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Senate

The Senate met at 9:30 a.m. and was called to order by the President pro tempore (Mr. STEVENS).

PRAYER

The Chaplain, ADM Barry C. Black, offered the following prayer:

Eternal Lord God, who rules the raging of the sea, great and marvelous are Your works; just and true are Your ways. Thank You for smiling upon America and for blessing this Nation with your generous providence. Forgive our tendency to forget Your goodness and our failure to express gratitude for Your gifts. Thank You for these Senators, who seek to produce fruits that will nourish this land. Give them a kindness that remembers those on life's margins and a courage that will narrow the gap between the creed and the deed. Remove the scales from our eyes, that we might discover celestial solutions to Earth's most difficult problems. Today, let our words, thoughts, and actions honor and glorify Your Holy Name. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, this morning the Senate will be in a period of morning business until 11:30 a.m. Following morning business, the Senate will begin up to 15 minutes of debate on the nomination of David Campbell to be a U.S. District Judge for the District of Arizona. At 11:45, the Senate will vote on the Campbell nomination. Immediately following that vote, the Senate will proceed to a vote on the motion to invoke cloture on the nomination of Victor Wolski to be a judge of the U.S. Court of Federal Claims. Therefore, the first vote will occur at 11:45 and that vote will be the first of two back-to-back votes.

For the remainder of the day, the Senate will resume debate on the motion to proceed to S. 11, the Patients First Act. A cloture motion on the motion to proceed to the bill was filed yesterday and that cloture vote will occur on Wednesday.

I ask unanimous consent that following disposition of the Wolski nomination, the Senate resume consideration of the motion to proceed to S. 11.

Mr. REID. Mr. President, reserving the right to object, I ask the majority leader if there were not a vote on the motion to invoke cloture on Wolski, would the distinguished majority leader consider allowing several hours this afternoon to debate Wolski? If cloture is invoked, of course, we would have 30 hours. It would seem to me that for the people who have been seeking this vote, we could vitiate the cloture vote and the leader could give us, say, 3 or 4 hours to debate Wolski and then vote.

Mr. FRIST. Mr. President, I would certainly entertain that. I ask if I might have a discussion with Chairman HATCH, the chairman of the Judiciary Committee, before committing to that, and I will get back shortly with the assistant Democratic leader.

The PRESIDENT pro tempore. Is the unanimous consent request withdrawn?

Mr. FRIST. No, it is not.

The PRESIDENT pro tempore. Is there objection?

Mr. REID. No.

The PRESIDENT pro tempore. Without objection, it is so ordered.

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, leadership time is reserved.

MORNING BUSINESS

The PRESIDENT pro tempore. Under the previous order, there will be a period of morning business until 11:30 a.m., with the time equally divided between the two leaders or their designees.

Mr. FRIST. Mr. President, I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

The PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. REID. Mr. President, I ask unanimous consent that the time during the quorum call be charged equally to both sides.

The PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. REID. I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

PATIENTS FIRST ACT

Mr. DURBIN. Mr. President, I would like to speak in morning business on the issue that is pending before the Senate, which is the motion to proceed on S. 11. This is a bill relative to an important issue that really we have to grapple with in this country, and that

is the question of medical malpractice. It is an issue which has come at us in so many different ways. Unfortunately, the bill that is before us, S. 11, which we are now considering under a motion to proceed, looks at the issue of medical malpractice from only one narrow perspective, and from my point of view a very ineffective perspective.

What the bill before us would suggest is if you or a member of your family or one of your children is a victim of medical malpractice, there would be a strict limitation in this bill of how much you could recover in court for what is known as noneconomic losses, pain and suffering. That strict limitation would be $250,000.

To many people, $250,000 seems to be a very substantial sum of money, and it is until it is put in the perspective of the injuries we are discussing. Yesterday, in the course of the debate, I told the story of a 6-year-old boy in my home State of Illinois who went to a downstate clinic with a high fever. Unfortunately, he did not receive appropriate medical care and a jury decided he had been a victim of medical negligence. The doctors who had treated him did not perform the type of medical procedures necessary to monitor his serious condition. As a result of that, this poor little boy at the age of 6 became quadriplegic and uncommunicative. It is now 11 years later. He is 17 years old. He needs care around the clock. He cannot respond to stimulus that ordinary people do. He certainly cannot communicate. His situation for the past 11 years is, frankly, what he will face as long as he is alive.

That is a harrowing prospect for his family and it means they are going to have to dedicate the rest of their lives, as mother and father, to try to make his life on Earth as bearable as possible. So $250,000 in that context has to be taken from a different perspective. It goes beyond his medical bills, of which he will receive compensation, to the question of pain and suffering for him and certainly for his family.

If this young man, now at the age of 17, is going to live 20, 30, or 40 years, what is $250,000 worth? That $250,000 turns out to be a very small amount when we consider that the injuries he suffered and the problems he has endured are going to be there for a lifetime. So for us to say we will decide in the Senate in S. 11, the bill that is before us, that this little boy and his family will never receive more than $250,000 regardless of the circumstances facing him for the rest of his life, I think is totally unfair.

In fact, it is a dramatic departure from where we have been in the United States for so long. We have said, first, that this is an issue to be decided by each State. Each State should decide if there is going to be a limitation on how much money someone can receive if they are a victim of a certain injury or malpractice.

Secondly, we have said historically this is an issue not to be decided by 100 Senators, men and women sitting in Washington, but literally by 12 of this family's neighbors and friends who live in the community, who will try to reach a fair amount of compensation when in fact they find fault on the part of the doctor and the hospital. That is the jury system. It is a system we have believed in in America from the start of this Nation. It really is a system which parallels free elections in America where we say we entrust our Government to the people of this country.

In the courtroom, we entrust these decisions to the people of America, 12 of them chosen at random to come to a fair conclusion. Those who are pushing this bill today say we can no longer trust the jury system in America; we cannot trust 12 of this little boy's neighbors and friends and people in the community to come forward and reach a fair verdict.

I think that is a terrible condemnation of a system of justice which has really been the bedrock of American principles and American values.

It is curious to me that many of the same people who decide today that the jury system consists of people who cannot be trusted will readily trust the jury system when it comes to questions of criminal penalties, penalties as severe as the death penalty. If we trust a jury of 12 to decide the life or death of a criminal defendant, is it not also fair to say we would trust them to decide a fair amount of damages, a fair amount of compensation, for this child and his family?

Well, no. S. 11, offered on the Republican side of the aisle, says the opposite. It says, we will make the decision here. We are smarter. We know what is fair, and $250,000 is adequate compensation for this little boy who will face a lifetime now of care on a daily basis, minute by minute, whose mother has had to quit her job so she can stay home and tend to this 17-year-old boy who was a victim of medical malpractice.

Let me also add that equally unfair and unjust in S. 11 is the treatment of people who are senior citizens, who have been the victims of medical malpractice, because what this bill compensates are medical bills and lost wages, and limits any other recovery to $250,000. So if one happens to be a senior citizen who has no active income, perhaps a little retirement and the money they derive from their savings, and they are a victim of medical malpractice, they are limited to $250,000 compensation.

I will come back later today and talk about a couple who were victimized frankly because a blood bank gave them blood that was tainted with the HIV virus, which resulted in this 70-year-old couple contracting that HIV infection, ultimately dying of AIDS. It was a sad situation and one that was graphic in terms of the malpractice involved. But because they were not wage earners, their compensation under this bill would be virtually nothing.

The medical care which they would receive, of course, would be compensated, but it would only be $250,000 for pain and suffering.

Let's go to the root cause of this debate. Why are we even talking about medical malpractice on the Senate floor? It is because we do have a serious national challenge. In many States, including my own, for many specialities of medical practice we have seen medical malpractice insurance premiums increasing at an alarming rate. When we have asked the General Accounting Office and private firms to analyze why this has happened, they have said there is a variety of reasons that have led up to it. Yes, in fact, there are more settlements in cases involving medical malpractice than there have been in the past, and in some marginal cases more verdicts. It is an indication of the fact there is more medical negligence being discovered, and even the Department of Health and Human Services gave us testimony a few weeks ago that we are facing medical negligence and medical errors across America, in their words, of epidemic proportion. So now we have this huge wave of exposure and liability coming at the medical profession, and naturally there are more lawsuits that are being filed to reflect this wave, this epidemic, of medical negligence.

What has happened on the insurance side to protect the doctors? Sadly, this has been, frankly, a casino mentality among many of the medical malpractice insurers. Back in the Clinton administration, when we had a strong, vibrant, growing economy, when the Dow Jones index was going up regularly and people saw their retirement incomes growing and their savings growing, many people were investing in the stock market and doing well and many insurance companies did as well, too.

In the case of medical malpractice insurers, they would collect the premiums from the doctors, invest them in the stock market or in bonds and do very well.

Now what has happened? In the last 2½ years under this administration, we have seen the economy in recession; we have lost jobs; we have lost businesses; we have seen people lose their life savings; they have made new decisions on whether they have to continue to work.

Business investment, as well, has not been as profitable. These insurance companies that thought they had a winning formula are starting to lose. The premiums collected from doctors, invested in bonds and the stock market, have not been as profitable. Because of this, many of these companies have gone out of business or raised their premiums because of anticipated exposure for medical errors. Those raised premiums have caused real hardship among doctors in America.

Senator DASCHLE came to the Senate floor yesterday—and I tried to make the point, also—to say we understand

this issue is serious. On the Democratic side of the aisle, we have offered to the Republican side of the aisle to come together on a bipartisan basis to deal with the malpractice insurance crisis and the malpractice crisis in America. But we cannot resolve this issue by introducing a bill, S. 11, that only goes after one discrete part of it—limiting the recovery of medical malpractice to victims.

This drastic response is not going to solve the underlying problem. We need to come together on a bipartisan basis as we did on terrorism insurance after September 11. We found a way to do it. But we can only do it if we engage the three elements that can lead to success. Those elements are: First, the medical profession itself. We have to bring together those doctors of good will across America who want to work with us to reduce medical errors, to bring more safety to the practice of medicine, to take away from the practice of medicine those doctors and practitioners who are largely responsible for medical malpractice. Fifty percent of the medical malpractice claims in America can be attributed to 5 percent of the doctors. We need to make certain the medical profession is more vigilant in taking these doctors out of the practice of medicine, are changing the way they practice medicine so fewer innocent victims emerge from this experience.

Second, we need to bring in the insurance industry. I know this is a sacred cow in the Senate, to talk about insurance companies and holding them accountable for the way they are treating doctors across America. But you cannot have an honest conversation about dealing with medical malpractice premiums without talking about the insurance industry. We could cap recoveries across America in every courtroom for every victim of medical malpractice with no guarantee that medical malpractice premiums are going to decrease for doctors across America.

Here is what I think we should do. First, we should eliminate the antitrust exemption for insurance companies across America. To think we allow these companies to collude, to come together and share pricing information to the detriment of their customers—in this case, their doctors—is indefensible. The McCarran-Ferguson Act should be repealed so the antitrust exemption is removed from the U.S. industry.

Second, we need to look at the whole question of reinsurance. Most of these malpractice insurance companies only protect doctors up to a certain amount—perhaps $1 million or $2 million—in terms of their exposure to liability. Then they sell off the additional exposure—$2 million to $10 million, $2 million to $20 million—and buy insurance to cover it. There are five major companies selling reinsurance in the medical malpractice area. Four are offshore and not regulated by any State or Federal regulation in the United States. We have no oversight of the way they are treating malpractice insurers in America. That is a guarantee that, no matter what we do in the Senate, there will still be ultimate vulnerability by the medical profession to unreasonable and excessive malpractice premiums.

The solution involves: Bringing together the medical profession to reduce medical errors, to reduce medical injuries; bringing the insurance industry in to make certain that we have some accountability and fairness in the premium charges; and, finally, bringing in those in the legal profession to make certain that any lawyer filing a frivolous malpractice lawsuit is going to be held accountable for the costs and attorney fees, initially, and ultimately, if he or she continues doing so, banned from filing future lawsuits; also making certain that punitive damages would be eliminated in virtually all medical malpractice cases. All of these factors will move us toward a solution to this problem.

This week, we are going to be visited by many doctors from across the United States. They will come and tell us of their legitimate concerns about malpractice premiums that are hurting their profession and limiting the availability of good medicine and good doctors across America. I do not quarrel with their premise that they have a problem that needs to be resolved, that we need to face squarely and honestly.

But this morning, at 11 o'clock, I will hold a press conference in which we will have five victims of medical malpractice. They will tell their heartbreaking stories, how they went to the doctor, they went to the hospital, and came home so injured and so changed that their lives were never the same. The $250,000 being offered by the sponsors of S. 11 is totally inadequate to the injuries they suffered. The limitation of $250,000 would make them wards of the state and dependent on government and charity for the rest of their life. That is what is being offered on the Republican side of the aisle.

The last point I make is this: When you read S. 11 closely, you will find it is not only about doctors and hospitals, it is also about protecting from liability HMO insurance companies and health care organizations, the makers of medical devices, and those pharmaceutical companies that are found to have been negligent in the sale of their products.

I cannot understand how the medical profession can allow itself to be used by the sponsors of this bill so that those who are coming in to represent these special interest groups—the HMOs and managed care organizations, the pharmaceutical companies, and the medical device companies—get protection, using as their argument the sympathy that is being generated on behalf of doctors who are struggling with malpractice premiums. That is unfair to the doctors; it is unfair to the hospitals; it is unfair to the Senate, that we would include in S. 11 that type of limitation.

Finally, this bill, S. 11, allows for punitive damages in the most limited circumstances. It requires that there be a deliberate act on the part of a doctor for punitive damages to apply, as well as malicious intent being another option under punitive damages.

When I made an inquiry yesterday as to what it would mean if a doctor were intoxicated or an addict to drugs and, because of that intoxication or addiction, performed some medical procedure which harmed a person for life, I was told that punitive damage section would apply. I have to say quite honestly it does not because the language of the section is only about deliberate and intentional conduct, not about the kind of gross negligence involved in addiction and intoxication.

As we look at S. 11, we owe the medical profession as well as the people of America more than is being offered. To bring this bill on a take-it-or-leave-it basis, to say we will have no committee hearings, no amendment process in committee, no opportunity for an exchange of information, is not fair to the people of America. I hope we can do better—I think we can—that when the vote takes place tomorrow on the cloture motion, we will see a number of Senators are going to come forward and ask that we try to resolve this difference in a fair way, in a balanced way, rather than this unbalanced and unfair way being offered.

Mr. REID. Will the Senator yield?

Mr. DURBIN. I am happy to yield.

Mr. REID. As I listen to the Senator today—and I am aware of what the Senator talked about yesterday—is the Senator saying he is not opposed to our doing something regarding medical malpractice?

Mr. DURBIN. That is exactly true. The Senator's home State, the State of Nevada, was a classic example of serious problems that were ultimately addressed last year by legislative action when the State of Nevada accepted its responsibility.

We need to deal with this through each State, and we need to find ways on the Federal level to try to make certain we do not have States in crisis, as mentioned yesterday, because of malpractice premiums.

Mr. REID. The Senator is absolutely right. In Nevada, the Governor, Republican Gov. Kenny Guinn, called a special session of the Nevada Legislature to address this problem which was created by one insurance company that decided to take a powder when the stock market fell, as the Senator aptly described.

The Senator, who previously served in the House of Representatives, also said during his statements in the Senate that if we are going to move important legislation such as this, there should be committee hearings discussing the legislation. It is true, is it not, that we have had no hearings on this legislation?

Mr. DURBIN. I would say to the Senator from Nevada, that is accurate. In fact, we had a limited hearing last February on the issue but not on this bill. Senator COLEMAN of Minnesota had a hearing in the Governmental Affairs Committee to talk about the general issue of medical malpractice, where the administration testified we are facing an epidemic of medical malpractice in America. But no one has sat down to measure whether this bill will actually reduce malpractice premiums. The only studies that have been done by the General Accounting Office, as well as by a group known as the Weiss Institute, have come to the conclusion that limiting the recovery of victims in medical malpractice lawsuits is no guarantee of malpractice premiums coming down. In fact, in many cases of States with caps on the recovery, limitations on recovery for malpractice victims, the malpractice premiums for doctors have gone up.

There is no linear connection or guarantee that limiting the recovery for victims is going to help the doctors, yet that is the only solution that is before us on the floor today.

Mr. REID. It is also true, is it not, I say to the Senator from Illinois, that the two studies of the Weiss and the General Accounting Office are not studies that have been paid for, were involved with or directed by attorneys? Is that a fair statement?

Mr. DURBIN. That is exactly right. I would say to the Senator from Nevada, it is true the medical profession feels very strongly on one side and the trial bar on the other. But what I have tried to do is gather information from those who have no axe to grind, people who are trying to analyze this problem honestly. The conclusions they have reached suggest to me this is a much more complex problem than what we see today.

Unfortunately, S. 11 I think is a political answer to a much more serious problem. If this is a question about whether the White House is going to take on the trial bar in some sort of confrontation for the next election, that is one thing. It is an interesting political battle. It is not going to solve the problem, not in my State or any other State. We have to deal with it honestly by saying the medical profession, the insurance industry, as well as the legal profession have to come to the table. We need to have not only committee hearings so we can see publicly what this issue is all about, but we need to have a good-faith effort. We can do it.

I think the Senator from Nevada recalls after 9/11 we had a problem with terrorism, of course, and the threat of terrorism. That had an impact on the construction industry and on investment. So people came to us and said: We can't get people to invest in building new buildings unless we do something about terrorism insurance.

We sat down on a bipartisan basis and worked it out. Senator DASCHLE came to the floor yesterday and said: Use the same model on malpractice. Bring us together, Republican and Democrat alike, and try to find common ground and a solution. If it is not through a committee process, let it be through an honest to goodness, good-faith negotiation, but we can achieve that goal.

Mr. REID. The Senator is aware, is he not, the reason terrorism insurance was held up for so long is that Republicans wanted absolute tort reform, everything involving medical malpractice, slips and falls, rear-end automobile accidents—everything. We said: Why don't we just deal with terrorism insurance? We finally prevailed, and we have done a good job. There is construction going on all over America today, and they are able to go forward because they can get terrorism insurance based upon the legislation we passed.

The Senator, as I understand it—I want to make sure I am correct in this—believes reform is needed?

Mr. DURBIN. Yes.

Mr. REID. No. 2, you believe we should do it through the ordinary process, have committee hearings.

Finally, you believe the insurance industry should be involved in this because the McCarran-Ferguson Act, named after Senator Pat McCarran of Nevada, was passed to give a few years of relief to the insurance industry so they could gather together during the Depression and not be involved with the Sherman Antitrust Act, and now, some 70 years later, they are the only business other than major league baseball that is not subject to the Sherman Antitrust Act. So the Senator believes they should be like other businesses in America, subject to the Antitrust Act.

