

Again, everything has been done. All of the paperwork has been in, and here she sits.

UNANIMOUS CONSENT REQUEST—NOMINATION OF BONNIE CAMPBELL

Mr. HARKIN. Mr. President, I will now—and I will every day—ask unanimous consent to discharge the Judiciary Committee on further consideration of the nomination of Bonnie Campbell, the nominee for the Eighth Circuit Court, and that her nomination be considered by the Senate immediately following the conclusion of action on the pending matter, and that the debate on the nomination be limited to 2 hours, equally divided, and that a vote on her nomination occur immediately following the use or yielding back of that time.

The PRESIDING OFFICER. Is there objection?

Mr. FRIST. Mr. President, I object on behalf of the leader.

The PRESIDING OFFICER. Objection is heard.

Mr. HARKIN. I wish I knew why people are objecting. Why are they objecting to Bonnie Campbell? Why are they objecting to a debate on the Senate floor? Why are they objecting to bringing her name out so that we can have a discussion and a vote on it?

I want to make clear for the Record, it is not anyone other than the Republican majority holding up this nominee. Every day we are here—I know there will be an objection—I am going to ask unanimous consent because I want the Record to show clearly what is happening here and who is holding up this nominee who is fully qualified to be on the circuit court for the Eighth Circuit.

Now I want to turn my comments to something the Senator from Minnesota was talking about; that is, the prescription drug program from the debate last night. Quite frankly, I was pretty surprised to hear Governor Bush talking about his prescription drug program. He calls it an ''immediate helping hand,'' and there is a TV ad being waged across the country to deceive and frighten seniors. He talks about ''Mediscare''; that was Bush's comment last night. He accused the Vice President of engaging in ''Mediscare,'' scaring the elderly.

If the Bush proposal for prescription drugs were to ever go into effect, seniors ought to be scared because what it would mean would be the unraveling of Medicare, letting Medicare wither on the vine.

Let's take a look at the Bush proposal. We know it is a two-stage proposal. First, it would be turned over to the States. It would require all 50 States to pass enabling or modifying legislation. Only 16 States have any kind of drug benefit for seniors. Each State would have a different approach.

The point is, many State legislatures don't meet but every 2 years. Even if we were to enact the program, there are some State legislatures that wouldn't get to it for a couple years.

Our most recent experience with something such as this is the CHIP program, the State Children's Health Insurance Program, which Congress passed in 1997. It took Governor Bush's home State of Texas over 2 years to implement the CHIP program. It is not immediate.

He calls it ''immediate helping hand.'' It won't be immediate because States will have a hard time implementing it. In fact, the National Governors' Association says they don't want to do it. This is the National Governors' Association:

> If Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states.

That is exactly what Bush's 4-year program does. Beyond that, his plan only covers low-income seniors. Many of the seniors I have met and talked with wouldn't qualify for Bush's plan.

A recent analysis shows that the Bush plan would only cover 625,000 seniors, less than 5 percent of those who need help. His plan is not Medicare; it is welfare. What the seniors of this country want is Medicare, not welfare. Seniors would likely have to apply to a State welfare office. They would have to show what their income is. If they make over $14,600 a year, they are out. They get nothing, zero.

After this 4-year State block grant, then what is his plan? Well, it gets worse. Then his long-term plan is tied to privatizing Medicare; again, something that would start the unraveling of Medicare. It would force seniors to join HMOs.

So under Governor Bush's program, after the 4-year State program, then we would go into a new program. It would be up to insurance companies to take it. So seniors who need drug coverage would have to go to their HMO. They would not get a guaranteed package. The premium would be chosen by the HMO, the copayment chosen by the HMO, the deductible chosen by the HMO. And the drugs you get? Again, chosen by the HMO.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. HARKIN. Mr. President, I ask unanimous consent for at least a couple more minutes to finish up. I didn't realize I was under a time schedule.

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

Mr. HARKIN. Bush's plan would leave rural Americans out in the cold. Thirty percent of seniors live in areas with no HMOs. And contrary to what the Senator from Minnesota said, if I heard him correctly, under the Bush program, the Government would pay 25 percent of the premiums and Medicare recipients would have to pay 75 percent.

The Bush program basically is kind of scary. Seniors ought to be afraid of it, because if it comes into being, you will need more than your Medicare card. You will need your income tax returns to go down and show them how much income you have, how many assets you have. If you qualify, you are in; if you don't, you are out. That would be the end of Medicare.

I yield the floor.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. Mr. President, I ask unanimous consent that I be given time as needed, yielded off the continuing resolution.

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

CHILDREN'S HEALTH ACT OF 2000

Mr. FRIST. Mr. President, I have come to the floor to discuss and share with my colleagues very good news, some news that is bipartisan, that reflects what is the very best of what the Senate is all about.

It has to do with a bill called the Children's Health Act of 2000, a bill that is bipartisan, that reflects the input of probably 20 to 30 individual Senators on issues that mean a great deal to them based on their experience, their legislative history, what they have done in the past, their personal experiences, and responding to their constituents. This bill passed the Senate last week and passed the House of Representatives last week and will be sent to the President of the United States sometime either later tonight or tomorrow.

The Children's Health Act of 2000, is a comprehensive bill, a bill that forms the backbone of efforts to improve the health and safety of young people today, of America's children today. But equally important, it gathers the investments to improve the health, the well-being of children of future generations.

It is fascinating to me because it was about a year or a year and a half ago that Senator JEFFORDS and I, after working on this particular piece of legislation for a couple of years, reached out directly across the Capitol to Chairman BLILEY and Representative BILIRAKIS to work together to address a

whole variety of children's health issues, including day-care safety, maternal, child, and fetal health, pediatric public health promotion, pediatric research, efforts to fight drug abuse, and efforts to provide mental health services for our young people today.

The good news, with all of the other debates that are going on and the partisanship going back and forth, is that we in the Senate, as the Congress, we as a government have been successful in accomplishing this bipartisan, bicameral effort.

The bill that Congress now sends to the President includes two divisions or two parts. The first part, part A, addresses issues regarding children's health. The second part, part B, addresses youth drug abuse.

I would like to take a few moments to outline not the entire bill, but a number of the provisions in this bill, because I think it reflects the care and the thoughtfulness with which this bill was put together.

The first is day care safety. Perhaps the most critical section of the first part of this bill relates to day care health and safety. We based it on the bill which was called, the Children's Day Care Health and Safety Improvement Act, a bill that I introduced, again, in a bipartisan way, with Senator DODD on March 9 of this year.

Currently, there are more than 13 million children under the age of 6 who, every day, are enrolled in day care. About a quarter of a million children in Tennessee go to day care. The day care safety bill recognizes that it is our responsibility as a society, as a Government, to make sure that these day care facilities are as safe as possible, such as the health of children in child care is protected, so that when a parent, or both parents, drop that child off at day care, they can rest assured that the child will be in a safe environment throughout the day.

The danger in child care settings recently has become evident in my own State of Tennessee, again drawing upon how we learn and listen in our own States and bring those issues together and discussing them on the floor of the Senate and then fashion them into a bill. Tragically, within the span of just two years, in one city in Tennessee, four children died in child care settings. In addition, one in five child care programs in another city in Tennessee were found to have potentially put the health and safety of children at risk during the year 1999.

But this isn't just a Tennessee concern. It affects parents and day care centers and children nationwide. According to a Consumer Product Safety Commission Study in 1997, 31,000 children, ages 4 and younger, were treated in hospital emergency rooms for injuries they sustained while in child care or at school. More than 60 children have died in child care settings since 1990. The statistics are startling. They are unacceptable. The thousands of parents dropping their children off and leaving them in the hands of child care providers every day deserve the reassurance that their children will be safe throughout the day.