If we did some reform here and we involved the committee structure and we involved the insurance industry, I think we could move the bill pretty quickly. Does the Senator agree?

Mr. DURBIN. I agree with the Senator.

One other thing that needs to be part of the record: Even if we enacted S. 11, which is the cap on recovery for medical malpractice victims—children, elderly people and families alike—there is no guarantee medical malpractice insurance premiums will come down. In Nevada, significant reform legislation was passed but, as I understand it, the premiums did not start coming down for some period of time, if at all.

Mr. REID. It is absolutely true. The fact is, if you look around the country, insurance rates have not gone down where these medical malpractice reforms have been initiated.

But another thing it doesn't take into consideration is the tremendous harm done to people who have no ability to move forward when a doctor does something wrong to them.

I think the Senator indicated there are about 100,000 people killed because of medical malpractice in America every year. But that doesn't take into consideration the people who are paralyzed, people who are injured and damaged in many other ways. With this cap, these cases simply do not go forward.

So it is really not fair to analyze what goes on in those States because you don't take into consideration the damage, the harm, the pain and suffering of these people who have no way to recover their expenses as a result of a direct negligent act by a physician.

Mr. DURBIN. I agree. I say to the Senator from Nevada, I do not profess to be an expert, but I did, in my private practice as an attorney before I came to the Congress, have several malpractice cases. In some I defended doctors and in some I sued doctors for what I believed to be malpractice. Those are heartbreaking cases and should not be dismissed easily by the Members of the Senate until they sit down and talk to families.

I can recall a family who brought in an infant girl to my office. She had gone to the doctor for her ordinary baby shots, which I am sure the Senator from Nevada and my family have done; we have brought our children in for them without any real concern. This poor little girl, because she had a condition known as roseola, a form of measles that was undetected before the administration of the baby shot, ended up with a serious reaction to the pertussis vaccine for whooping cough and literally became a quadriplegic. This little girl was going to live the rest of her life in a virtual coma-like state and need constant care.

What we hear from the other side of the aisle is that that is not worth more than $250,000.

I would say, if I were the parent of that little girl, I would view this a lot differently. I would want to have a jury of my peers to decide what it is worth, what is the value.

But S. 11 takes away the authority of the jury to make that decision and decides we will make the decision here for every case in America—no matter how serious the injury to the infant or the person who is the victim of malpractice, no matter what the circumstances—to strictly limit it to a $250,000 recovery.

I think that is unfair. I think the Senator from Nevada has made the point.

The last point I will make on this issue is that I think we need to give the doctors immediate relief on malpractice premiums. I am going to introduce legislation with Senator GRAHAM of South Carolina that will provide an immediate tax credit, in addition to the deductibility, an immediate tax credit of up to 20 percent for relief to the specialties that are hardest hit by these increases in premiums for malpractice insurance—neurosurgery, OB/GYN, trauma surgeons. I really believe we need to do something quickly.

S. 11 does nothing but change a law which may or may not, in 3 or 4 years,

result in premiums going down. It is far better for us to do something on an immediate basis, an emergency basis. I hope the medical association and societies across America will take a hard look at this bill—it is being offered in good faith to deal with the immediate crisis—rather than penalize the victims of medical malpractice.

Mr. President, I yield the floor.

Mr. REID. Mr. President, if I could say one thing—I know the Democratic leader is in the Chamber—I have the highest respect and admiration for my colleague from the State of Nevada, Senator JOHN ENSIGN, who has introduced this legislation. He is passionately involved with doing something to solve this medical malpractice crisis. As I have indicated, I have supported his efforts to do something about it. He and I tend to disagree on how to do it. But I want the record to be spread with the fact that I have great respect and admiration for his moving forward on this problem.

I only wish there had been full committee hearings on his legislation. I think it would have improved it before it reached the floor. I think he has been shortchanged by not having his legislation brought before the appropriate committee, had hearings, and then brought here. I think with some changes in this legislation it is something we could all support.

The PRESIDING OFFICER. The Democratic leader.

Mr. DASCHLE. Mr. President, I compliment again, as I did yesterday, the distinguished Senator from Illinois for his great work on this issue and for beginning this educational process that I think has to be a part of the debate at this time.

I also want to thank, as is always the case, the distinguished assistant Democratic leader for his involvement in these discussions as well.

I have concerns about where we are with regard to this issue on at least two counts.

First of all, the procedural count: I wish I had $1 for every occasion when Republicans would lament the fact that the committee process was bypassed. Yet here we are. There has been no hearing. There has been no markup. There has been no committee consideration at all of what is one of the most complex and extremely controversial issues to face the Senate and the country. To bypass the entire committee process and bring the bill straight to the floor does an injustice to the issue.

As Senator REID has noted, a bill of this magnitude deserves careful consideration, deserves the opportunity to be heard, and deserves the chance to have some debate in the committee among the experts who know this issue. I think it would be very helpful.

It is interesting that the president of the Tort Reform Association said don't count on insurance premiums going down if this legislation passes. I think Senators need to know that. If the president of the Tort Association of America says, look, don't expect any relief, what is it we are doing? This isn't from some trial. This is a person who advocates tort reform, but he is in the name of real honesty saying: Look, this is not the reason we are arguing for tort reform today. It is not going to bring down insurance premiums.

I think procedurally we have a real concern about the reason we are here today. I think that is something that ought to be considered very carefully. This is an important bill. It deserves the kind of careful, substantive attention that only committees can bring.

Second, of course, is the issue itself. As the distinguished Senator from Illinois has said so ably, we understand how important it is to address the seriousness of insurance premiums. We have two approaches before us: The one offered by the Senator from Illinois, and the one offered by the Senator from South Carolina which will give immediate relief. We are talking within the next couple of weeks, if this went to the President's desk, immediate relief for meaningful insurance cost reduction.

When I go home that is the issue about which doctors tell me they are concerned. They can't afford to pay the premiums. There is no better way to reduce the premiums than to give them the immediate relief offered in the Graham-Durbin bill. But I must say this is also a recognition of the concern.

There has to be a way to address the problems created when mistakes are made. Tommy Thompson himself—certainly no advocate of the status quo—has recognized that last year, the year before that, and the year before that 100,000 people died as a result of mistakes made in operating rooms, in clinics, and hospitals across the country. That is not my figure. That is not some special interest figure. That is the Secretary of Health and Human Services—100,000 people died.

I oftentimes find myself equating numbers with Vietnam and Vietnam-era veterans. We lost 58,000 people in Vietnam. We are losing almost twice that number every year due to mistakes made in operating rooms and in hospitals.

What I find perplexing—interesting—is that our Republican colleagues, who say the States know best how to govern, are saying: Well, in this case we don't think that is the case. In this case what we think is we know better. Washington is going to dictate to the States what the laws with regard to tort will be. Not only are we going to set the cap at $250,000, but we are actually, under the legislation before us today, going to preempt every single State law except the cap.

We are going to tell the States we know better and we are going to dictate to the States what it is they are going to have to abide by from here on out—total Federal preemption of State law. It is amazing that is coming from our Republican colleagues.

I would also say I am concerned because I can probably even consider looking at caps if there was any conclusive evidence that caps work. There is a very respected analytical group that made, with some fanfare, a decision a couple of years ago to examine this whole relationship between caps and premiums. They announced when they started the study that they did not know how it is was going to turn out. It could be pro-cap or it could be anti-cap. They didn't know. But they believed an objective review of the available information ought to be considered. They studied it. They looked at every single State. They released their findings about 3 weeks ago.

Do you know what they found? They found that there is no relationship. In fact, what they found is, in those States where there are caps, insurance premiums went up more than in those States that didn't have caps.

They are not arguing that caps had anything to do with it. But it is an interesting fact. Those States today with caps have actually seen higher insurance premiums than those without caps, according to this very respected independent study just released.

Both on the substantive as well as on the procedural issue, we have great concern with the fact that we are here today. We have a solution. I would argue to anyone on the other side who really wants to resolve this issue that we go back to what we did last year with terrorism insurance. That, too, was a tort reform question. Member after Member came to the floor and said unless we deal with tort reform we will never solve the terrorism insurance question. We sat together in a bipartisan fashion—Republicans and Democrats—worked out a reinsurance concept and passed it on the Senate floor, finally, after a great deal of tribulation and negotiation, with a large margin.

If you go to New York or to Chicago or to the hometown of the Senator from Illinois or a lot of other places, you will find that the terrorism insurance bill worked. I would argue it worked in part because procedurally we decided to come together and resolve it and solve it. I think it worked in partly because we addressed the issue with real solutions. We didn't get hung up on all of this tort reform because that wasn't the issue there either.

Today, we still celebrate a success story. We celebrate a success story here, too. We have a bipartisan Graham-Durbin bill. It might not be everything. Maybe we can figure out a way to make it an even better bill. I think we have to deal with reinsurance. I think we have to find a way to deal with reinsurance reform. We have to provide immediate relief and the tax credit relief proposed by the Senator from Illinois. We can do that. I think it is important that we do it. I think it is important that we recognize unless we do it that way we are not going to solve this issue.

Cloture will not be invoked tomorrow—not because we don't want to solve this problem but because we don't want to have a bill that is poorly conceived and will not solve the problem and which will be rammed down the throats of the country. We can find a better way to do this.

I would just implore my colleagues on the other side to work with us to make that happen.

Let me again thank the distinguished Senator from Illinois for his work.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank the Democratic leader for his comments and for his leadership on this issue. I think he has shown a good-faith effort in the past to deal with issues and with the complexity of terrorism insurance. And that opportunity is still here today.

This week in Washington, many representatives of the medical profession will come to visit us and talk about the seriousness of this issue. They don't need to convince me; I am convinced.

The question is, How do we resolve it fairly and not just for doctors but for the victims of medical malpractice. We can do this. But I don't believe S. 11 is the way to approach it.

If we are going to allow this to disintegrate into a political face-off between the White House and the trial lawyers of America, perhaps when it is all over someone will have bragging rights for a 30-second ad. It will not help the doctor with whom I met who is serving Primbrook Township, south of the city of Chicago about an hour-and-a-half drive. You will find some of the poorest rural towns in America in Primbrook Township. This doctor is literally giving his life to the poor who need medical care. He said to me 2 weeks ago in Washington: Senator, I am here to receive this Jefferson Award, and I am proud of it, but I need help with malpractice insurance. I want to help him.

Limiting the recovery by malpractice victims may ultimately give someone some satisfaction that they have scored a political victory over the trial bar, or perhaps their limitation of victims' recovery will give them some satisfaction, but it is not going to help that doctor. It is not going to reduce his premiums. It is not going to give him an opportunity to continue his practice.

So I say to my friends in the medical profession—and this doctor is a good example—we honor and respect what you do. We need you. We need to work with you. Do not get so caught up in a political agenda involving the White House and the trial lawyers that you overlook the fact there are many people of good faith and good will who want to sit down and help.

We believe this can be done. It can be done in a way that is not going to deny the parents and the family of the small child, who, as I mentioned earlier, is going to live a lifetime of medical dependency because of medical malpractice. It is not going to be done in a way that is going to deny a woman who went in for simple cosmetic surgery and ended up with horrific burns on her face that required a dozen operations and years and years of suffering. That is not the way to resolve this.

Do this in a fair way for doctors; do it in a fair way for medical malpractice victims. Do not be afraid to call in the special interest group, the insurance companies, and tell them they have to be part of this conversation. We have the power in Congress to bring them in. We have the power to change the laws to make sure they treat doctors and hospitals fairly and to make certain the medical profession comes forward.

It is interesting to me that as I have discussed the issue of medical malpractice with doctors in my State and across the Nation, they have been of one mind and one voice and they have agreed: We need to do more to make certain we reduce the incidence of medical errors.

A doctor, who is a friend of mine, in Decatur, IL, also works on the board of a local hospital. He said he went to the hospital pharmacy where they literally write thousands of prescriptions each year for the patients who come through that hospital and they wanted to find out how many errors had been made in the prescriptions that had been written. They came up with a handful of examples. The doctor said to me: Senator, I know better, and you know better. We're not doing a good enough job here to make certain that mistakes are not made in the drugs that are prescribed and the prescriptions that are written.

We can do a better job—and we should—to have medical safety. Doctors want the best results. They do not want bad results. Certainly, the families and patients do not, either. We can work together to try to improve medical care in America in a professional way.

The bill I am going to introduce is going to allow for the transfer of information, data on medical safety, and the transfer of information without legal liability, so a doctor who would report an incident at a hospital that may lead to a change in a procedure or perhaps to a disciplining of a doctor is not going to be held legally responsible for having come forward with this information.

I think that is the only fair and honest way to deal with this issue. But if we are going to deal with it, let us look at each of those components: the medical profession, the insurance industry, as well as the legal profession.

What I do not want to see occur is what S. 11 really mandates; that is, instead of a jury of 12 in communities across America taking a look at each individual case to decide what a fair, reasonable verdict and outcome might be, we would have a jury of 100, 100 Senators, men and women elected here, who would sit in judgment of every single case in America involving medical malpractice.

We are not going to hear the story of the parents, who are going to come from that downstate community in Illinois, who took their little boy in with a high fever, who expected medical care—which each of us would expect as parents bringing in our baby with a fever to a clinic—and did not receive it because no temperature monitor was in place and, as a consequence, that little boy's high fever led to complications, quadriplegia, and the fact that he now has a lifetime of medical dependence on his parents. He will never enjoy the simple things in life which each of us takes for granted.

We are not going to hear that story in the Senate as a jury would hear in a courtroom. We will not hear the details of his life and what it means now: the pain and suffering he goes through every single day. No, we will not hear those facts. We will not make a decision based on the reality of the malpractice that this family and boy endured.

Instead, we will make a decision, under S. 11, that says $250,000 is the maximum amount that boy and his family will ever receive for the injuries which they have suffered when it comes to pain and suffering. That isn't fair. We should not stand as a jury and make that decision. We ought to trust a jury system that has been part of American justice for a long time, a system that we rely on every single day in thousands of courtrooms across America.

I think a sensible approach is to say that we do have a problem; we will work with the doctors; we will work with the insurance companies; and we will work with the legal profession to find a reasonable alternative to it. S. 11 is not that alternative.

If, in fact, the cloture motion is defeated tomorrow, which means we do not proceed to the bill, I make this offer, not only to the sponsors of that bill but to all who are interested in this issue, that I will personally engage myself in trying to find a reasonable, good-faith alternative that reduces malpractice rates, premium rates, particularly for those doctors who have no experience of wrongdoing—now, there are some doctors paying high rates who, frankly, have to pay them because they have been found guilty of malpractice—but for the innocent doctors, who have given their lives to medicine and who come forward every single day in a valiant effort to save and improve lives, I will stand on their side to make certain that they are treated reasonably and fairly.

Please do not turn to S. 11 as your only recourse because S. 11, being offered on the floor today, is one bill which is as unfair to malpractice victims as the insurance premiums are unfair to doctors in many places in America today. Let us work together—

as we can; as we did under the terrorism insurance legislation—to find a reasonable alternative.

Mr. President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will please call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. SCHUMER. Mr. President, I ask unanimous consent to address the Senate for about 15 minutes on an upcoming judicial nomination.

The PRESIDING OFFICER. All remaining time is on the majority side. Is there objection?

Mr. ENSIGN. Mr. President, I was scheduled to make a statement on the medical liability bill, and I am prepared to do that at this time.

Mr. SCHUMER. Mr. President, I ask the Senator how long he intends to speak.

Mr. ENSIGN. Probably 10, 20 minutes.

Mr. SCHUMER. I ask unanimous consent that after the Senator from Nevada finishes his remarks, I be recognized for 15 minutes on the nomination of Mr. Wolski on which we will vote at 11:45 a.m.

The PRESIDING OFFICER. It was the Chair's understanding there would be a substitute in the chair so he could make a statement on the Republican time following Senator ENSIGN's speech and that the debate would begin at 11:30 a.m. on the judges.

Mr. SCHUMER. Mr. President, are you saying there is no time between now and 11:30 a.m.?

The PRESIDING OFFICER. All the time has been reserved on the Republican side.

Mr. SCHUMER. I thank the Chair.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, I have come to the Chamber to talk about the legislation we are going to be discussing for the next couple of days. It is very important legislation that affects people in virtually every State in the country.

We have patients today being denied access to medical care in many States across the country, and we are going to explore why that is happening and what I believe the solution should be. Several States are losing medical professionals at an alarming rate, leaving thousands of patients without a health care provider to serve their needs.

In Bisbee, AZ, the town's only maternity ward closed. Today expectant mothers must drive more than half an hour to have their babies delivered. In Mississippi, 11 out of 21 obstetricians terminated service in four rural counties. In my home State of Nevada, our only level 1 trauma center closed for 10 days, leaving every patient within 10,000 square miles unserved by a trauma unit.

The bottom line is patients cannot get care when they need it most. By definition, this is a crisis. This crisis boils down to two factors: affordability and availability of medical liability insurance for providers.

The States in red are currently in crisis. A number are new States in crisis. We can see they have been added, including the Chair's State of Wyoming. My State has been in crisis for quite some time now, and it has led to a lot of the national press, but it is certainly not alone. The States indicated in yellow are the States that have problem signs. The States that currently seem to be OK are indicated in white, and we can see that very few States are in pretty good shape. Most of those States have enacted medical liability reform that has been in place long enough to stabilize the rates on medical liability insurance.

On affordability, the American Medical Association found that in the year 2000, medical liability insurance rates increased at least 30 percent in 8 States and by at least 25 percent in more than 12 other States. In this past year, the physicians in my State would be pleased if the rates had only gone up that much. These rates are forcing more physicians, hospitals, and other health care providers to limit their practices or to leave the profession altogether.

Anecdotally—and obviously this hospital would not want this word to get out—at this time of the year when they get applications for new residents, they normally get about 18 to 20 residents applying for slots at that hospital. That is an average of 18 to 20 each year. This year they have received zero applications, and that is because of the medical liability crisis that is occurring in my State.

Rates are forcing so many physicians and hospitals into a situation they did not want to be in. They went into these practices because of the compassion they felt for patients, and they are not being able to deliver the services because of the out-of-control costs of medical liability insurance.

On the issue of availability, thousands of doctors nationwide have been left with no liability insurance as major insurers are either leaving the market or raising the rates to astronomical levels.

Why are insurers raising rates or leaving the market? Because there is no stability in the marketplace for providing medical liability insurance. Why is that the case? Because our health care system is being overrun by frivolous lawsuits and outrageous jury awards. This excessive litigation is leading to higher health care costs to every American and an unstable peace of mind for our health care providers.

This chart shows the average payment in red from the year 1989 to the year 2001 and the median payment. We can see the dramatic increase, especially in the last few years, and if this chart continued out, it is continuing that trend up to the point where the average being paid in jury awards is continuing to skyrocket, and it is doing that because of the number of over $1 million awards being made by juries.