A recent study by the American Academy of Pediatrics reinforced this need further when it reported a disturbing trend among children with SIDS, Sudden Infant Death Syndrome. They looked at SIDS infants in day care. There were 1,916 SIDS cases from 1995 through 97 in 11 States and they found that about 20 percent, 391 deaths occurred in these day care settings. Most troubling was the fact that in over half of the cases the caretakers placed children on their stomach, where those same children at home were put to sleep on their backs by their parents. Parents and advocates who are dedicated to helping to eliminate the incidence of SIDS have urged that child care providers be required to have SIDS risk reduction education. When you hear these statistics and read these reports, you will agree. That is why I included a provision in this bill to carry out several activities, including the use of health consultants to give health and safety advice to child care providers on important issues, including SIDS prevention.

Overall, our bill authorizes $200 million to States to help improve the health and safety of children in child care settings. The grants can be used for all sorts of activities, including child care provider training and education, inspections in criminal background checks for day care providers; enhancements to improve a facility's ability to serve children with disabilities; to look at transportation safety procedures; to look and study and provide information for parents on choosing a safe and healthy day care setting.

This funding could also be used to help child care facilities meet the health and safety standards, or employ health consultants to give health and safety advice to child care providers. Many of us in this body have grandchildren or children. Our highest concerns are for the safety of those children and grandchildren. I understand the fears that so many parents have. Parents should not be afraid to leave their children in the care of a licensed child care facility. This bill, very simply, helps ensure that our child care centers will be safer.

A second portion of the first part of this bill includes provisions called the Children's Public Health Act of 2000 which, again, had been introduced in a bipartisan way by myself, Senator JEFFORDS, and Senator KENNEDY on July 13 of this past year. The purpose of this bill is to address a whole variety of children's health issues, including maternal and infant health, including pediatric health promotion, including pediatric research. Senator ORRIN HATCH, whose name was mentioned on the floor a few minutes ago, has been a real leader in another area of traumatic brain injury. Unintentional injuries are the leading cause of death in the age group between 1 and 19 years. It is those unintentional injuries that is the number one cause of death. In fact, more than 1.5 million American children suffer a brain injury each year. Therefore, in this bill we strengthen the traumatic brain injury for the CDC, the National Institutes of Health, and the Health Resources and Services Administration.

Birth defects are the leading cause of infant mortality and are responsible for about 30 percent of all pediatric admissions. This bill also focuses on maternal and infant health. This legislation establishes for the first time a National Center for Birth Defects and Developmental Disabilities at the CDC, to collect, analyze and distribute data on birth defects.

In addition, the bill authorizes a program called Healthy Start, a program to reduce the rate of infant mortality and improve those perinatal or those outcomes around the time of birth, by providing grants to areas with a high incidence of infant mortality and low birthweight. To address the fact that over 3,000 women experience serious complications due to pregnancy and that two out of three will die from complications in their pregnancy, this bill develops a national monitoring and surveillance program to better understand the maternal complications and mortality to decrease the disparities among various populations at risk of death and complications from pregnancy.

Asthma has an increasing incidence in this country and we don't know why. This bill combats some of the most common ailments. For instance, it provides comprehensive asthma services and coordinates the wide range of asthma prevention programs in the Federal Government, to address the most common childhood diseases. Asthma is a disease that affects over 5 million children in this country today.

Obesity is another problem. Again, we don't fully understand it, but it is a problem that is increasing in magnitude. Childhood obesity has doubled in the past 15 years and produced almost 5 million seriously overweight children in adolescence. It is an epidemic. This bill addresses childhood obesity and supports State and community-based programs promoting good nutrition and increased physical activity among American youth.

Lead poisoning prevention. As I look at problems across Tennessee, I was concerned to learn that in Memphis over 12 percent of children under the age of 6 may have lead poisoning. Such poisoning, we know, can contribute to learning disabilities, loss of intelligence, to hyperactivity, to behavioral problems.

In this bill, we include physician identification and training programs on current lead screening policies. We track the percentage of children in health center programs, and conduct outreach and education for families at risk for lead poisoning.

The Surgeon General's report of May 2000 noted that oral health is inseparable from overall health, and that while a majority of the population has experienced great improvements in oral health disparities affecting poor children and those who live in underserved areas represent 80 percent of all dental cavities in 20 percent of children.