This is a chart reflecting the median jury award. We can see this is the $1 million line, and we can see what has happened. It has gone up. This, unfortunately, has created a situation where doctors, hospitals, and health care providers cannot afford to buy the insurance they need to continue practicing.

This excessive litigation is leading to higher health care costs for every American and an unstable peace of mind for our health care providers. Health care professionals are forced to practice defensive medicine by ordering unnecessary tests just to avoid being sued for ''underdiagnosing'' their patients. A study by the Department of Health and Human Services found defensive medicine is costing the Federal Government an estimated $28 billion to $47 billion in unnecessary health care costs.

Who else pays for these unnecessary costs? Every American with health insurance in the form of higher premiums and, obviously, the American taxpayer. Too often costs are so great that employers have to stop offering coverage altogether, thereby increasing the number of uninsured Americans. A lot of those uninsured Americans are younger, healthier people. So the people who are left in the health care field are a higher risk pool, which drives up the cost even more, which causes more and more people to not be able to afford health care insurance; therefore, more uninsured. It is a vicious cycle that goes on and on. This cycle has to be stopped. We can do that by passing national medical liability reform right now.

Comprehensive reform is critical on a national level because every American patient should have access to affordable and high quality health care. Likewise, every responsible, meritorious member of the health care community should not be afraid to provide such care because of the fear of litigation.

To achieve these reforms, I have introduced the legislation that is before us today, known as the HEALTH Act. It has several key reforms. It includes a $250,000 cap on noneconomic damages, joint liability, and collateral source improvements, and limits on attorney's fees according to a sliding scale award.

In addition, my legislation includes an expert witness provision to ensure that relevant medical experts serve as trial witnesses instead of the so-called professional witnesses who are used to further abuse the system today. If one talks to physicians, there is literally a whole industry that has been created of these ''professional witnesses.'' It would make sense that if somebody

was testifying in a case involving neurology, that the person should have expertise in the field of neurology. I think that makes incredible common sense, but that is not the way it works today. As long as somebody is a physician, they are able to testify and be called an ''expert.''

Our legislation today says that if they are to be called an expert, they must have expertise in the field in which they are testifying. Over 50 organizations are in support of my bill, including business groups, medical associates, device manufacturers, and the list goes on. I have heard from people all over my State, and not just physicians. This is not a doctors versus lawyers issue. This is about patient access to medical care. That is why we have heard from nurses, physical therapists, and people who work in doctors' offices and understand the problem that is going on. We have heard, of course, from physicians, but we have also heard mostly from the patients who understand; we have gotten so many calls from women whose physicians used to deliver babies. The women are now pregnant and their obstetricians no longer can deliver babies because they may be a high risk delivery and they can no longer afford to provide that type of a service.

The broad coalition that has come forward to urge meaningful reform highlights that this problem affects a number of industries, not only our health care system. Starting the Senate debate with our strongest proposal is critical because we must not approve a weak bill that the President will not be able to sign into law. Doing something weak as a Band-Aid would actually make things worse, and that is why we need very strong legislation.

Opponents of this legislation ask how I know this approach works. It works because this legislation is modeled after the highly successful legislation that passed and has been in place for over 20 years in California. It is known as MICRA. MICRA has brought about real reform to California's liability system. The number of frivolous lawsuits going to trial has declined dramatically. Injured patients receive a larger share of their rewards because of the limits on the fees that go to the trial attorneys. Disciplinary actions against incompetent health care providers have increased.

The bottom line is that California's medical liability system works. This is a quote by one of our colleagues from the other side of the aisle, Senator DIANNE FEINSTEIN, January 14, 2003:

> With the California law, we have a time-tested solution. California passed MICRA in 1975, so we have our 27 years of successful experience with the law.

One important point, neither MICRA nor my legislation limits the amount of economic damages that an injured patient can recover. As in every other profession, mistakes are made by health care providers. I practiced veterinary medicine after graduating from Colorado State University. I saw firsthand that mistakes are made.

Medicine is an art and a science, and there is a human being practicing that very inexact science. Every day somewhere mistakes are made. They are unfortunate. We should do everything we can to limit those mistakes, but we know mistakes will be made.

Sometimes they are mistakes in judgment. When one looks back in hindsight, they can see how they could have made that decision differently. But when they are faced with it at the time, because the human body does not read the textbook—this is how the disease is supposed to progress, this is how the injury is supposed to progress—the human body does not read that. So sometimes it reacts differently to the way the physician was trained, and so what looks like a mistake in a court of law could have actually been a very difficult judgment call. Yet a lot of these are frivolous lawsuits that are going to trial.

In our legislation, we are trying to bring some balance back to the system. We do limit the amount of noneconomic damages, pain and suffering as it is most often referred. People say, how can that be limited? How can losing a leg be limited or how can a dollar figure be put on that?

Well, a dollar figure can never be put on it. No amount could ever be justified to somebody for some of the things that happen to them, but we have to look at the overall good of our system.

With the system we have now, we are losing doctors, and we are losing the kind of patient care we need. How does one put a dollar figure on the doctor not being there, on the health care provider not being there, on the hospital closing, on the trauma center closing?

We had a press conference several months ago in Washington with a woman whose father was in Las Vegas visiting, and it happened to be the week that our trauma center closed. During that week, unfortunately, he needed our trauma center. I cannot tell my colleagues that he would have lived if it was open, but the reason trauma centers exist is because they provide intense expertise in the area of trauma. They have great results, much better than normal emergency rooms. Unfortunately for this family, that trauma center was closed.

By the way, the only way we were able to reopen the trauma center in Las Vegas was because the State stepped in and said that we are going to limit not to $250,000, but we are going to limit to $50,000 any injuries and malpractice that occurs. That is not just noneconomic, that is even economic damages. That is the only way that the trauma center in Las Vegas was able to open. We are losing all kinds of experts in emergency rooms in other areas in Las Vegas as well.

People talk about decreasing the amount of mistakes by physicians, and we need to do that. It is very difficult and very complex to do. One of the ways we can do that is to enact legislation to encourage voluntary reporting. The current system actually is a protectionist-type system that if somebody voluntarily reports mistakes, they set themselves up for lawsuits. So we have no way to follow where the mistakes are being made and to point out trends so we can correct those mistakes.

The House has passed patient safety legislation. We are going to be working on that in the HELP Committee, of which I am a member. I hope, in a bipartisan fashion, we can craft patient safety legislation that will make the outcomes more of what we all want to see. That means fewer mistakes. But understand that there is no way to have a mistake-free environment in such an area where the science is so inexact. We have an opportunity here.

We have an opportunity with so many States now in crisis. The States in red on the chart are in crisis; the States in yellow show serious problem signs. We have a chance in the Senate—the House of Representatives has already enacted this legislation—to make a real difference in patients' lives. We can make sure trauma centers do not close. We can make sure when a woman needs access to an obstetrician she can have that access.

A friend of mine has Parkinson's disease, lives in Las Vegas, and has to go to Loma Linda where his specialist treats him. We do not have that particular field of subspecialty in southern Nevada. He talked his physician into coming to Las Vegas before the crisis hit Nevada. When the crisis hit and we lost our major carrier of medical liability insurance, the rates literally doubled and tripled overnight, and that physician decided to stay in California. Why? Because they have enacted a law that has kept rates reasonably low.

My next chart shows differences in larger cities around the country. First, OB/GYN in Los Angeles, a well-to-do area that has enacted medical liability reform, $54,000 on average for an OB/GYN; in Denver, also where they have had enacted legislation, $30,000. Then we have New York, Las Vegas, Chicago, with Miami the worst. These are places that do not have medical liability reform. In Miami, rates are over $200,000 on average for an OB/GYN.

People say doctors make plenty of money. Have you talked to an OB/GYN lately about their average income? In Las Vegas, the average income is around $200,000 for an OB/GYN who goes through 8 years of undergraduate and medical school and then a 5-year residency. They come out $250,000 to $300,000 in debt minimum and they work about 100 to 110 hours a week to make $200,000. And their rates now in Las Vegas are around $130,000 to $140,000, up from a couple of years ago around $40,000 or $50,000 a year.

Because of managed care they are not able to increase their rates, so it comes out of their pockets. That is why a lot of them are leaving our

State. That is why a lot of new people are not going into the practice of obstetrics and gynecology. Especially for delivery of high-risk patients, rates have skyrocketed. Many physicians simply will not treat high-risk patients.

What are the women to do with a high-risk pregnancy? More and more women today are choosing to have babies later and later in life, and more and more of them have high-risk pregnancies as a result. With fewer and fewer doctors able to deliver high-risk pregnancies, this does not add up. That is why it is so critical to enact this legislation before the Senate today.

I know where the politics lie. We will probably not be able to pass this legislation at this point. However, I want people to take a hard look, talk to the patients in your States, find out what is really happening at the grassroots level. This is not a question of how much money a physician makes. This is not a question of whether hospitals or insurance companies are going to be profitable. This is a question of whether when somebody needs the health care services to save lives or deliver babies, that health care will be there because the provider is there.

I am passionate about this issue because people are in jeopardy of not getting the kinds of lifesaving services they need, the types of services that improve the quality of life for so many Americans. That is why this legislation is so critical today.

As we go forward over the next 24 hours debating this bill, I encourage Members to have a healthy debate with an up-or-down vote and start hearing from the American people on this issue. If Senators listen to their constituents, they will hear loudly and clearly we need to reform our medical liability system so we can afford to have health care that is so desperately needed.

I yield the floor.

The PRESIDING OFFICER. The Senator from Idaho.

Mr. CRAIG. Are we in morning business?

The PRESIDING OFFICER. We are in morning business with remaining time on our side of 4 minutes 21 seconds.

Mr. REID. Mr. President, I ask that the Senator from Idaho be given whatever time he needs. He is talking about a very important subject.

The PRESIDING OFFICER. There is a unanimous consent to begin debate on judges at 11:30.

Mr. REID. I ask unanimous consent the Senator have whatever time he needs up to 25 minutes to the hour for this very important statement.

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

BIRTH ANNOUNCEMENTS

Mr. CRAIG. Mr. President, the Democrat leader and I were visiting a few moments ago about our Fourth of July break and what we were doing. That is one of the reasons I am speaking this morning. I thank the Senator from Nevada for that courtesy.

We all went home during the Fourth of July break to celebrate a birthday, the birthday of our great Nation. We gathered with family and friends. We set off fireworks. Some Members were in parades. It was all about a birthday, the birthday of this great Nation.

My wife Suzanne and I were also home in Idaho because of other birthdays. On May 31 of this year, our daughter Shae and her husband David had twins. Two new grandchildren entered both Suzanne's and my life, a boy and a girl, born on May 31. The little boy's name is Drew Calvin Howell and he weighed 5 pounds and 3 ounces. His sister, I am sure always to be called the little sister, is Peyton Shae Howell, and she was born at 11:54. Drew was born at 11:32. She weighed 4 pounds and 1 ounce. They are twins and were premature so they stayed the first 3 weeks of their lives in intensive care in a Boise hospital before they were allowed to come home.

Here we are, Fourth of July, and they are really home for the first time. It is the first time grandpa had a chance to hold them and love them and see them and be around them. It was a treat for our family but especially for Suzanne and myself to be with our grandchildren.

This Fourth of July in Idaho with our family took on special meaning as we celebrated the birthday of these grandchildren, these twins, with our daughter Shae and her husband David. It is always an important time in families when grandchildren enter them. Drew and Peyton are the sixth and seventh grandchildren, so we feel very privileged by that.

Often we come to the floor to talk about momentous and meaningful events. The Republican Senator from Nevada just spoke about a critical issue of reforming health care in our country, and malpractice. But probably there is no more important event than when grandchildren enter our lives.

I yield the floor.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Under the previous order, morning business is closed.

EXECUTIVE SESSION

NOMINATION OF DAVID G. CAMPBELL, OF ARIZONA, TO BE UNITED STATES DISTRICT JUDGE FOR THE DISTRICT OF ARIZONA

The PRESIDING OFFICER. The hour of 11:30 having arrived, the Senate will proceed to executive session for the consideration of Executive Calendar No. 227 until the hour of 11:45, with the time equally divided between the chairman and the ranking member of the Judiciary Committee or their designees.

The clerk will report.

The legislative clerk read the nomination of David G. Campbell, of Arizona, to be United States District Judge for the District of Arizona.

The PRESIDING OFFICER. The Senator from Idaho.

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

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

UNANIMOUS CONSENT AGREEMENT

Mr. FRIST. Mr. President, I ask unanimous consent that the cloture vote with respect to the Wolski nomination be vitiated; provided further that at 2:15 today the Senate resume the motion to proceed to S. 11; further, I ask unanimous consent that on Wednesday the time between 9:30 a.m. and 11 a.m. be equally divided between the two leaders or their designees; that at 11:30 the Senate proceed to the vote on invoking cloture on the motion to proceed to S. 11; and, regardless of the outcome of that vote the Senate then proceed to an immediate vote on the confirmation of Victor Wolski to be a judge of the U.S. Court of Federal Claims.

I further ask unanimous consent that immediately after the confirmation of the Wolski nomination the Senate proceed en bloc to Executive Calendar Nos. 89, 129, and 130; and, further, that the nominations be confirmed and the motions to reconsider be laid upon the table, the President be immediately notified of the Senate's action, and the Senate then resume legislative session.

Finally, I ask unanimous consent that following that action the Senate then proceed to the consideration of Calendar No. 77, S. 925, the State Department authorization bill.

The PRESIDING OFFICER. Is there objection?

Mr. DASCHLE. Mr. President, reserving the right to object—I will not object—I will make a comment and then pose a clarification.

I talked to the majority leader earlier today about the concerns that we have regarding Mr. Wolski. Although it was not our intent to extend the debate indefinitely, it was our view that, given the nature of his nomination, it deserved a little additional attention and some specific time for debate beyond that which we were provided this morning.

I wish to express my appreciation to the majority leader for giving us that opportunity. I hope, if there are breaks in the debate either today or tonight, that Senators who have an interest in this particular nomination use that time in addition to the amount of time that is earmarked for the debate on the

nomination tomorrow morning. So we will certainly find a way in which to make that part of the schedule.

The clarification: As I understand it—and I ask for the majority leader's affirmation—Nos. 89, 129, and 130 are the nominations involving the Federal Claims Court. They are the other nominees whose names are still pending on the Executive Calendar. I ask the majority leader if that is, indeed, the case.

Mr. FRIST. Mr. President, that is the case, and the understanding as put forth in the unanimous consent request is that we proceed to them en bloc. They are the other three on the claims court.

Mr. DASCHLE. Mr. President, I have no objection.

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

The PRESIDING OFFICER. The Senator from Arizona.

Mr. KYL. Mr. President, I ask unanimous consent to speak for no more than 2 minutes on the nomination of David Campbell upon which we are about to vote.

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

Mr. KYL. Mr. President, I advise my colleagues that the person we are about to vote on is one of the smartest candidates for Federal district court that I have ever seen nominated by a President of either party. His name is David Campbell. He is nominated to be a U.S. District Judge for the District of Arizona.

He has a distinguished record in the State of Arizona, primarily with the Phoenix law firm of Osborn and Maledon. He was a graduate of the University of Utah Law School in 1979, where he was a note editor on the Law Review and was awarded the Order of Coif.

He clerked for both Judge Clifford Wallace for the U.S. Court of Appeals for the Ninth Circuit and for U.S. Supreme Court Justice William Rehnquist.

He has practiced primarily in the civil area but has a broad experience, including a lot of work with the Arizona State Bar Association's Committee on Rules of Professional Responsibility, and he has been cobar counsel in a majority bar disciplinary case.

In addition to his work in the law practice, he has taught as adjunct professor of law at the Arizona State University Law School and was a visiting professor at the J. Reuben Clark Law School at Brigham Young University where he was named Professor of the Year.

He has published articles and has had a distinguished career as a lawyer in the State of Arizona.

I think the Senate will be proud to have confirmed him to the Federal bench. He epitomizes what we are looking for in judicial temperament, intelligence and integrity, and I think the State of Arizona and the U.S. bench generally will be the better as a result of our confirmation of David Campbell.

I commend the President for his nomination of David Campbell.

I also express appreciation to David's wife Stacey and their five children for putting up with what will now be a career on the Federal bench for this very fine candidate, David Campbell.

I urge my colleagues to support the confirmation of his nomination to be a U.S. Federal judge.

I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. HATCH. Mr. President, I rise today to express my strong support for the confirmation of David G. Campbell to serve as a judge of the United States District Court for the District of Arizona.

David Campbell is an extremely well-qualified nominee with a significant amount of litigation experience, and he will make an excellent addition to the federal bench.

He received his undergraduate degree magna cum laude, as well as his law degree, from the University of Utah—which, in my view, is a reliable and persuasive indication of his excellent judgment.

Upon graduation from law school, Mr. Campbell clerked for Ninth Circuit Judge Clifford Wallace, and for then Associate Justice William Rehnquist on the United States Supreme Court.

He joined the Phoenix law firm of Meyer, Hendricks, Victor, Osborn & Maledon in 1982 and became a partner there in 1986. Since 1995, Mr. Campbell has been a partner at its successor firm, Osborn Maledon, where he practices in the area of general civil litigation. The American Bar Association bestowed on Mr. Campbell its highest rating of unanimously well qualified in recognition of his outstanding legal skills and reputation.

In addition to his distinguished legal career, Mr. Campbell has been a great asset to his community and has donated many hours of pro bono service and volunteer time to help individuals and families in need in his community. His volunteer service has included building homes for the homeless in Mexico, providing Christmas supplies to crises nurseries, and providing back to school clothing for disadvantaged children. He was also named Professor of the Year in 1991 by the J. Rueben Clark Law School at Brigham Young University for his service as a visiting civil procedure professor.

I am confident that David Campbell will be a model jurist, and I urge my colleagues to join me in supporting his confirmation.

The PRESIDING OFFICER. The question is, Will the Senate advise and consent to the nomination of David G. Campbell, of Arizona, to be United States District Judge for the District of Arizona?

The yeas and nays have been ordered and the clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Oklahoma (Mr. INHOFE) is necessarily absent.

Mr. REID. I announce that the Senator from Delaware (Mr. BIDEN), the Senator from North Carolina (Mr. EDWARDS), the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), the Senator from Connecticut (Mr. LIEBERMAN), the Senator from Georgia (Mr. MILLER), and the Senator from Florida (Mr. NELSON) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The result was announced—yeas 92, nays 0, as follows:

[Rollcall Vote No. 263 Ex.]