Our bill encourages pediatric oral health by supporting community-based research and training to improve the understanding of etiology, pathogenesis diagnoses, or the why of the disease progression, the diagnosis of the disease prevention and treatment of these pediatric oral, dental, and cranial facial diseases. Behind all of those is pediatrics research.

Our bill strengthens pediatric research. It does it in such a way by establishing a pediatric research initiative within the National Institutes of Health. It will enhance collaborative efforts. It will provide increased support for pediatrics biomedical research and ensure that opportunities for advancement in scientific investigations and care for children are realized.

I should also mention childhood research protections, children who are involved in research, and how they are protected.

Included in this bill are provisions to address safety initiatives in children's research by requiring the Secretary of Health and Human Services to review the current Federal regulations for the protection of children who are participating in investigations. It will address issues such as determining acceptable levels of risk and obtaining parental permission. They will report to Congress on how to ensure the highest standards of safety.

This year the Senate Subcommittee on Public Health, which I chair, held two important hearings relating to gene therapy trials and human subject protections. We discovered a lapse of protection for individuals participating in clinical trial research. In the next Congress, we intend to make the further review in updating of human subject protections a major priority of this subcommittee.

The second part of this bill, division B of the bill, contains provisions which address very specifically the curse of pediatric or youth drug abuse.

The 1999 National Household Survey on Drug Abuse conducted by the Substance Abuse and Mental Health Services Administration reported that 10.9 percent of youth ages 12 to 17 currently use illicit drugs. They further estimated that 11.3 percent of 12- to 17-year-old boys and 10.5 percent of 12- to 17-year-old girls used drugs in the past month.

Just as discouraging is the growth in youth alcohol abuse. These same reports reveal that 10.4 million current drinkers are younger than the legal drinking age of 21 and that more than 6.8 million have engaged in binge drinking.

Sadly, all of these numbers detailing youth substance abuse have risen since 1992.

We addressed this tragedy again head on by incorporating the Youth Drug and Mental Health Services Act, which in a bipartisan way was introduced by myself and Senator KENNEDY last spring which was first passed in the Senate in November of 1999.

This youth drug bill addresses the problem of youth substance abuse by authorizing and by reauthorizing and improving and strengthening the Substance Abuse and Mental Health Services Administration. This bill puts a renewed focus on youth and adolescence substance abuse and mental health services. At the same time, it gives flexibility, and it demands greater accountability by States for the use of Federal funds.

Created in 1992 to assist States in reducing substance abuse and mental illness through these prevention and treatment programs, the Substance Abuse and Mental Health Services Administration provides funds to States for alcohol and drug abuse prevention and treatment programs and activities, as well as mental health services. Its block grants account for 40 percent and 15 percent, respectively, of all substance abuse and community mental health services.

In my own State of Tennessee, the Substance Abuse and Mental Health Services Act provides more than 70 percent of overall funding for the Tennessee Department of Health, Bureau of Alcohol and Drug Abuse.

This bill very quickly accomplishes six critical goals. It promotes State flexibility by easing outdated or unneeded requirements and governing the expenditure of Federal block grants.

Second, it ensures State accountability by moving away from the present system inefficiencies to a performance-based system.

Third, it provides substance abuse treatment services and early intervention substance abuse services for children and adolescence.

Fourth, it helps local communities treat violent youth and minimizes outbreaks of youth violence through partnerships among schools, among law enforcement activities, and mental health services. It ensures Federal funding for substance abuse or mental health emergencies.

And six, it supports and expands programs providing mental health and substance abuse treatment services to homeless individuals.

I will close by basically stating, once again, how excited I am about this particular bill as we send it to the President. Over the next several days during morning business, I look forward to the opportunity of coming back and discussing this bill further with my colleagues who have participated so directly in this particular bill.

I wish to respond very briefly to some comments that were made prior to me beginning my comments and the discussion on the floor in the hour preceding my comments that centered on prescription drug plans, the modernization of Medicare, and who has the best approach. The debate was very much between the Bush proposal and the Gore proposal. Let me very quickly summarize the objections that seniors have to the Gore proposal and the prescription drugs. I can do this very quickly. It really boils down to one sentence.

Under the Gore proposal, seniors will have only one choice, and they will only have one chance to make that choice. Then there is no turning back. No. 1, the Gore prescription drug proposal is centered around a Washington-run drug HMO.

Why does that bother seniors? Because an HMO ultimately, and often we see it too commonly today, sets prices, determines access, and can deny that access without any choice.

No. 2, the Gore proposal has a $600 access fee. That means if you do not use prescription drugs today, you are going to be paying $600 more today for getting nothing further; $600 access. That is before you buy any drugs whatsoever, a $600 access fee.

Our seniors are asking: Am I going to be one of the 13 million people who do not even have $600 in prescription drug requirements a year? If so, if I join that plan, I automatically am going to be paying more for what I get today.

That is for 13 million seniors. Seniors are asking: Am I going to be one of those 13 million?

Just one example: Under the Gore prescription drug proposal, if you have $500 a year in prescription drugs, and you joined his plan, you are going to have to pay $530 for $500 worth of prescription drugs today.

That is why seniors are going to object. That is why the Gore plan really, as I see it, has absolutely no chance for passage.

One other thing on the access fee: Let me tell our seniors very directly, if this bill were to pass today, if the Vice President were successful in getting this bill through today, as a senior your Medicare premiums, how much you pay every month, is going to double from what it is today. Your Medicare premium for what you pay today for Medicare is going to double. It will go from $45 to $90 within 2 years, if you join this plan.

The third I said is one choice; one chance; no turning back. You have one chance under the Gore proposal. If you are 64½ you either get this prescription drug benefit or you don't.

The problem is that a lot of heart disease doesn't develop until you are 65, or 67, or 70, or 75, or 80, or 85 years of age. At 64½, if you didn't go into these prescription drug programs, you have no chance to go into it in the future. You have only one chance; that is, when you are 64½.

People say you only live 65, or 67, or 77 years of age. If you live to be 64½,

you are likely to live to 80 or 85 years of age. You have one choice—a Washington HMO; one chance when you are 64½ and no turning back.

I make it very clear to our seniors what we are talking about when we talk about the prescription drug plan proposed by Vice President GORE.

Mr. JEFFORDS. Mr. President, it gives me great pleasure to join my colleagues today in celebrating the passage of Children's Health Act, which Senators FRIST, KENNEDY, myself, and many others introduced earlier this year. The Children's Health Act passed the Senate on September 22, the House on September 27, and is now one step closer to becoming law.

The Children's Health Act will significantly improve the well-being of children in this nation. This bill authorizes prevention and educational programs, clinical research, and direct clinical care services for child specific health issues.

President Clinton needs to sign this legislation into law now. Our nation's medical research and treatment systems must be encouraged to recognize that children have unique needs. Without the initiative of the Children's Health Act, research into many of the diseases and disorders that effect children will be overlooked and neglected.

I am also excited that the Children's Health Act includes legislation that the Senate passed last year to reauthorize the Substance Abuse and Mental Health Services Administration (SAMHSA). The Youth Drug and Mental Health Services Act is critically important for strengthening community-based mental health and substance-abuse prevention and treatment services.

We introduced SAMHSA reauthorization with strong bipartisan cosponsorship of many members of the HELP Committee. The service and grant programs administered by SAMHSA have gone far too long without being reauthorized. We will now be able to improve access and reduce barriers to high quality, effective services for individuals who suffer from, or are at risk for, substance abuse or mental illness, as well as for their families and communities.

This legislation includes the formula compromise for the Substance Abuse Treatment Block Grant that was originally included in the 1998 omnibus appropriations bill. This is an issue of paramount importance to small and rural states, and I am pleased that this legislation ratifies and continues the agreement reached in 1998.

The Children's Health Act and the Youth Drug and Mental Health Services Act are both the product of many months of work and collaboration among its many stakeholders. We have come this far because of the bipartisan dedication of members of HELP Committee and especially the leadership of Senator FRIST and Senator KENNEDY. I commend them both for their considerable efforts to help so many children and American families.