YEAS—92

Akaka	DeWine	Lott
Alexander	Dodd	Lugar
Allard	Dole	McCain
Allen	Domenici	McConnell
Baucus	Dorgan	Mikulski
Bayh	Durbin	Murkowski
Bennett	Ensign	Murray
Bingaman	Enzi	Nelson (NE)
Bond	Feingold	Nickles
Boxer	Feinstein	Pryor
Breaux	Fitzgerald	Reed
Brownback	Frist	Reid
Bunning	Graham (SC)	Roberts
Burns	Grassley	Rockefeller
Byrd	Gregg	Santorum
Campbell	Hagel	Sarbanes
Cantwell	Harkin	Schumer
Carper	Hatch	Sessions
Chafee	Hollings	Shelby
Chambliss	Hutchison	Smith
Clinton	Inouye	Snowe
Cochran	Jeffords	Specter
Coleman	Johnson	Stabenow
Collins	Kennedy	Stevens
Conrad	Kohl	Sununu
Cornyn	Kyl	Talent
Corzine	Landrieu	Thomas
Craig	Lautenberg	Voinovich
Crapo	Leahy	Warner
Daschle	Levin	Wyden
Dayton	Lincoln	

NOT VOTING—8

Biden	Inhofe	Miller
Edwards	Kerry	Nelson (FL)
Graham (FL)	Lieberman	

The nomination was confirmed.

The PRESIDING OFFICER (Mr. SESSIONS). Under the previous order, the President shall be immediately notified of the Senate's action.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will now return to legislative session.

The Senator from Wyoming is recognized.

MORNING BUSINESS

Mr. ENZI. Mr. President, I ask unanimous consent that the Senate begin a period of morning business until 12:30 p.m.

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

PATIENTS FIRST ACT

Mr. ENZI. Mr. President, throughout the West, and all over the country,

more and more physicians are closing up shop and moving their practices out of State because they can no longer afford their medical liability insurance premiums in States that don't have some kind of a control over the amount that can be awarded.

Whenever I go home for a town meeting or when I visit with constituents, I hear story after story about people who are facing the loss of the sole option for health care in their towns because of the skyrocketing premiums their doctors must pay.

One constituent told me about her family physician in Newcastle, WY. She had to close her doors because the cost of insurance premiums made it impossible for her to provide obstetrical services to the pregnant women of the town. She said: Telling a pregnant woman I won't be there to deliver her baby was one of the hardest things I had to do as a family physician.

She then joined two other doctors in Newcastle to announce as of July 1 they would be unable to deliver babies because of a more than 50-percent increase in their liability insurance premiums. That means pregnant women in the Newcastle area will now drive 30 to 90 miles when it comes time to deliver their babies. This is a problem for the people of Newcastle, but it is one that also faces the people who live in a lot of towns throughout my State of Wyoming and many other States.

Take Jackson, WY, for instance. A surgeon there paid $16,000 for liability insurance in his first year in practice. He is now facing an increase in his rates that will place his premium at $164,000. That is a jump of $148,000 in 1 year. Emergency room and trauma doctors are facing similar jumps in the cost of liability insurance. An emergency room doctor in Rawlins, WY, nearly closed his practice after his insurance company announced it would no longer provide coverage for emergency room services. Fortunately, his hospital was able to find him coverage at the last minute, but this is merely a temporary solution to a critical problem.

Recruiting physicians to practice in rural States such as Wyoming is a difficult job. The high cost of medical liability premiums is making it nearly impossible. These examples highlight the problem we are facing. This problem is not just about lawsuits and insurance rates, it is about people who cannot get the medical attention they need. It is about communities without doctors to serve them. It is about a health care system in crisis.

The cost of medical liability insurance and the role of medical litigation raise very complex issues, but the focus is not and should not be on doctors or trial lawyers or insurance companies fighting among themselves. Our focus should be on patients and on ensuring accessible and affordable health care for all Americans. In Wyoming, ensuring access to affordable health care is a persistent challenge. We probably would have a shortage of health care providers even if our medical liability system worked perfectly, but the costs of medical litigation and of medical liability insurance are taking matters from bad to worse for the people of my State.

In fact, a study released yesterday by the Agency for Health Care Research and Quality found that States that limit pain and suffering awards in medical lawsuits have more physicians per capita than States such as Wyoming that have no such limits.

Here are some other examples of the impact this crisis is having on Wyomingites:

Two physicians who practice internal medicine in my hometown of Gillette have been notified that their medical liability insurance will be canceled as of July 31—not increased, canceled. If they are unable to find insurance coverage to replace their canceled policy in 2 weeks, they will be forced to close their practice in a town that is already experiencing a shortage of primary care doctors.

Another doctor in Casper, WY, was barely able to find insurance coverage for this year. The doctor delivers more than 350 babies each year. Nearly half of the mothers are covered by Medicaid. He also performs nearly one-half of the gynecological surgeries in the Casper area. The only insurance he was able to find cost him $140,000 per year with an additional $69,000 to purchase ''tail'' coverage in case he is sued for something that happened before his new insurance took effect.

In Wyoming, a physician who delivers a baby can be sued any time until the child's eighth birthday. So this ''tail'' is quite long, which means the premium could be quite high. In addition, this coverage is a short-term policy only good for 1 year, and he expects his cost of insurance will increase substantially again next year. Without his service, many pregnant mothers will find it difficult to obtain important prenatal care, especially expectant mothers in low-income families.

Earlier this year, a doctor in Wheatland, WY, went to a high school basketball game between the Wheatland Bulldogs and the nearby Douglas Bearcats. At the game, he announced he would not be delivering any more babies in Wheatland or Douglas and may be leaving the State because of the cost of liability insurance. The irony is that he had delivered just about every player on both teams. This was not somebody new in practice.

We also have doctors who are being forced to leave Wyoming to find relief from the financial burden of liability insurance. One doctor from Riverton, WY, grew up there, married a native of Wyoming, and returned to Riverton to raise his family and practice medicine in the State he loves. But between paying off student loans from medical school and paying expensive premiums on liability insurance, he is being forced to move to a State that has limits on pain and suffering awards. By moving, he will reduce his premiums by $43,000 a year.

The threat of lawsuits is enough by itself to raise insurance premiums in a State such as Wyoming. Plus, with so few doctors purchasing insurance in the pool, one major payout, whether the doctor was at fault or not, can really send premiums for every doctor right through the roof. As a result, many doctors in Wyoming are moving to States with larger risk pools and fairer liability laws, just as their colleague from Riverton is doing.

People who are truly injured by errors made by health care providers ought to be compensated fairly for their losses. However, the medical justice system today does not achieve this objective. If fair compensation is the standard, our medical justice system falls woefully short of the mark. Most people who are injured as a result of health care errors do not receive any compensation. However, some who are injured receive multimillion-dollar judgments as compensation for a bad outcome often without regard for whether the physician or hospital was even negligent.

The unpredictability of our medical justice system really does not serve patients or providers well. The only people who come out ahead are the personal injury lawyers who happen to find the right case. When it becomes impossible for insurance companies to predict their losses with any certainty, premiums go up. It is a fact of the business, and it is no different for property insurers or life insurers than it is for medical liability insurers.

Yes, people are hurt by health care errors, but skyrocketing medical liability premiums are hurting people, too. They are hurting physicians and hospitals in my home State by forcing them to curtail services or, in the case of doctors, to leave their practices entirely. Those doctors who continue to practice now look at each patient as a potential lawsuit. So they order more tests, whether or not the patient needs the tests. They spend less time discussing a course of treatment with the patient so they can spend more time writing a report after the appointment to justify the treatment decision in case they get sued.

Ordering more tests and writing more reports costs an already overworked doctor time with his or her family and time to catch up on his or her sleep. Doctors should not have to make choices between what is right for their patients and what is right for themselves, but our medical litigation system does not offer them a real alternative.

Most importantly, the medical liability crisis in my State is hurting innocent citizens who are losing their trusted hometown doctors to other States that have reformed their medical justice systems.

What do we know about our overall system of medical justice in America

today? We know compensation to patients injured by medical errors is neither prompt nor fair. We also know verdicts with huge awards that do not match the severity of injuries or the conduct of the defendants destabilize the insurance markets. This sends premiums skyrocketing, which forces many physicians to curtail, move, or drop their practices. This leaves patients without access to necessary medical care.

Finally, we know litigation does nothing to improve quality or safety. In fact, the constant threat of litigation drives the inefficient and costly practice of defensive medicine and also discourages the exchange of information about preventable health care errors that we could use to improve the quality and safety of patient care.

The current medical liability crisis and the shortcomings of our medical litigation system make it clear that this is the time for a major change. We need a medical justice system that promotes accountability and fairness instead of discouraging them.

Regardless of how we vote on this legislation before us, we all ought to start working toward replacing the current medical tort liability scheme with a more reliable and predictable system of medical justice. We need a system that restores rationality to the way in which we compensate the injured and learn from mistakes. We need a system that restores the trust that patients and providers used to have in each other. It is incumbent upon all of us to strive for such a system so that we may raise the overall standard of health care in this country.

The legislation we are considering today is an important step in the short term toward making the medical justice system work better for everyone, not just a fortunate handful of personal injury lawyers. I urge my colleagues to join me and vote for this bill.

I ask unanimous consent that at 2:15, Senator KYL be recognized to speak for up to 15 minutes to be followed by Senator FEINSTEIN for up to 25 minutes.

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

RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 having arrived, the Senate will stand in recess until the hour of 2:15.

Thereupon, the Senate, at 12:32 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. VOINOVICH.)

PATIENTS FIRST ACT OF 2003—Motion to Proceed—Resumed

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. REID. Mr. President, if the Senator will yield just for a brief second, it is my understanding the Senator from Arizona has authority to speak up to 15 minutes, followed by a 25-minute speech by the Senator from California. Is that true?

The PRESIDING OFFICER. That is correct.

Mr. REID. I ask unanimous consent that following the statement of the Senator from California, Senator CORNYN be recognized for 30 minutes, followed by Senator HOLLINGS for 30 minutes, and following Senator HOLLINGS, I ask that Senator VOINOVICH be recognized for up to 30 minutes, and then he would be followed by a Democrat.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Arizona.

Mr. KYL. Mr. President, I am pleased to address one of the most important issues I think we are going to be talking about all year. I hope our colleagues will permit us to conclude our debate with a vote so we can actually adopt some legislation to deal with this crisis of lawsuit abuse in the United States. Some call it medical malpractice reform. Whatever you call it, we have to deal with it.

Unfortunately, what we have heard is that some of our colleagues are going to prevent us from having a vote on the bill that is before us, S. 11. It is a bill that addresses one of the most fundamental problems we have, and that is access to available quality medical care by a lot of people in our society today. We need to reform this flawed medical malpractice system which is prohibiting people from getting the quality medical care they need and deserve.

We debated just before the Fourth of July recess Medicare reform to provide prescription drug benefits to all of our senior citizens. We took a lot of time talking about why our senior citizens needed access to care and how we were going to improve that access. But all of that will go for naught, it will do no good, if there are no hospitals and there are no pharmacists, if there are no physicians and other health care providers—or an insufficient number of those providers—to help those people in need, whether they be senior citizens or others, because of the high cost of malpractice premiums and therefore the inability of these providers to continue to serve the people in their communities.

Last year, the American Medical Association released a study on this lawsuit abuse problem. It concluded that 12 States were having a full-blown crisis and that 30 States were seeing serious problems in terms of the ability of physicians and hospitals to stay in practice to take care of their patients.

Today, just a year later, that study has been updated and the AMA has now concluded that 19 States are having a full-blown crisis in dealing with the medical malpractice insurance rates just for physicians. Let me give some examples of how this is affecting different communities around the country so you can see it is truly a nationwide problem.

In my State of Arizona, health care providers have experienced dramatic increases in their insurance rates. Between 2001 and 2002, two hospitals in Phoenix saw a threefold increase in their malpractice premiums, paying more than $1.7 million. Meanwhile, in Winslow, AZ, the hospital premiums have more than doubled, to $1.8 million.

Some of you know the town of Winslow, AR, from a famous song by the Eagles. It is a town with great history and rich in tradition in Arizona but it is not very big. It doesn't have the patient base to support a hospital that has to pay almost $2 million a year in medical malpractice premiums. It is not just in my State of Arizona. Methodist Hospital in south Philadelphia recently closed its maternity ward and prenatal program because of its medical liability insurance rates. Greenwood Hospital in Mississippi was unable to keep its level II trauma center rating because the neurosurgeons in the area had left citing the high cost of liability insurance.

I spoke with a woman whose husband had been very seriously injured in an automobile accident in Mississippi. She told the story of how—because of the lack of physicians and because of the high cost of premiums—her husband has suffered so terribly as a result of that accident and the inability to get quick medical attention.

Back to my home State of Arizona, the Copper Queen Community Hospital in Bisbee, AZ, was recently forced to close its maternity ward because the family practitioners in that community were looking at a 500-percent premium increase. Expectant mothers now must travel more than 60 miles to the closest hospital, which is either in Sierra Vista or in Tucson. According to the recent news accounts, four women have since had to deliver babies en route.

To cite the news accounts, Time magazine has a June 9 cover story about the doctor being out and why so many patients are losing doctors to the rising cost of malpractice.

This is now truly a national event.

In the Time magazine piece dealing with this question of physicians having to leave the practice, there is a particularly interesting story about a woman in Arizona whose name is Vanessa Valdez. The title of the story is ''Taking the Highway to Have a Baby.'' The story points out that Vanessa has to drive about 50 miles to see her OB/GYN and to have a baby. She lives in the town of Douglas, which is on the Arizona-Mexico border. But there is no obstetrician within an hour's drive to deliver her child. There were six family practitioners in that community but they couldn't afford the soaring malpractice premiums. As a result, the hospital was forced to close its delivery room, and suddenly rural Cochise County has but one delivery room for the 118,000 residents. That is in Sierra Vista, 50 miles from Valdez's home of Douglas.

This is beautiful country. It is a great place to live. But it is no place to live if you are going to get sick or you know you are going to have a baby because you have an hour's drive to get to a doctor. That is not right. It is not as if this is out in the middle of nowhere and you chose to live there with all of the attendant risks involved. No. There are a lot of communities in this area but none of them had physicians able to continue to practice because of the medical malpractice premiums they had to pay.

One other example: Nevada was very much in the news last year because of the crisis in that State. Nevada's top level trauma center was recently closed for 10 days after 58 orthopedic specialists in Las Vegas temporarily quit because of the skyrocketing insurance costs. Also, a lot of the physicians delivering babies and performing high-risk surgeries have indicated that they won't be able to continue to practice without some kind of relief.

Ultimately, this destructive lawsuit abuse hurts the patients. Yes. The doctors can't make it, so they leave. But ultimately it is the patients who are the ones who suffer.

Therefore, we are trying to deal with that through legislation that will make it a little bit more difficult for this kind of lawsuit abuse to occur so that the insurance companies won't have to charge quite as high a rate, so the physicians and hospitals can stay in business, and so the people of the communities can continue to be served.

Also, the threat of lawsuit abuse often forces doctors to perform a lot more in the way of tests and surgeries and other kinds of treatments than they otherwise would do simply to protect themselves from a claim that they weren't doing enough for the patients—sometimes expensive tests, sometimes invasive procedures.

All of this is called defensive medicine—trying to do everything they can to make sure some smart lawyer out there doesn't try to pick at what they did and find some kind of fault with it and find a client who is willing and able to hire a lawyer to bring a lawsuit against the doctor.

That is another effect of this lawsuit abuse. Another is the fact that a lot of times doctors are no longer willing to perform risky procedures that may be necessary to really help somebody or even save somebody's life. Obviously, the more serious the condition, frequently the more risky the procedure. You want to be served by a physician who is willing to go to the mat for you in that case. But if the physician is looking at a big medical liability suit, if the result doesn't happen to work out right, then that physician is going to be less likely to try to treat you.

All of this results in an inferior quality of medical care for American citizens, which is wrong. It is not at all uncommon for these lawsuits to be brought and the lawyers to get over half the settlement. That is wrong. That is one of the issues with which this legislation deals.

The Congressional Budget Office determined that the House bill, which passed and which was pretty similar to S. 11, would reduce direct Federal spending for Medicare, Medicaid, and other Federal health programs by almost $15 billion over the next 10 years. Since the Federal Government is a payer for many of the medical services, particularly for our seniors who are indigent, it is a saving to the Federal Government as well for this lawsuit abuse to be addressed. Because employers will pay less for health insurance for their employees and more of the employees' compensation will be in the form of taxable wages and other fringe benefits, including, of course, money that could be plowed back into greater health care for the employees, the Congressional Budget Office estimated that enacting this legislation would increase Federal revenues by about $3 billion over the next 10 years as employees receive higher wages.

Just a note about the legislation itself, there are a lot of different ways you can do this. I had actually cosponsored a bill somewhat different than this. But the basic idea is the same, even though we might want to change specific provisions of this legislation. It basically sets sensible limits on the noneconomic damages that can be obtained in these lawsuits. The noneconomic damages are those damages that go above and beyond the bills that have to be paid. When you get sick and the physician allegedly committed malpractice, you had to go to another doctor to get the problem resolved. Those are economic damages as you lost wages, and any other expenses that you have. And those economic losses are fully compensated. But above and beyond that, you are entitled and juries will award substantial damages for noneconomic losses, mostly called pain and suffering because of what you had to go through. Certainly people recover something for their pain and suffering. The question is how much.

In order to avoid lawsuit abuse, some States—for example, the State of California has put a $250,000 limit on those noneconomic damages. That is precisely what this legislation does as well. However, states with higher caps can keep those under this legislation too. It also reserves punitive damages for cases that justify it. Part of lawsuit abuse is very large punitive damage awards which have nothing whatsoever to do with either the economic or noneconomic losses but nevertheless help to enrich the lawyers.

There are some other features of the legislation as well. But the point I wanted to make is whatever the specifics of the legislation, we need to act.

I hope our colleagues will permit us to conclude the debate and have a vote on this legislation so we can get together with the House of Representatives, which also passed a bill, have a conference committee work out any differences, all have a chance to vote on that, and then hopefully have a bill we can send to the President.

If we are never able to have a vote on this, it is not just the doctors, hospitals, and other providers that are going to suffer; it is the American people because they will not have access to the quality of medical care which they need and deserve. I hope we cannot only debate this legislation but also permit it to come to a vote so we can address this serious crisis in America today.

The PRESIDING OFFICER. The Senator from California is recognized.

Mrs. FEINSTEIN. Mr. President, I wanted to use 12 minutes of the Senate's time to discuss my reaction to this bill and my general thinking about the subject of medical malpractice insurance premiums.

I think it is pretty clear that medicine is at a crossroads. I think it is pretty clear that something has to be done. My own State of California was at the crossroads 28 years ago. A bill was passed through the legislature called the Medical Injury Compensation Reform Act, known as MICRA. MICRA had a rough road initially. It had a number of court challenges. Finally, it was sustained by the California Supreme Court.

What we saw—I will go into this in more detail later on—was that premium costs began to settle down. In fact, I think it is fair to say that the California medical profession is very pleased with the MICRA bill as it stands today.