I also want to thank my colleagues in the House for their strong cooperation and support. I am so proud of being involved in this effort and I think the entire House of Representatives and Senate should be very proud of approving the Children's Health Act.

UNANIMOUS CONSENT AGREEMENT—H.J. RES. 110

Mr. FRIST. Mr. President, I ask unanimous consent when the Senate convenes tomorrow morning, the time prior to 10 a.m. be equally divided in the usual form and the previously ordered vote on H.J. Res. 110 now occur at 10 a.m.

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

DEPARTMENT OF THE INTERIOR AND RELATED AGENCIES APPROPRIATIONS ACT, 2001—CONFERENCE REPORT

Mr. FRIST. I ask consent that the Senate now resume consideration of the Interior conference report and Senator FITZGERALD be recognized.

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

Mr. FITZGERALD. Mr. President, Senator WYDEN has requested to speak for 5 to 10 minutes. I ask unanimous consent he be allowed to do that, then I be able to go back and speak as though it were a continuation of the speech I have had ongoing since early this morning.

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

ASSISTED SUICIDE

Mr. WYDEN. Mr. President, I come to the floor tonight to discuss the possibility that there will be an effort very shortly to override Oregon's assisted suicide law as part of a package that includes legislation that is extremely important to the country, such as legislation that would protect women from domestic violence, such as legislation that would also deal with sex trafficking—an extraordinary scourge that victimizes women and children. I think it would be extremely unfortunate to victimize the victims in that way. It is clearly not in the public interest.

Oregon's assisted suicide law involves a very controversial matter. I happen to be against assisted suicide, against the Oregon law, but the bill that cleared the Judiciary Committee on a 10–8 vote, a very narrow vote, is strongly opposed by the American Cancer Society. The American Cancer Society believes that legislation will harm those in pain. I am very hopeful that rather than tie this assisted suicide legislation to vitally needed legislation that would protect the victims of domestic violence and women and children from sex trafficking, the Senate would adhere to the agreement that was entered into in August.

In August, on a bipartisan basis, the Senate made it very clear, and I specifically addressed this on the floor of the Senate, that I was open to a fair fight, to an open debate on the assisted suicide question. In fact, I made it very clear that while I intend to use every opportunity to speak on the floor of the Senate and make sure the Members understand, for example, that the American Cancer Society believes this legislation will harm those in pain, I was willing to accept the will of the Senate on any cloture vote that might be scheduled. That was the agreement entered into in August. It provided for a fair fight on this issue.

Tonight we are told that there may be the possibility, as I have touched on, of an effort to override Oregon's assisted suicide law. By the way, Oregon is the only State in the country that has such legislation. It would be linked to the other desperately needed measures, such as the legislation to protect women victimized by domestic violence. I hope that will not be the case. I would have to oppose very strongly that kind of effort. It seems to me it is not in the public interest, and it is particularly regrettable since it runs contrary to the spirit of what was agreed to in August: That there would be an opportunity for both sides on the floor of the Senate to have this debate about assisted suicide; I would have a chance to address the issue in some detail, but if there were an effort to file cloture, I would accept the will of the Senate on that measure.

In addition, we just learned in the last few minutes there is a possibility schoolchildren in 700 rural school districts around the country could also be held hostage because, again, there may be an objection to the county payments bill legislation authored by Senator CRAIG of Idaho and myself—again, bipartisan. There may be an objection to that bill, again, on the grounds that somehow it should be examined some more and possibly linked again to the assisted suicide question.

I think, again, these issues ought to be considered on the merits. The county payments legislation passed this body by unanimous consent; 100 Senators agreed to make sure that these schoolchildren in 700 rural school districts got a fair shake. We have been working with the House. We have now come up with an agreement among the House, the Senate, and the White House. I think we can pass it 100–0 in the Senate. But we are told someone is going to object to the county payments legislation for the unrelated reason that they are not able to work out an arrangement that allows them to throw the Oregon assisted suicide law in the trash can on an arbitrary basis.

What the Senate worked out in August was fair to all sides. It ensured that we have a chance to discuss the matter of assisted suicide. It is a controversial question. I personally am