The problem I have—and I am probably one of the few on my side of the aisle who is not opposed to the issue of caps because I think in this situation they are helpful, but my problem is with the bill that is before us today because that bill is nearly identical to the bill passed out of the House and, frankly speaking, it is not one that I can support.

This bill before us sets a $250,000 cap for noneconomic damages in medical malpractice suits. Now, this can be applied not only to suits against doctors but to suits against HMOs, nursing homes, and medical product manufacturers. It is a very broad provision. This cap would even apply for extraordinary cases. I will give you one: A youngster, Jessica Santillan, a 17-year-old who died after doctors mistakenly transplanted the wrong kidneys into her body.

So under this bill, suits against drug and device manufacturers also, such as the makers of the weight loss drug Phen-Fen, the Dalkon shield contraceptive device, faulty heart valves, and other products that have caused innocent deaths, would be limited to $250,000 in noneconomic damages. I find that unacceptable.

Secondly, this legislation would severely limit the availability of punitive damages not only for doctors but

also for manufacturers. In general, punitive damages are capped at the greater of $250,000 or twice economic damages in this bill. But the bill also wipes out any punitive damages in several different types of lawsuits against medical product manufacturers. It would immunize the manufacturer or seller of drugs from punitive damages for any packaging or labeling defect on their product. So, presumably, if a drug package label had mistakenly directed a patient to take 10 pills a day instead of 1 pill a day, a patient could not sue for punitive damages, regardless of the harm caused or the basis of the mistaken direction.

It would also limit the availability of punitive damages against any manufacturer or distributor of medical products if the product complied with FDA regulations. Let me give you an example: a product such as the Bjork-Shiley artificial heart valve. It originally received FDA approval, but these valves broke in an estimated 619 patients and led to hundreds of deaths. Under this bill, they would be immune from any punitive damage case. I think that is wrong.

This FDA exemption, in a sense, sets a downward and unacceptable course. If a company has an FDA-approved product on the market and then learns of a dangerous complication presented by that product or a failure of that product, it should have the incentive to remove that product from the marketplace as soon as possible. I think to provide an exemption if the product has FDA approval creates a disincentive to the rapid removal of that product from the shelf.

So while I cannot support this proposal, there are, however, proposals which I could support because I do believe that rising premiums are creating a crisis all across this country in terms of access to care. Others have placed before this body a number of situations. Let me just repeat a few.

Obstetricians and gynecologists in Florida pay over $200,000 a year for malpractice insurance as opposed to $57,000 a year in California. And there is no more high-cost State than California. So OB/GYN premiums in Florida, $200,000; in California, because of MICRA, $57,000; surgeons in Michigan pay $110,000 for malpractice insurance. Twenty percent of the OBs and GYNs in West Virginia and Georgia have been forced out of their practice due to rising premiums.

Nine hundred doctors in Pennsylvania have left the State since 2001 to avoid annual premiums as high as $200,000. The Methodist Hospital in Philadelphia discontinued its prenatal program for low-income women because of high premium costs.

The neurosurgeons of Wheeling, WV, have left the area, and local trauma patients requiring neurosurgery need to be airlifted out of the State.

Not only are insurance premiums skyrocketing in some States, but insurers are leaving the market, and that is a very dangerous signal. There were 14 companies underwriting liability in Mississippi; today, there is but one willing to write new policies. Texas had 17 insurance carriers; today it has 4.

In California, we have nonprofits handling the insurance for California's doctors, and that is one reason the system works.

I have spent a number of months taking a good look at the California law to see what could be transferred to the national level. And I want to say, here and now, this Senator would support reasonable caps on noneconomic damages because I deeply believe they can lead to more stable premium rates.

At the time MICRA was enacted in 1975, the cost of health insurance in California was higher than any other market except New York City. In the 6 years before 1975, the number of malpractice suits filed per 100 physicians in California more than doubled.

MICRA has kept costs down. In 1975, California's doctors paid 20 percent of the gross costs of all malpractice insurance premiums in the country. Today, they pay 11 percent of the Nation's total malpractice insurance premiums. Clearly, costs have dropped in comparison with other States.

All over the United States, premiums have grown 505 percent in the past 25 years. California's premiums have grown 167 percent. In other words, premiums have grown three times slower in California than in other States. That alone shows that MICRA is working, regardless of what anyone might say.

Also, because of MICRA, patients get their money 23 percent faster than in States without caps on noneconomic damages. Bottom line: California's malpractice premiums today are one-third to one-half lower, on average, than those in Florida or New York.

Because the California law has proven successful at keeping premiums down—and I know there are those who do not want to believe it; they will say it is some other reason; but I believe it has—I used the law as a departure point for crafting a proposal which I believe is both just and fair and which I believe should stabilize and, over time, reduce premium costs.

I very much appreciate the efforts of Senator FRIST and Senator MCCONNELL in working with me to explore this option. I am not going to offer it on the floor today for one reason: Unfortunately, it would not have the necessary votes.

Specifically, my proposal would do the following: It would create a schedule for attorney's fees. It would create a strict statute of limitations, requiring that medical negligence claims be brought within 1 year from the discovery of an injury or within 3 years of the injury's occurrence. It would require a claimant to give a defendant 90 days' notice of his or her intent to file a lawsuit before a claim could actually be filed. It would allow defendants to pay damage awards in periodic installments. It would allow defendants to introduce evidence at trial to show that claimants have already been compensated for their injuries through workers compensation benefits, disability benefits, health insurance, or other payments—that is only fair—and it would permit the recovery of unlimited economic damages.

My proposal would differ from California's law in two key areas: One, noneconomic damages and, two, punitive damages. The California MICRA law has a $250,000 cap on noneconomic damages. In contrast, I would propose a $500,000 general cap on noneconomic damages. Today 15 States have caps of $500,000 or less for noneconomic damages. Twelve States have a cap of $500,000 or less on noneconomic damages, and that includes Alaska, Florida, Louisiana, Massachusetts, Michigan, Mississippi, Nevada, Oregon, Texas, Hawaii, North Dakota, and South Dakota. Three States have caps of $250,000-or-less and they include Montana, New Hampshire, and California. Thus, 15 States already have caps of $500,000 or lower.

In catastrophic cases, where a victim of malpractice was subject to severe disfigurement, severe disability, or death—in other words, a catastrophic exemption—the cap would be the greater of $2 million or 50,000 times the number of years of the life expectancy of the victim. This really takes into consideration terrible morbidity done to a young child whose life span might be 50 or 60 years more. Clearly, a cap of $250,000 or $500,000 is really not fair to that youngster. Therefore, the catastrophic exemption we would propose would provide the greater of $2 million or 50,000 times the number of years of life expectancy of the victim.

In addition, we would propose a less onerous punitive damages standard than California law. California law is very strict today with respect to a plaintiff's ability to prove punitives under the very high standard of fraud, oppression, or malice. In other words, if you can't prove fraud, oppression, or malice, you can't prove punitive damages. If a doctor is in the middle of surgery and walks out to go to his bank to make a deposit while the patient is under a general anesthetic, in my view, that doctor should have punitive damages brought against him because that clearly is not accepted medical procedure.

California's law is much stricter. You have to prove fraud, oppression, or malice. Under this law, I am not aware of a single case where a plaintiff has obtained punitive damages in California over the past 10 years. So at least in my view, for situations such as the one I just indicated, the California law is too strict in this regard.

Instead we would offer a four-part test where a plaintiff would have to show by clear and convincing evidence—and this was put together based on measures that have passed this Senate in the not too distant past—that

the defendant, one, intended to injure the claimant unrelated to the provision of health care; or two, understood that the claimant was substantially certain to suffer unnecessary injury and, in providing or failing to provide health care services, the defendant deliberately failed to avoid such injury; three, the defendant acted with a conscious flagrant disregard of a substantial and unjustifiable risk of unnecessary injury which the defendant failed to avoid; or four, the defendant acted with a conscious flagrant disregard of acceptable medical practice in such circumstances.

Clearly, the doctor who walked out of a surgery and left a patient under a general anesthetic would fall under this fourth plank. It certainly is a flagrant disregard of acceptable medical practice which would be, you don't go to your bank in the middle of an operation to make a deposit when the patient is under a general anesthetic.

I firmly believe a variant of this type could lead to a compromise in the proposal in the Senate. Why didn't I go ahead with it? Much to my chagrin and, I think, surprise, both the American Medical Association and the California Medical Association rejected this proposal. The AMA contends that despite the fact 15 States have caps of $500,000 or less, they believe that a $500,000 cap is too high and it would not stabilize premiums.

The California Medical Association is opposed to it for a different reason. Although we leave State law in place, whether that State law is retroactively passed or prospectively passed, the CMA felt the State legislature might—I say ''might''—change the $250,000 cap to $500,000. So both of these associations have rejected that proposal which meant I wouldn't have a chance to get the necessary votes on either my side of the aisle or pick up a few votes on the other side of the aisle.

They refused to move from a cap of $250,000 for noneconomic damages in even catastrophic cases. To me this is wrong because a $250,000 cap in 1975, when the California law set this cap, adjusted for inflation was worth $839,000 in 2002. So last year a $250,000 cap, passed in 1975, would be worth $839,000, if passed today. If a figure of $250,000 was adequate in 1975, why couldn't a figure of $500,000, which is lower than the 1975 cap adjusted for inflation, be acceptable this year?

Now if a victim receives $250,000 today, this is equal to $40,000 in 1975. So when California led the Nation by passing the Medical Injury Compensation Reform Act and setting a cap for noneconomic damages of $250,000 in 1975, everybody should know that that is worth $40,000 today. In my book, that is unacceptable.

There are many specific instances of why it is unacceptable. Let me share one case. That is Linda McDougal. She is 46. She is a Navy veteran. She is an accountant, a mother. She was diagnosed with an aggressive form of cancer and underwent a double mastectomy. Two days later she was told that a mistake was made. She didn't have cancer and the amputation of both her breasts was not necessary.

A pathologist had mistakenly switched her test results with another woman who had cancer. Is this Congress willing to say there should be a cap of $250,000 on noneconomic damages for this kind of mistake? I think not.

A cap on noneconomic damages must take into account severe morbidity produced by a physician's mistake, such as amputating the wrong limb or transfusing a patient with the wrong type of blood.

Unfortunately, because of the opposition of both the American Medical Association and the California Medical Association, I am not proposing an amendment at this time. My purpose was to help physicians and patients, and I deeply believe that a $500,000 noneconomic damage cap, coupled with the catastrophic exception I outlined, would accomplish this, would accomplish it fairly, and would stabilize premiums over the long term.

I also suggest that State laws, where they exist, should prevail. So the California MICRA law, or any other State law, would prevail regardless of whether that State law was already enacted or retroactive.

So, bottom line, I could not get 60 votes for this proposal with the opposition of physicians. So the result may well be an alternative because I don't believe the House bill can pass in the Senate in its present form.

Let me say this. I have given this bill a great deal of thought. I really mean what I say—that I am prepared to support a reform bill. I am prepared to support a cap on noneconomic damages. But it has to be a cap that is realistic in view of today's time. It cannot be a cap that was passed 28 years ago that has an actual value of $40,000 today. So I am hopeful there will be another time and another place when a bill such as the one I have tried to outline might be found to be acceptable. In the interim, I will vote against S. 11. But, again, I stand ready to participate in a solution along the lines I have mentioned.

Mr. President, I yield the floor and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. CORNYN. Mr. President, I wish to say a few words about the issue of medical liability reform, a matter that cries out for a remedy from the Congress because of its sheer scope and size.

When it comes to health care, I believe the proper role of the Government is to protect the freedom of all people to act in their own interests and in the interests of their health. I think it is appropriate that we make sure their decisions are not made by the Government but by themselves and their families. Patients and doctors, rather than lawyers and bureaucrats, should be trusted to decide what treatment is best for themselves and their patients.

I strongly believe that when people have good choices in a health care system built upon free market principles, it ultimately translates into high-quality care. One of the obstacles, though, to achieving access to that high-quality care is the current crisis involving medical liability litigation.

Today, America is experiencing a medical liability litigation crisis that is increasing the cost of health care, it is decreasing access to physicians and hospitals for many patients, and it is generally lowering the quality of care. As a matter of fact, we could hardly call our medical liability system a ''system'' because it is such a mess. In recent years, average jury awards have more than doubled, from more than $460,000 in 1996 to more than $1 million in the year 2000.

In the past year, medical liability insurance premiums in many States have increased by more than 20 percent, on average, and more than 75 percent for certain specialties. That is just in 1 year. Between 1991 and 2001, the number of medical malpractice payments of $1 million or more that were reported to the National Practitioners' Database increased from 298 to 806. The overall result is sky-high costs for liability insurance, increased costs for those who provide health treatment, and costs that have really created a crisis of enormous proportions, one that is threatening the quality of care, diminishing access to care, and exploding the cost of care.

According to studies at the Department of Health and Human Services, doctors across the country are closing their practices, they are limiting the types of patients they see, or they are leaving communities where they have long practiced because they cannot afford the rapidly increasing costs of medical liability insurance or, worse yet, insurance coverage is unavailable altogether.

Fear of liability suits—even frivolous litigation—also results in the practice of defensive medicine.

A recent survey, for example, conducted by an organization known as Common Good, revealed some disturbing trends: 79 percent of physicians admit that the fear of litigation has caused them to order more tests than they thought medically necessary, and 74 percent refer more patients to specialists than their best medical judgment would otherwise dictate. Half have recommended invasive procedures they do not consider on a medical basis to be necessary, but they have done it in an effort to protect themselves against the second-guessing that goes

along with the medical liability regime.

Defensive medicine increases risks for patients and it raises health care costs by as much as $126 billion per year. This is a crisis not just for the Nation's physicians, it is a danger to America's patients—in other words, every single one of us.

For example, pregnant women in Nevada, Mississippi, West Virginia, and Florida must drive hours just to find an obstetrician who can care for them, and many still cannot get the essential prenatal care they desperately need. The only level 1 trauma center in Las Vegas had to close temporarily last year because its surgeons could not afford medical liability insurance. Some physicians' annual premiums had increased from $40,000 to $200,000 in just a year.

In many States, physicians are retiring or moving their practices because they either cannot afford the liability insurance or simply cannot buy the liability insurance they need in order to protect what they have worked a lifetime to achieve.

In Mississippi, physicians are actually moving across the river to Louisiana to serve the same patients they would serve in Mississippi because they can no longer afford to practice in that State, and most cities in the State of Mississippi with populations under 20,000 no longer have any physician who will even deliver a baby.

There are many more examples from my State, the State of Texas. The city of Austin, for example, is suffering from a shortage of neurosurgeons caused by retirements and relocation to avoid liability coverage costs, a shortage so heavy that some patients have to travel more than 65 miles away to find treatment.

In 100 of the 254 counties in the State of Texas, there is no obstetrician; in other words, there is no medically trained specialist who will deliver a baby in 152 Texas counties. After 44 years, Spring Branch Medical Center near Houston has stopped delivering babies altogether due to the soaring malpractice insurance costs and the shrinking pool of physicians that will actually deliver babies.

According to the Texas Medical Association's physician survey last year, more than half of all Texas physicians, including those in the prime of their professional career, are considering early retirement because of the State's medical liability insurance crisis, and earlier this year the Fort Worth Star-Telegram reported about one story that illustrates the way this problem affects patients who need care the most. The story said:

> Last summer, a pregnant woman showed up at Dr. Lloyd Van Winkle's Castroville office in south Texas, less than 10 minutes from delivery. Her family doctor in Uvalde had recently stopped delivering babies, citing malpractice concerns, and the woman was trying to drive 80 miles to her San Antonio doctor and hospital. ''She made it as far as Castroville and decided she wasn't going to make it any further,'' Van Winkle said.

We all want to prevent disease and injury. When patients get sick, we all want to prevent medical errors, and when errors do happen, we can all agree that a patient should be compensated fairly. But if you can find some goal hidden somewhere within the current dysfunctional medical liability system, that goal would not be either the prevention of errors or the fair compensation for injury. Very clearly, the current medical liability crisis operates for the benefit of a few at the expense of the many.

Personal injury trial lawyers should not be able to drive good doctors out of medicine or to reduce patients' access to health care. This system undermines the ability of physicians to treat their patients without fear, and it destroys the trust and the important relationship between patients and their physicians, and it truly abandons the American patient—that is, every one of us—when we need the help the most.

I am proud to say that in my home State of Texas, the State government has stepped up in the legislative session just ended and passed some needed reforms in this and other areas. This year, despite overwhelming pressures from special interest groups, the State passed historic liability reform which makes it possible for doctors to practice in Texas without fear of unwarranted and frivolous lawsuits. The law puts caps on punitive damages while allowing for patients who are truly hurt to be fairly compensated. Judgments will be based on the amount of involvement in the act caused in the suit without consideration of who has the deepest pocket.

I must add, though, that even in my State of Texas, there will be a vote of the people on whether the Texas Constitution will be amended to provide a means to achieve this historic reform and much needed reform, and that vote remains to be given and taken. Yet there is still little recourse for patients in States without meaningful reform, and this is truly a nationwide crisis and not one that should be addressed by individual States, given the sheer magnitude of the crisis, its geographic expanse and, frankly, the amount of Federal taxpayers' dollars to go in to paying for the current dysfunctional system.

Our health care system is still burdened with frivolous lawsuits and outrageous jury awards. According to a Health and Human Services study, premiums in States without meaningful liability reform went up 39 percent in the year 2001 and an additional 51 percent in 2002. An out-of-control system in one State can have an effect on malpractice premiums in other States, even those States that have made some incremental step toward reform.

This is a national problem, and it demands a national solution. This legislation is comprehensive reform that will enact several critically needed components. For example, it caps noneconomic damages awarded in medical malpractice cases at $250,000. It will eliminate joint and several liability; in other words, the person at fault will pay for their percentage or their share of fault and no more. It will create a uniform statute of limitations; in other words, a period of time in which a lawsuit can be filed and pursued in court in a way that will preserve both the rights of the patient, as well as make sure that so much time does not pass that memories dim, records are destroyed, and the facts are difficult to discern.

It will reform the collateral source rule, another arcane rule of our legal system that says that even if someone has already been paid from one source they can still keep that information from the jury and seek to be paid yet again for the same loss.

Finally, it will create reasonable limits and court approval of attorney contingency fee awards. In many places, the amount of money that a lawyer will receive, and others will receive, in terms of costs of expert witnesses and the like routinely exceeds the amount of money that an injured patient will receive, somewhere on the order of out of every dollar that is awarded by a jury the injured patient only gets 40 cents. It is the lawyer and the bureaucracy in our litigation system that absorb the rest.

If this were truly about what is best for the patients, we would see reform. We would see it in the Senate. Unfortunately, this is about the 60 cents on the dollar that goes to people, other than the patient, who are obstructing true reform.

This legislation is a comprehensive reform and is modeled after the highly successful MICRA law in California, one that has been very successful both in making sure injured patients are fairly compensated while at the same time holding down the escalating costs of medical liability insurance in a way that allows most physicians to practice their chosen profession and which provides better access to good quality health care.

This act will help protect our critical care hospitals and provide needed relief for nursing homes and medical specialists. The cost of health care will be reduced as the need for high premiums for liability insurance will become a thing of the past.

We must remember that this crisis is not, in the end, about what is best for doctors, hospitals, insurance companies, or personal injury trial lawyers. What this bill is about is what is best for patients—in other words, what is best for the American people.

This crisis is threatening the quality of care, jeopardizing access to care, and escalating the costs of care. In my own State, one can travel to the gulf coast and Corpus Christi where emergency room physicians live in fear that they will be called to answer to a patient in a hospital emergency room, someone who they know they have never seen before and will never perhaps see again

after treating them in the emergency room, and for a patient visit that they will likely not get paid or will get paid only pennies on a dollar for their usual fee, but yet because of the medical liability crisis they will put at risk everything they have worked a lifetime to build and achieve for themselves and for their family. That is even when they can buy insurance.

The truth is, the costs of medical liability insurance have escalated so dramatically because of this crisis that many physicians cannot even buy adequate amounts of coverage. If they can, it is at such a cost that they figure why bother, why bother to practice, and so they simply leave.

I reiterate that in the end this is not about doctors, lawyers, hospitals, or insurance companies. This is about who gets access to quality health care, and in many parts of my State, and in many States across the Nation, access to health care is simply not there because of this crisis.

I believe we should end the liability lottery, where select patients and some trial lawyers receive astronomical awards, while others pay more—all of us really—for health care and many suffer access problems because of it. We should pass meaningful medical liability reform that includes real and lasting change and bring the lessons of Texas and other States that have done so to the Nation's Capital and the American people.

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from South Carolina is recognized.

Mr. HOLLINGS. I thank the distinguished Presiding Officer.

My most respected colleague from Texas said it is not about doctors and it is not about insurance companies. I would have to dissent from that view from the standpoint of my experience over some 30 years dealing with this particular problem.

We started in the early 1970s with my good friend Victor Schwartz. Product liability was the style of the day, the crisis. The Little Leaguers could not play anymore at the playgrounds. Football was going to have to be abolished because they could not buy safe helmets. They were all being sued because of the helmets. We faced down the situation of so-called product liability and tort reform with the help of the National Legislative Association, the National Governors Association, and some others.

We went to Y2K. We would go to terrorism insurance. I resisted, being an old States righter. I have an unusually good insurance commissioner in South Carolina. In fact, we have low rates as a result of his administration. But from a studied view of this particular situation, the problem is, yes, the doctors and, yes, the insurance companies.

Why do I say that? Well, according to the Secretary of Health and Human Services, Mr. THOMPSON, there are 100,000 deaths a year in America as a result of medical malpractice. That is people killed. That is casualties. We had 58,000 people killed over 10 years, just about, in Vietnam.

Now, the doctors have to get ahold of themselves in the State of West Virginia, for example. There are some 40 doctors, I think it is, who account for some 25 percent, one-fourth, of the 2,300 malpractice claims.

Incidentally, they are moving down to South Carolina because I have talked to some of my doctor friends. There is no better friend of medicine than this Senator from South Carolina. I have worked with them closely over the many years I have been in the National Government, and as their Governor. We have a very disciplined, one might call it, medical practice in South Carolina. In fact, they have always told me, and again recently affirmed, that if we had the average licensed doctors of some of the other States we would immediately add 1,000 doctors. In other words, it is not easy to practice medicine in the State of South Carolina.

So we go immediately to the doctors disciplining themselves like the lawyers, and I can get example after example of us at the bar association disciplining the lawyers. Unfortunately, the doctors just recently returned now to that particular practice and they are beginning to see that they are having to pay for the whole thing. Otherwise, it is not tort reform; it is insurance reform.

The distinguished Senator from Texas mentioned California. I have heard, and it is true, that California has brought down the malpractice insurance rates for the doctors there. That was done with caps in the beginning, but it did not work—in 1975. And it wasn't until 1988 that they had Proposition 103, to institute insurance reform—not tort reform but insurance reform, where they had an immediate rollback of the rates of some 25 percent, regulation written by the insurance commission, and anyone who wanted to question any rate increase had a right before the commission to petition and be heard.

So, yes, there is a way to do it. But you will see, as I speak here this afternoon, it is not this tort reform. In fact, tort reform is being taken care of in the States. They are moving fast. They are already moving in the State of Illinois, as the distinguished Senator DURBIN has been pointing out, with respect to that, and other States have not waited.

The only trouble with the cap is that it has not brought down the rates. The cap States—I mentioned Illinois that has no cap. The rates are up there. But four of the first five—Florida, Michigan, Texas, West Virginia—these four of the five top States with the highest premiums have caps on damages.

So the proof of the pudding is in the eating. We have experienced this with caps. I have other examples to show. Time and again, the insurance executives say: Pass the caps, we are not going to lower the rates.

But the majority leader, the distinguished Senator from Tennessee, is one of the most eminent physicians. And I don't say that just speaking on the floor in a right fashion. He saved the life of a good friend of mine with a lung transplant back in Tennessee. She has been getting along extremely well as a result of the expertise, the touch, the sensitivity, the bedside manner of Dr. FRIST. So there is no question in this body that we have a very valued doctor friend as a Senator from Tennessee.

But Tennessee doesn't have that problem. Of course, there are no caps there. They are below the median in premiums, and they do not have damage caps. I am sure the distinguished doctor/Senator would long since have asked that his State move in that direction if that were the problem.

No, the problem is a political one. We have the doctors in town. It is almost like the computer crowd who came to town with Y2K, and the sky was going to fall—we had to immediately pass Y2K to make sure at the first of the century the world wouldn't end.

We have a similar situation now where we look for the needs of the campaign rather than the needs of the country. We call this bill, right in the middle of the energy bill, appropriations bill, and all the other important matters that we have, tort reform, medical malpractice, because the doctors are in town.

I guess instead of $2,000, those doctors could give $4,000 to political campaigns, so you might call this the $4,000 bill we will be voting on tomorrow morning, as to whether or not we should have cloture. I hope we do have cloture because we ought to nail this buzzard quickly and get rid of it.

You never hear anybody who has been represented as a result of medical malpractice complain about the fee. It is always the loser who complains about a plaintiff's fee. I never have found a plaintiff yet who complained about lawyers' fees.

That gets me right into lawyers because that is the pollster cancer we have in Government in Washington today. You get the pollsters—and they don't know. I never have found a pollster, incidentally, who ever served in government or public office. So they do not know the questions to ask, What about lawyers? Shouldn't we have tort reform? Of course, the Chamber of Commerce has us behaving like toadies for corporate America, doing everything they want because we want their money in order to run for office. So we only pay attention to the money needs and the campaign needs and not the needs of the country.

As far as tort reform is concerned, it is being taken care of at the State level. The big problem, of course, is the losses that have been, not from medical malpractice, incidentally, but from their investments.

Let's say a word about those lawyers because, after all, we just had the

Fourth of July. I saw a program about the forefathers. They were all mentioning the different ones who brought us this 227 years of freedom.

Is life so dear or peace so sweet as to be bought at the price of chains of liberty and freedom? I know not what course others may take, but as for me, give me liberty or give me death.

A lawyer said that.

I can see that 34-year-old Jefferson, with the quill in hand:

We hold these truths to be self-evident, that all men are created equal.

Equal justice under law, with the Declaration of Independence.

What is government itself, but the greatest of all reflections on human nature? If men were angels, no government would be necessary. If angels were to govern men, neither external nor internal controls on government would be necessary. In framing a government which is to be administered by men over men, the great difficulty lies in this: You must first enable the government to control the governed; and in the next place oblige it to control itself.

We are out of control: We have a $428 billion budget deficit, after talking about the surplus, surplus, and surpluses for 2 years. The public debt to the penny is $428 billion, and we have not finished the fiscal year.

Madison, the lawyer, the Emancipation Proclamation—Abraham Lincoln, the lawyer.

The only thing we have to fear is fear itself.

Franklin Delano Roosevelt, the lawyer.

You go right on down the line, giving meaning to equal justice under law.

Thurgood Marshall, the lawyer.

These were eminent lawyers and not jury fixers. We have 60,000 lawyers working on K Street. I am one of the 60,000 licensed to practice in the District of Columbia. There are 60,000, and 59,000 will never see the courtroom of law. They are supposed to fix the 535 of us lawmakers here in Government. They are salesmen. I delight in seeing them. They are a big help because we have to have the proceedings, and I listen to both sides and I make up my mind.

But they are, under the bill at hand that has been introduced, not limited in their fees. They sit there claiming frivolity. If you are a trial lawyer, you get the client who comes in. You have to perhaps get the doctor for him, get the medicine. Then if you get the case, get out on the highway, get some pictures and everything else like that, get the experts, draw up the pleadings. After the pleadings are drawn, make all the motions, the interrogatories, and discoveries. Still you haven't gotten a red cent. Time passes on, and what happens is you get to the trial and, after all the trial and the motions in the trial, you have to win all 12 jurors. And after the 12, you have to make the motions on appeal, you have to print up the briefs, you have to go and make the arguments before the appellate court. Then, if you finally win—if you finally win, yes, you get a good fee. But you probably spent a couple of years or more waiting around. And that is the practice of the trial bar.

I have been in it. I have also defended. And they are lazy. Man, they are lazy. I have seen them. They just absolutely sit there and let the runners and investigators do all the work, call that doctor and do this and do that, and then if it is inconvenient, they say: We have a witness who is sick, and we will move for a continuance—because, why? The clock runs. The clock runs, and they get, what, $450 an hour?

I remember when I passed the first textile bill here, a Senator on the other side of the aisle came and said: I know a lawyer downtown who has been paid $1 million to get that bill passed, and he didn't do anything. Here you are, a freshman Senator, and you passed it.

I said: Yes, and I passed it for free because I believe in it.

But you have big fees down here. The clock runs with this corporate crowd, just look at the bill. They say: Oh, no, no—they have no control over their fees. Just control the trial lawyers—with tort reform. You have the biggest myth on the courts we have ever experienced.

Let's go, since my time is limited, to the truth about malpractice premiums. According to the National Association of Insurance Commissioners:

Total profits as a percentage of premiums for 1999 [that is the most recent year for which data is available] are nearly twice as high in the medical malpractice line than the casualty and property insurance industry coverage. Recent price increases are merely an attempt by the insurance industry to maintain the extremely high level of profitability for malpractice coverage.

If that is all the profits, where are the losses? This is Enron. This is Kenny Boy. The Justice Department spent 2½ years and they can't get him. They have gotten everybody in the world. They have gotten WorldCom all the way through the courts up to the SEC and reaffirmed their bankruptcy plan, but you haven't heard any more about Kenny Boy.

Listen to what this says:

When terrorists slammed airplanes into the World Trade Center in 2001, the Donaldson Co. in Bloomington felt the blow almost immediately. The manufacturer's property insurance renewed just days later, with nasty surprises.

Our premium quadrupled from $500,000 to $2 million.

I ask unanimous consent to have this article from the Metro edition of the Star Tribune in Minneapolis printed in the RECORD.

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

[From the Star Tribune, Mar. 9, 2003]

FEW SPARED AS INSURANCE RATES SOAR; CORPORATE, HOUSEHOLD BUDGETS FEEL SAME PAIN

(By Dee DePass)

When terrorists slammed airplanes into the World Trade Center in 2001, the Donaldson Co. in Bloomington felt the blow almost immediately. The manufacturer's property insurance renewed just days later, with nasty surprises.

''Our premium quadrupled from $500,000 to $2 million'' and suddenly excluded $150 million worth of terrorism coverage, said Marty Kohne, Donaldson's safety, environment and insurance manager.

After Enron imploded, Donaldson's cost to insure its directors and officers tripled to $300,000 a year.

''You get very frustrated because all these events affect you, but you have no control,'' Kohne said.

It's a common sentiment among insurance buyers of every kind, both corporate and consumer. Pushed by events as divergent as Enron's collapse, terrorism, natural disasters, and health care inflation, insurance costs are spiraling industrywide unlike anything seen in more than a decade. The insurance inflation is part of what's stifling corporate profits and eating into household budgets, and experts believe it could be at least another two years before prices stabilize.

Insurance executives contend they've had little choice but to make major adjustments in premiums. Paul Bridges, senior vice president of Marsh USA, the nation's largest insurance broker, explained the increases this way:

''We had an insurance industry that used to make all of its money off of investment returns on Wall Street. But with the death of the dot.bombs, those stopped,'' he said. ''Then, with recent losses, margins reversed and [insurers] weren't making money for stock holders.''

''We started ratcheting up prices partly on the backs of disasters'' last year, added Bridges, noting that premiums are still on the rise. Commercial policies ''started off rising 30, 40 and 50 percent and some even 100 percent.''

THERE'S NO ESCAPING

The burden is being felt at firms of all sizes.

Minneapolis CPA Barry Rogers runs his own firm with six employees. There have been no major illnesses among his workers, so he was shocked when his agent announced last year that his premiums were ''only going up 12 percent.''

''We had one person who had outpatient surgery done, and that was the extent of it,'' Rogers said of the firm's previous claims.

The firm's health care premiums jumped from $145 per worker to $163, with the co-pay from $15 per office visit to $25.

Rogers and his agent eventually worked out a plan to reduce the co-payment back to $ deductibles for hospitalization climbed from $300 to $500.

Statewide, commercial health insurance premiums rose 12 percent in 1999, 16 percent in 2001, according to the Minnesota Department of Health. Estimates are that rates will go up again around 12 percent this year.

Health care companies reported their costs rose 9, 13 and 10 percent in 1999, 2000 and 2001, respectively.

In many cases, the rising health care costs are being partly passed along by employers, effectively canceling out workers' cost-of-living raises. Workers are then finding that their personal insurance costs also take more money. Last year, homeowner premiums rose 10 percent nationwide. This year, homeowners' rates are expected to rise again.

''There's no doubt about it, '02 had lots of premium increases,'' said Kenneth Ciak, president of American Express Property Casualty, which collected $260 million in premiums last year.

CORPORATE COVERAGE

''Frankly, it's about time,'' Ciak said. ''On the personal lines side, we have not had a 9/11 catastrophe, but there are a fair number of storms that have occurred and the homeowners' product has just been underpriced. We have not made money for the last four or five years.''

While homeowners paid $37 million nationwide to protect their homes against storms, fire and other disasters in 2001, insurers reported losses and expenses equal to 114 percent of all home premiums collected last year.

Even corporate coverage, which for years was predictably and modestly priced, has exploded in cost, thanks to recent events. The accounting scandals at Enron, WorldCom and other companies have erased an change for reasonable directors and officers insurance or cheaply priced surety bonds.

The recent $1.4 billion settlement by investment banks with regulators over allegations of misleading stock recommendations also has increased the pricing pressures on such policies, as insurers brace for investor lawsuits alleging biased stock research. Directors and officers insurance protects companies if their executives are sued by shareholders or other plaintiffs.

A 2001 survey by Tillinghast-Towers Perrin found that insurance claims against executives averaged $5.7 million for each of its 2,037 corporate respondents that year, up 75 percent from 2000. Shareholder lawsuits alone leaped 178 percent to cost insurers $17 million on average in 2001.

PAYING FOR ENRON'S SINS

Companies that haven't been sued aren't escaping the fallout.

Apogee Enterprises of Minneapolis manufactures and installs exterior building glass. The company has 5,500 workers, 12 directors and no directors and officer claims in its history. Nevertheless, it is paying or Enron's sins.

''Last year we paid about $150,000 [in premiums]. Now we can expect it to go way up, maybe triple . . . even though [four underwriter groups] are very comfortable with Apogee and our governance,'' said Michael Clauer, Apogee's chief financial officer.

''That's the reality of Enron. If you want the coverage, you pay the price,'' Clauer added.

Marcy Korbel, a Marsh vice president of financial professional services, recently shared similar bad news with risk managers from General Mills Inc., 3M Co. and other firms.

Industrywide, directors and officers ''premiums average 50 to 300 percent increases and that's only if there are no claims,'' she said. ''We are seeing increases of more than 300 percent if there is claims activity and even more for companies with market caps over $1 billion.''

Policy prices have to reflect reality, said Bob Hartwig, senior economist for the Insurance Information Institute.

''The end of 2001 and all of 2002 were horrific years for this country in terms of corporate governance. We have had some of the worst scandals in the history of this country,'' Hartwig said.

PREMIUMS GOING UP

Enron alone hit 11 insurance companies for $350 million in director and officers claims. Enron's bankruptcy also cost the St. Paul Companies $10 million in surety bond losses and $12 million in unsecured debt the insurer held in the energy company. AIG has announced a $1.8 billion charge in part to deal with claims for both Enron and WorldCom.

All of this was on top of 9/11, which brought insurers $40 billion in losses.

The St. Paul Companies, which lost $941 million in 9/11 claims, hoisted commercial premiums 32 percent in 2001, and 27 percent last year to squeak back into the black after a dismal 2001. The company lost nearly $1 billion in 2001. It earned $290 million in 2002, about half the $567 million it earned in 2000.

St. Paul CEO Jay Fishman has said premium increases will continue this year.

At Apogee, the company's property premiums have risen 40 percent, while its general liability premiums doubled. To compensate, it has adopted higher property deductibles and is self-insuring for workers compensation claims.

''Not only did we assume more of claims but we also incurred even more costs because premiums keep going up. It's been a very challenging year for us,'' Clauer said.

On top of that, the company is still waiting for some projects to get going because of the lack of terrorism insurance, a product that is only beginning to be offered again now and is likely to add another cost equal to about 10 percent of the property's regular insurance costs.

''We still have projects on hold because of the developers' inability to get terrorism insurance,'' Clauer said.

SURGING PREMIUMS

After going through a long period of subdued prices in the '90s, premiums for business and homeowners insurance are rising fast, pushed by a confluence of events including terrorism, corporate crimes and natural disasters. Percentages for 2002 are estimated, percentages for 2003 are forecast.

Premium percent change from prior year—'90 4.5 percent; '02 14.0 percent; and '03 12.2 percent.

Mr. HOLLINGS. Mr. President, Enron alone hit 11 insurance companies for $350 million in director and officer claims. Enron's bankruptcy also cost St. Paul $10 million in surety bond losses and $12 million in unsecured debt insurers held in the energy company. AIG has announced a $1.8 billion charge in part to deal with claims for both Enron and WorldCom.

All of this was on top of 9/11 which cost insurers $40 billion in losses. Now, we find 9/11 and Enron. Kenny Boy is responsible for the losses. It is not medical malpractice. In fact, in all of the cases, only 1 out of 9, or 12 percent, of the cases actually go to court. Some 26 percent of that small percentage actually are tried. The verdicts are up instead of down. But now we find out from where they come.

I have another article in the final edition of the Gannett Corporation on Friday, January 3, 2003. I ask unanimous consent that it be printed in the RECORD.

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

[From USA Today, Jan. 3, 2003]

J.P. MORGAN, INSURANCE FIRMS SETTLE LEGAL DISPUTE

(By Edward Iwata)

Hoping to cut loose the Enron albatross, J.P. Morgan Chase early Thursday settled a legal dispute with 11 insurance firms that had accused the Wall Street bank of engaging in sham financial deals with the collapsed energy-trading firm.

Later in the day, J.P. Morgan Chase said it will take $1.3 billion in fourth-quarter charges to cover losses on its dealings with Enron and to create a $900 million reserve for related but unresolved legal claims.

J.P. Morgan Chase had sued the insurers last year, after the companies refused to cover $1.1 billion in losses on several failed energy trades in the late 1990s involving Enron and Mahonia, an offshore company associated with J.P. Morgan Chase.

The insurers—plus congressional investigators who have looked into Enron's ties with Wall Street banks—alleged that the deals between Enron and J.P. Morgan Chase were fake accounting transactions designed to hide debt and boost revenue.

Under the complex settlement submitted in court, the insurance companies could pay from $520 million to $660 million to J.P. Morgan Chase.

Neither side admitted wrongdoing, and both claimed a legal victory.

John Callagy, an attorney at Kelley Drye & Warren in New York who represents J.P. Morgan Chase, says the settlement bolsters the bank's contention that the Enron deals were legitimate. ''There was absolutely no evidence of fraud,'' he says.

Alan Levine, a lawyer at Kronish Lieb Weiner & Hellman in New York and the lead attorney for the insurers, says, ''We're very satisfied with the economics of the settlement.''

J.P. Morgan Chase's troubles relating to Enron haven't ended, though. The bank still faces the giant Enron bankruptcy case, a shareholders' class-action lawsuit against Enron and several Wall Street banks and federal investigations into the Enron scandal.

The insurers' settlement should have no legal impact on the other legal fights, says one attorney close to the cases. However, lawyers often use settlements as leverage in talks in related cases.

In the insurers' case, the settlement came early Thursday morning, near the end of a monthlong trial in New York before U.S. District Judge Jed Rakoff. The jury was ready to start its deliberations Thursday.

As part of the settlement, Travelers Property Casualty could pay up to $159 million; Chubb's Federal Insurance, $110 million; Lumbermens Mutual Casualty, $94 million; Allianz's Fireman's Fund, $93 million; St. Paul Fire & Marine Insurance, $80 million; CNA Financial's Continental Casualty and National Fire Insurance, $47 million; Safeco, $33 million; Hartford Financial Services, $25 million; and Liberty Mutual Insurance, $13 million.

Mr. HOLLINGS. Mr. President, it says:

Hoping to cut loose the Enron albatross, J.P. Morgan Chase early Thursday settled a legal dispute with 11 insurance firms that had accused the Wall Street bank of engaging in sham financial deals with the collapsed energy-trading firm.

As part of the settlement, Travelers Property Casualty could pay up to $159 million; Chubb's Federal Insurance, $110 million; Lumbermens Mutual Casualty, $94 million; Allianz's Firemen's Fund, $93 million; St. Paul Fire & Marine Insurance, $80 million; CNA Financial's Continental Casualty and National Fire Insurance, $47 million; Safeco, $33 million; Hartford Financial Services, $25 million; and Liberty Mutual Insurance, $13 million.

Let us talk about those losses. Where do we go?

I quote from an article dated June 30 in U.S. News and World Report.

The case of Samuel Desiderio, while tragic, seems to give perfect voice to the complaints of many doctors who see a legal system gone wild. As a 4-year-old, he suffered brain damage following surgery at a New York City

hospital. A state court jury awarded him a hefty $80 million for medical expenses and pain and suffering. In April, just two months ago, an appeals court approved boosting the award against his doctors and the hospital to an astonishing $140 million.

But as Joan Butsko's modest award suggests, caps may not be the answer. Insurance costs are up, but it's not clear that juries or the courts are the culprits, or even that the crisis is as dire as it's being portrayed. The statistics don't line up as neatly as doctors and insurers would have them, and left out of the argument is recognition that ordinary market forces may be at work instead.

For starters, there's no explosion of cases that might drive up legal costs. The number filed each year has remained fairly steady during the past decade, according to the National Center for State Courts. Further, most malpractice plaintiffs never even see a jury—two thirds of their cases are dropped or dismissed—and when they do, it often isn't a sympathetic one. Only a tiny sliver of cases filed—just 0.9 percent of some 5,500 cases surveyed for 2002—produce jury verdicts for patients claiming injury. And even the size of that small wedge is down by half since 2000, according to the Physicians Insurers Association of America, the trade group for malpractice insurers owned or operated by doctors, which account for about 60 percent of the market.

Within that wedge, the number of payments that doctors' insurers make following jury verdicts has held steady in recent years, at around 400 annually, according to a U.S. News review of hundreds of thousands of payments of all kinds reported to the federal National Practitioner Data Bank. These payments total about $143 million each year. Malpractice insurers are required by law to report their payouts to the system.

Doctors and insurers say that frequency of claims aside, the prime issue is the size of awards. Indeed, the size of insurer payments stemming from jury verdicts has been increasing in recent years, U.S. News has found; in 2002 it reached a median of $295,000. But, that's far below the median jury award of $1 million the AMA and others often cite. Even assuming two defendants per case—a number insurers say is typical—plus other adjustments, the median payment remains hundreds of thousands of dollars short of the $1 million figure.

But it's not clear that verdicts are really the whip behind settlements. Over time, the size of a typical settlement payment has grown somewhat faster than a typical jury verdict payment. And while the sum from jury awards has remained stable over the past decade, the total of payouts from settlements has soared, especially recently, when doctors say the crisis has emerged.

Mr. President, that is what punitive damages do. They really set the pace.

Dickie Scruggs and Ron Motley, the trial lawyers in the tobacco case, did more to cure people of cancer or prevent people from getting cancer than Dr. Koop and Dr. Kessler.

I have been in the vanguard since Warren Magnuson had me have cancer hearings all the way back in 1967 and 1968. And over the years, we have tried everything in the world to stop people from smoking.

If my time is up, I ask unanimous consent for 10 additional minutes, Mr. President.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. HOLLINGS. I thank the distinguished Presiding Officer.

People talk about those two lawyers and say, ''Look at all the fees they got.'' I say look at all the good they did. Over the many years, we have had the American Cancer Society, we have had fundraisers, we have had cancer institutes, we have had all kinds of research and everything else like that, but how do you stop people from smoking? When they got that 360-some-billion-dollar settlement with the Government, the Attorney General, the medical community, and everybody concerned, and the State attorneys general, that failed to pass the Senate, so it was taken up, and I think it was $232 billion that the States settled for. That money is being paid out. In many States they have programs to teach youngsters to avoid smoking. I go to the heart of the Pee Dee in South Carolina where they grow tobacco, and you will see a big sign on the courthouse that says: ''No smoking.''

Now, that really got me. Those two lawyers really deserve every dime they get out of the legal fees. They had been bringing cases upon cases upon cases, and I think their average victory was some 4 in 100 cases.

They just lost another case down in Charleston last year. Of course, there have been ridiculous verdicts, like in Florida, where the punitive damages is somewhere around $27 million, but had been $145 billion. Well, that was a six-man jury and a judge who did not know what they were doing. That was just a seven-man conspiracy. I agree, it was wild and unjustified.

My point is, these trial lawyers are really doing a wonderful service. I can go to the class actions, I can go to the asbestos cases. The onslaught has got to be stopped here on this so-called tort reform because it is totally political. It is totally campaign funds. It is totally the election next year and not the needs of the country.

Mr. President, that is what is going on, and colleagues have to wake up and realize we have a President who runs off to Africa, who has not settled Afghanistan, who does not know where he is in Iraq. All he knows is the election is next year, in November. So there we are. We are being put upon with not the needs of the country but, frankly, with the needs of the campaign.

I have an article here dated September 7 of last year from the New York Times. I ask unanimous consent to have that article printed in the RECORD.

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

[From the New York Times, Sept. 7, 2002]

INSURERS SCALE BACK CORPORATE LIABILITY POLICIES

(By Jonathan D. Glater and Joseph B. Treaster)

Shellshocked by corporate scandals and fearful of the hefty payments they will have to make to settle shareholder lawsuits, the big commercial insurance companies are cutting back sharply on liability coverage for American corporations, their directors and senior executives.

The cutbacks are taking the form of higher deductibles and lower limits on overall coverage. But the insurance companies are also demanding that corporations pay part of any court settlements or jury awards out of their own pockets. As a result, corporations in telecommunications, energy, financial services and pharmaceuticals—where the risk of being sued is thought to be highest—could face payments of up to half of the cost of any settlement.

The three leaders in this line of coverage—the American International Group, the Chubb Group and Hartford Financial Services—have already begun requiring some customers to share the expense of settlements.

The cutbacks effectively limit the size of policies insurance companies will sell to any one company, said Andrew Marcell, who is in charge of insurance for directors and corporate officers at Guy Carpenter, a New York reinsurance broker and a unit of the Marsh & McLennan Companies.

''Companies that until recently were willing to provide $50 million in coverage are now offering $25 million, and companies that offered $25 million are now providing $10 million to $15 million,'' Mr. Marcell said.

Enron had $350 million in this kind of coverage and some corporations had been buying up to $1 billion worth. But now, Mr. Marcell said, ''$250 million in coverage is pretty hard to come by.''

The sharing of the burden of settlements may also leave directors' and officers' personal assets exposed, lawyers said.

''This is very bad news for directors and officers,'' said Michael Young, a partner at the law firm of Willkie Farr & Gallagher in New York who often represents directors and officers. ''The insurance industry is sending out the word that for outside directors, insurance that provides 100 percent protection is going to be increasingly difficult to get and companies are going to have to pay through the nose for it.''

John Keogh, a unit president of the American International Group, said that some corporations could avoid sharing the costs of lawsuits with insurance companies and get full coverage up to limits of their policies by paying higher premiums. But David H. McElroy, who is in charge of this kind of insurance at Hartford Financial Services, said the riskiest clients could not get full coverage at any price.

The insurers say they are merely acting in self-defense as they watch corporate giant after corporate giant collapse as they come under fire for deceptive accounting and management abuses that have drained companies like WorldCom, Global Crossing and Tyco of hundreds of millions in corporate money.

As share prices of these companies have plunged, shareholders have turned to lawsuits in an attempt to recover at least some of their losses.

Combining the expected costs from some of the latest lawsuits, which are still in their early stages, and scores of others that have been working their way through the courts over the last few years, insurers estimate that they will have to pay out $7.5 billion this year on liability policies for directors and officers—but they collected only $4.5 billion in premiums.

''The expected claims paid out are going to be multiples of the premiums that have been collected,'' said Mr. Keogh of A.I.G. He would not comment on specific numbers. Some insurers said that they expected the actual losses to be lower, but that the industry would still lose money this year. Quietly, several insurers have also begun trying to cancel certain policies, arguing that corporate fraud makes them void—a nightmare for executives.

The cutback in liability coverage and increases in premiums are hitting corporations

hard. Bruce S. Zaccanti, an insurance consultant at Ernst & Young, said a nationwide real estate management company he had been advising paid $3 million for $100 million in coverage last year. This year, the company's premium jumped to $4.5 million for $70 million in coverage. On top of that, he said, the deductible has jumped to $15 million from $5 million.

By forcing the companies to share the cost of settlements, the insurers also hope to prod them to fight harder to keep those costs down. When all the costs have been covered, the insurers said, the corporations are often eager to settle quickly—rather than work for a smaller settlement.

''There is no doubt in our minds that insureds' settlement behavior has been less reluctant than maybe it once was when there was an economic alignment,'' said Tony Galban, vice president and manager of directors and officers liability insurance underwriting at Chubb Specialty, a subsidiary of Chubb & Son.

In recent years, the average size of settlements in securities lawsuits has increased drastically, rising to $16 million in 2001, according to the Securities Class Action Clearinghouse, an organization at Stanford University that tracks securities litigation. Before 1995, when a law was passed making it tougher to bring securities fraud claims, the average settlement was less than half that amount.

The possibility that individual directors and officers could be forced to dip into their own wealth may make it harder to recruit executives to serve on corporate boards, said Brooks Chamberlain, head of the global insurance practice at Korn/Ferry International, an executive search firm. Fearful of personal liability, more and more recruits are conducting their own due diligence on prospective employers, he said.

Smaller companies, companies with financial problems, companies in certain industries perceived to have a higher incidence of fraud, and companies with fewer hard assets but sizable market capitalizations will have more trouble, Mr. Chamberlain said.

According to Mr. Young of Willkie Farr & Gallagher, directors want some assurance that somebody else will be able to pay any settlement or damage award.

''What if the company goes into bankruptcy? Then who covers?'' he asked rhetorically. ''Or what if the company's just not wealthy enough?

The changes have already had the odd effect of leading to the creation of a new type of policy that will protect only independent directors. A.I.G. will sell the policies that cannot be canceled even in the case of management fraud, Mr. Keogh said.

But Gregory M. Schmidt, general counsel at the LIN TV Corporation, an owner of television stations in several states, wondered whether companies might choose not to take on the additional cost of these policies and instead promise to cover any settlement costs owed by the directors. ''The question is whether that's going to be satisfactory'' to the directors and officers, he said.

LIN's policies are not up for renewal until March, he said, but executives at the company are monitoring changes the insurers are announcing.

''We're worried,'' he added.

Mr. HOLLINGS. We really are in trouble. I have in my own State the widow of a physician who worked at a hospital in Columbia, where her husband died after surgery. They had to sue as a result of his death.

How can we, the Congress, solve this problem? Let the doctors discipline the doctors. They are going to have to do it on the one hand. And let's have insurance reform. Yes, the Durbin-Graham approach is salutary in that it does away with the fixing of rates. That ought to be done away with. But the only way to really get at the problem itself is what they did in California with proposition 103 that passed in 1988 and that is to regulate the rates themselves.

You can get the information only then from the insurance companies, and I have tried my best as a member of the Commerce Committee, subject to insurance jurisdiction, to try to again and again, year in and year out. And the insurance companies won't tell you anything because they say they are State regulated and we have no jurisdiction whatsoever over them. If there is one thing that is engaged in interstate commerce, it is insurance.

Let's don't just go with terrorism insurance, and just tax credits to pay the premiums, and patchwork little Band-Aids on this problem. Let's get to the real heart of the problem. The insurance companies lost money. They lost it on Kenny Boy. And now the officers and directors of these corporations are being sued, and the rates have gone up with respect to corporate bad practice. The only way to get at it is insurance reform itself.

We are just acting like a dog chasing its tail when we go on about tort reform, and the lawyer's fees, and joint and severable liability, and product liability. If they are real problems, every State has a legislature and they are subject to that jurisdiction. They can do it. But as far as insurance goes, I have worked with them. I have seen them, after 50 years of governmental service at every level. I had to clean up my own insurance department as Governor of South Carolina. I know it intimately.

I can tell you that we have an insurance reform bill, and I want to work with my colleagues on this, for this is how to take care of the medical malpractice increase in premiums.

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Ohio is recognized.

Mr. VOINOVICH. Mr. President, I rise today in strong support of S. 11, the Patients First Act, of which I am an original cosponsor. Throughout my career in public service, health care has been one of my top legislative priorities. We all want access to quality, affordable health care. And when the quality is not there, when people die or are truly sick due to negligence or other medical error, they should be compensated. But when healthy plaintiffs file meaningless lawsuits to coerce settlements or to shake the money tree to get as much as they can get, there's a snowball effect and all of us pay the price.

For the system to work, we must strike a delicate balance between the rights of aggrieved parties to bring lawsuits and the rights of society to be protected against frivolous lawsuits and outrageous judgments that are disproportionate to compensating the injured and made at the expense of society as a whole.

I have been concerned about this issue since my days as Governor of Ohio. I wish we had the outpouring of support for medical liability reform 6 years ago that I see now. In 1996, I essentially had to pull teeth in the Ohio Legislature to pass my tort reform bill. I signed it into law in October 1996. Three years later, the Ohio Supreme Court ruled it unconstitutional, and if that law had withstood the Supreme Court's scrutiny, Ohioans wouldn't be facing the medical access problems they are facing today: doctors leaving their practice, patients unable to receive the care they need and costs of health insurance going through the roof.

During my time in the Senate, I have continued my work to alleviate the medical liability crisis. To this end, I worked with the American Tort Reform Association to produce a study that captured the impact of this crisis on Ohio's economy in order to share these findings with my constituents and colleagues. Guess what we found? In Ohio, the litigation crisis costs every Ohioan $636 per year, and every Ohio family of four $2,544 per year. These are alarming numbers! In these economic times, families can not afford to pay $2,500 for the lawsuit abuse of a few individuals.

It is not just the individuals but the lawyers who bear some of the responsibility. I recently received my yellow and white pages. Look what I found on the front and back covers, advertisements for personal injuries. This is the yellow pages of the Cleveland phonebook and the white pages, advertisements on the front cover and on the back cover. One of them says: Medical malpractice. It talks about wrongful death, quadriplegic/paraplegic. They have pictures, birth injuries, nursing home negligence, Erb's palsy, cerebral palsy, heart attacks/late treatment, cancer late diagnosis, emergency room negligence.

It goes on to say, ''Our firm will advance expenses for our clients in most cases,'' and ''Clients do not have to repay expenses unless there is a successful outcome.'' This kind of stuff is in the yellow pages and on television every night.

When I got out of law school, solicitation was a violation of the canons of professional ethics of lawyers. That has all changed today. I think unfortunately so.

Next to the economy and jobs—the most important issue facing our country today is health care. In fact, it is a major part of what is wrong with the economy. We have too many uninsured, employers face spiraling costs, and those who have insurance face soaring premiums every year. The impact on

businesses is great. It affects their ability to offer health insurance to employees. Too many times, they pass on the added costs to their employees, whose family budgets are often already stretched razor thin. And then there are those who lose their jobs and can't afford COBRA, assuming their company is still in business and COBRA is available.

This issue is a personal one for me. My daughter-in-law, who is expecting her fourth child, recently learned from her obstetrician that after her delivery, she is no longer going to deliver any more babies. Her doctor is in a four-physician group, all of them obstetricians. They have never had any lawsuits against them, yet their insurance premiums have skyrocketed from $81,000 three years ago to over $381,000 today. That's $75,000 per person over a period of 3 years. How can physicians be expected to afford rate hikes like these? And how many babies do they have to deliver in order to pay for medical insurance. Think of somebody getting out of medical school that is an OB/GYN and being told: Before you open the door, you will have to pay a premium of $75,000 to $80,000 to practice medicine.

This crisis is out of control, and when you listen to the statistics, you will be astounded:

From 1994 to 2000, the median award for medical negligence in childbirth cases, $2.05 million, was the highest for all types of medical malpractice cases analyzed.

The median medical liability award jumped 43% in one year, from $700,000 in 1999 to $1 million in 2000; it has doubled since 1995.

Medical liability reform could produce $12.1 billion to $19.5 billion in annual savings for the Federal Government and increase the number of Americans with health insurance by up to 3.9 million people.

There are some who say the Federal Government doesn't have a dog in the fight. We certainly have, when medical liability reform could produce $12.1 billion to $19.5 billion in annual savings and increase the number of Americans covered by insurance.

Seventy-six percent of physicians in Ohio, surveyed by the Ohio State Medical Association, said rising professional liability premiums have impacted their willingness to perform high-risk procedures.

Over half said they are considering early retirement as a result of rising costs.

There has also been an immense jump in million-dollar verdicts. In 1995–97, a little over 36 percent of cases resulted in an award of $1 million or more. By 1998–99, the rate of million dollar awards reached 43 percent. By 2000–01, it was at 54 percent, with one quarter of all awards exceeding $2.7 million. It is going up like a rocketship.

These numbers are shocking, and they continue to grow. We feel this crisis very strongly in Ohio. Medical Liability Monitor ranked Ohio among the top five states for premium increases in 2002. OHIC Insurance Co., among the largest medical liability insurers in the State, reports that average premiums for Ohio doctors have doubled over the last 3 years. But don't listen only to the statistics. Let's talk about doctors—human beings who have practices and patients:

Dr. Perm Jawa, a Cleveland urologist, says that soaring liability premiums leave him in perpetual fear of career-ending lawsuits. ''I shy away from major cases now. Sometimes you know what the best thing is but you don't want to be doing it because there are potential complications with it,'' Jawa said. ''You're not as aggressive as you should be.''

In Columbus, Dr. David Stockwell has seen coverage for his two-physician OB–GYN practice climb to over $100,000 a year. And he expected his premiums to rise 20 to 25 percent in May.

Dr. Robert Norman, a geriatrician in Cuyahoga Falls, saw his annual medical liability premium jump $5,700 to $34,000 last year. He had been warned that it could reach $100,000 this year if he continued treating patients in nursing homes. But in May he received an unexpected ultimatum from his insurer and every other carrier he queried: agree to stop seeing nursing home patients or lose liability coverage altogether. As a result, 150 of Dr. Norman's patients had to find a new doctor.

Dr. Stephen Cochran lost his hospital privileges at Akron General Medical Center when his insurer's financial stability rating was downgraded recently. He is seeking another insurer, but meanwhile, he says, ''We receive daily phone calls from the patients: 'Why aren't you here? Why aren't you seeing me? I want my doctor.' '' He says. ''It's been very stressful to a lot of the patients, particularly the geriatric patients . . . This [the malpractice crisis] has probably changed the nature of our practice more than anything that has happened in the last 10 to 20 years.''

After practicing for 15 years—their entire careers—in Cleveland, Dr. Christopher Magiera and his wife, surgeon Patricia Galloway, decided to leave Ohio to seek refuge from overwhelming liability premiums. Their insurance agent warned them that both would soon be paying $100,000 in annual premiums, up from $30,000 this year. Magiera and his wife decided to ''get out before the situation became hopeless,'' he said. They resettled in Wisconsin. Good for Wisconsin.

This is disgraceful. This crisis is forcing doctors to close their doors and greatly affecting patient access to care.

I want to commend the physicians' grassroots efforts—they are really starting to get attention for this issue. On May 3, 2003, I spoke in my home State of Ohio at the annual conference of the Ohio State Medical Association. I also participated in a physicians rally last October in Columbus, OH which was sponsored by the Ohio State Medical Association. I was impressed with all of the speakers, in particular, Dr. Evangeline Andarsio, an OB–GYN from Dayton, who described the changes in the profession and the effect of the litigation cloud:

> The professional liability crisis is creating a barrier to patients' access to good medical care, especially pregnant women. . . . a paradigm shift needs to occur in our society. Our laws must change to begin to reflect this paradigm shift.

After speaking at this rally, I received a letter from a young doctor, telling me that he was leaving Ohio because he couldn't afford his medical liability insurance premiums. Dr. Cly had received a notice from his insurance carrier that his premiums would be increased by $20,000–30,000. This, plus the $20,000 increase from last year, forced him to make the difficult decision of uprooting his family and his practice to another State. Dr. Cly was unable to make the insurance premiums and still take care of his student loan obligations and his family. Even though he has never had a malpractice claim or judgment against him during his residency training or his private practice years, his rates continued to skyrocket to the point where he could no longer afford them. His move to Fort Wayne, IN, will save him $50,000 per year in liability insurance.

In his letter to me, which I would like to submit for the record, Dr. Cly writes:

> I represent young physicians in Ohio. Most young physicians I speak with are all considering relocating to a place where the ability to practice medicine is better and the liability situation is more stable. I do not want to leave. I have developed close relationships with many patients, families, nurses, physicians, and staff here in Dayton, Ohio. I always planned to retire here and raise my children here. It saddens me greatly to have to make this decision. I feel as if I am giving up and ''throwing in the towel'' by leaving, but I believe my decision is the right one for my family.

I ask unanimous consent that this entire letter be printed in the RECORD.

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

MAY 16, 2003.

Hon. GEORGE V. VOINOVICH,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR VOINOVICH: Thank you for you listening to the challenges Ohio physicians are facing regarding the medical malpractice insurance premiums. As you may recall, I was the young physician from Dayton, Ohio who spoke with you after your speech to the Ohio State Medical Association May 3, 2003, while you were walking to another meeting. I work alongside Dr. Evangeline Andarsio at Miami Valley Hospital.

I too, am an obstetrician/gynecologist here in Dayton, Ohio. I have been in Dayton since 1988 when I attended the University of Dayton. I later went to Wright State University School of Medicine in 1992. After graduating from medical school, I did my residency training at Miami Valley Hospital from 1996

until 2000. I have been in private practice for the past 3 years.

In order to attend college and medical school I had to take out educational loans and work during those years. As a result, I have accumulated $150,000 in student loans. With the decreasing reimbursement and increasing medical liability insurance premiums I am not able make much effort in paying off my student loans. In addition, I am married with a set of 5 year old boy and girl twins. I haven't been able to afford to save for their future college educations yet, nor have I been able to put away much money in a retirement plan for me and my wife.

Unfortunately, the liability insurance rates are being unfairly and significantly increased once again this July by our carrier, OHIC. I am expecting another $20,000–30,000 increase from the $20,000 increase last year. Currently, prior to the July increase, I am paying $55,000 for my insurance premium. It is important to know that I have never had a malpractice claim or judgment during my residency training or private practice years.

I no longer afford to stay in Dayton or Ohio to practice medicine. I am leaving the state, in July, 2003, and I will be moving to Fort Wayne, Indiana to practice medicine. I will save approximately $50,000 per year in liability insurance alone. In addition, the managed care penetrations is much less and the reimbursement is better. These factors will allow me to begin eliminating my debt and saving for my family's future.

I represent young physicians in Ohio. Most young physicians I speak with are all considering relocating to a place where the ability to practice medicine is better and the liability situation is more stable. I do not want to leave. I have developed close relationships with many patients, families, nurses, physicians, and staff here in Dayton, Ohio. I always planned to retire here and raise my children here. It saddens me greatly to have to make this decision. I feel as if I am giving up and ''throwing in the towel'' by leaving, but I believe my decision is the right one for my family.

I am extremely thankful of your willingness to help physicians with this crisis. I am genuinely concerned about the future of medicine for our patients. If these issues aren't corrected soon, many patients will suffer due to the lack of access to care.

If I can be of any assistance please contact me. My home phone is xxxxxxxxxxx. My cell phone is xxxxxxxxxxx. My 24 hr pager is xxxx xxxxxxxx. My office numbers, until June 27, 2003, are listed above. My email is geoffcly@msn.com.

Sincere Thanks,

GEOFFREY CLY, MD.

Mr. VOINOVICH. For those of my colleagues who think medical liability reform is a State issue, I ask them to read this letter and see how the medical liability crisis transcends State lines—particularly my friends from the neighboring State of West Virginia. Our Ohio physicians who practice along the border are feeling the effects of their proximity to West Virginia and its favorable plaintiff's verdicts. They are feeling these effects in their increasing insurance premiums.

This is a nationwide crisis. And it's not only doctors crossing State borders to find better insurance rates—it's patients as well. Citizens living along the thousands of miles of State borders very often obtain their medical care across that line. Federal action is appropriate and critically necessary. Even more so because this crisis affects Federal health care programs, including Medicare and Medicaid, and costs the Federal Government billions of dollars every year.

In fact, the cost of this crisis to the economy is quite staggering. With over 41 million Americans without health insurance, including an estimated 1.25 million Ohioans at some time in 2001, we have to look at a new system—because this crisis is not only bad for doctors and patients, it also affects our competitiveness in the global marketplace. Many of our company's insurance costs have skyrocketed because of medical lawsuit abuse costs that their competitors just do not have.

The Nation's medical schools and students feel the effects of the medical liability crisis. According to the National Resident Matching Program, a private, nonprofit corporation, the number of American medical students applying to general surgery residency programs declined by 30 percent from 1992 to 2002. If this trend continues, less than 5 percent of medical school graduates will choose a career in surgery by 2005, and only 75 percent of general surgery residency positions will be filled by graduates of medical schools in the United States.

Thank God we have foreign doctors who have come to the United States of America. In Ohio, one out of six doctors is an Asian Indian.

And, in its 2003 biennial survey of medical residents in their final year of training, the firm of Merritt, Hawkins & Associates, MHA, noticed a disturbing trend. When asked if they would study medicine or select another field if they had their education to begin again, one quarter of all residents surveyed indicated they would select another field—this compared with only 5 percent in 2001. It is sweeping across the country and everybody is getting hit. It is going to have a disastrous effect—it already is—and we have to do something about it. When asked to identify what factors caused them a significant level of concern, sixty-two percent of residents indicated that malpractice is a significant area—compared to just 15 percent of residents surveyed 2 years ago.

Specific medical specialties feel the crisis more than others. A September 25, 2002 report by the American Association of Neurological Surgeons, Congress of Neurological Surgeons, and Council of State Neurological Societies, entitled ''Neurosurgery in a State of Crisis'' found that professional liability costs among Ohio neurosurgeons have skyrocketed since 2000. For a $5 to $7 million coverage policy, in 2000, a physician would have paid $75,000. By 2002, this number had jumped to $168,000.

Not only in Ohio, but across the nation, between 2000 and 2002, the average premium increase was 63 percent. As a result, of those neurosurgeons polled: 14 percent said they plan to, or are considering moving; 25 percent said they either plan to, or are considering, retiring; 34 percent said they already do, or are considering, restricting their practices.

In my hometown of Cleveland, OH, at one of our hospitals, the neurosurgeons just left. There was no one there to take care of emergency patients, although just recently because of something the Cleveland Clinic did, they agreed to step in, but there were four neurosurgeons serving about 15 hospitals, and they just decided they were getting out. Who is going to pick that up for them? What is going to happen to those patients?

Patients cannot get emergency medical treatment because fewer neurosurgeons are covering ERs, and trauma hospitals are shutting their doors and diverting patients with serious head and spinal cord injuries to other locations.

Patients cannot find a neurosurgeon close to home because neurosurgeons are moving to States where insurance costs are relatively stable.

Further exacerbating this problem is the high retirement rate. According to the American Board of Neurological Surgery, in 2001 alone, over 300 neurosurgeons retired. This is 10 percent of our Nation's neurosurgical workforce. And for the first time in over a decade, there are now fewer than 3,000 board certified neurosurgeons practicing in the U.S.

Earlier this year, I participated in a press conference with my distinguished colleague from Pennsylvania, Senator SANTORUM, and my distinguished colleague from Nevada, Senator ENSIGN. During this conference, I met a doctor from Florida who had rushed his son to the hospital with his head hemorrhaging, only to find that there were no pediatric neurosurgeons there. He asked if a regular neurosurgeon could help, but they could not because pediatric neurosurgeons require special liability insurance. Due to the exorbitant costs of insurance for pediatric neurosurgeons, only seven were practicing in the State of Florida and the nearest one was 150 miles away. Fortunately, the boy survived, but this type of scenario does not need to happen.

I was recently speaking with some doctors in Cleveland who told me that the nephrologists practicing there will not even look at a baby facing kidney problems, because adding pediatric work to their existing practices will cause their premiums to skyrocket.

The effects of the medical liability crisis can also be felt by the obstetrics-gynecologists community. In fact, obstetrics-gynecology is among the top three specialties in the cost of professional liability insurance premiums. Nationally, insurance premiums for OB-GYNs have increased dramatically: the median premium increased 167 percent between 1982 and 1998. The median rate rose 7 percent in 2000, 12.5 percent in 2001, and 15.3 percent in 2002 with increases as high as 69 percent, according to a survey by Medical Liability Monitor, a newsletter covering the liability insurance industry.

According to Physicians Insurance Association of America, OB-GYNs were first among 28 specialty groups in the number of claims filed against them in 2000. OB-GYNs were the highest of all specialty groups in the average cost of defending against a claim in 2000, at a cost of $34,308. In the 1990s, they were first—along with family physicians-general practitioners—in the percentage of claims against them closed with a payout of 36 percent. They were second, after neurologists, in the average claim payment made during that period.

Although the number of claims filed against all physicians climbed in recent decades, the phenomenon does not reflect an increased rate of medical negligence.

That is something we should point out. It does not reflect an increased rate in negligence.

In fact, OB-GYNS win most of the claims filed against them. A 1999 American College of Obstetrics and Gynecology survey of its membership found that over one-half of claims against OB-GYNS were dropped by plaintiffs' attorneys, dismissed or settled without a payment. Of cases that did proceed, OB-GYNS won seven out of ten times. Enormous resources are spent to deal with these claims, only 10 percent of which are found to have merit. The costs to defend these claims can be staggering and often mean that physicians invest less in new technologies that help patients. In 2000, the average cost to defend a claim against an OB-GYN was the highest of all physician specialties: $35,000.

According to an ACOG survey of its members, the typical OB-GYN is 47 years old, has been in practice for over 15 years, and can expect to be sued 2.53 times over his or her career. Over one-fourth of ACOG fellows have even been sued for care provided during their residency. In 1999, 76.5 percent of ACOG fellows reported they had been sued at least once so far in their career. The average claim takes over 4 years to resolve.

Practicing medicine and having lawsuits hanging over your head, and only 10 percent are well taken, can you imagine, Mr. President, how it is to practice medicine under those conditions?

How does all of this affect patients' access to care?

As premiums increase, women's access to general health care—including regular screenings for reproductive cancers, high blood pressure and cholesterol, diabetes, and other serious health risks—will decrease. OB/GYNs are disappearing.

It leads to more uninsured women. Last year, 11.7 million women of childbearing age were uninsured. Without medical liability reform, a greater number of women ages 19 to 44 will move into the ranks of the uninsured.

The legislation we are debating today gets us on our way to enacting meaningful medical liability reform.

There are going to be a lot of excuses. We are going to hear from some colleagues as to why this is not a good thing, and they are going to get into specific caps and so forth.

The fact is, this legislation provides a commonsense approach to our litigation problems that will help keep consumers from bearing the cost of costly and unnecessary litigation, while making sure those with legitimate grievances have recourse to the courts.

That is what we want to do. We want to make sure those who are legitimately harmed have recourse to the courts and are compensated.

The bill sets sensible limits on noneconomic damages to help restrain medical liability premium increases, while ensuring unlimited economic compensation for patients injured by negligence.

In other words, there is no cap on economic compensation. All of those issues that can be documented, you can be reimbursed for. It limits attorney's fees so the money awarded in the court goes to the injured parties, who are the people who really need it. It mandates that relevant medical experts testify in malpractice trials, as opposed to highly paid ''expert witnesses'' who are often used to influence juries and foster abuses in the legal system. It also allows physicians to pay any large judgments against them over a period of time in order to avoid bankruptcy, and requires all parties to participate in alternative dispute resolution proceedings, such as mediation or arbitration, before going to court.

It is a sensible way of handling a problem in our country and, at the same time, looking at the societal costs that are being paid today by all Americans.

Providing this commonsense approach to our medical liability premiums is a win-win situation. Patients would not have to give away large portions of their judgments to their attorneys, truly injured parties can recover 100 percent of their economic damages, punitive damages are reserved for those cases that are truly justified, doctors and hospitals will not be held liable for harms they did not cause, and physicians can focus on doing what they do best: practicing medicine and providing health care.

I end with the words of Dr. Andarsio, whom I quoted earlier:

> Help us to maintain an ability to have a practice that offers patients excellent access to care—to continue one of the most important relationships in our lives—the doctor-patient relationship—thus maintaining individualized and compassionate care.

In my own particular case—and it may be why I am probably more fired up about this than some people in the Senate—when I was about 2 years old, I contracted osteomyelitis.

It is a disease in the marrow of the bone. There was a lot of controversy among a couple of doctors on how I should be treated for that osteomyelitis. There was one physician who had the courage to try some new things. His name was Dr. Holloway. Dr. Holloway saved my life. I will not ever forget going to his funeral.

There are a lot of other people around this country like GEORGE VOINOVICH who are in need of access to orthopedic surgeons and other types of medical care. I want them to have the same opportunity I had, to have a life. That is what this is about.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. MCCONNELL. Mr. President, I also understand we are under an agreement that we go back and forth. It could be that a Democratic speaker might have been next. Therefore, I ask unanimous consent that I be allowed to go ahead and speak since I am in the Chamber and prepared to speak.

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

Mr. MCCONNELL. Mr. President, I have heard colleagues on the other side of the aisle extol the virtues of the Weiss report to justify opposing limits on noneconomic damages. Some of our colleagues on the other side of the aisle seem to view this report as the end all and be all of reports on the effect of damage caps.

This Weiss report makes the rather bold and somewhat astonishing assertion that States with caps on damages actually have higher premiums than States without caps on damages. I never heard of such a conclusion. Indeed, it flies in the face of common sense, common experience, and the expertise of actuaries and insurance commissioners.

As one can imagine, I was intrigued by this report and wanted to learn more about it. Upon reviewing the report, it reminded me of the saying by Mark Twain, or Will Rogers, who said: There are lies, there are damn lies, and then there are statistics.

I am wondering how Weiss calculated the median premiums found in his report. No one can seem to figure that out because the report never really explains how the median premium was established.

The Weiss report uses data over a decade-long period. We are talking about the cost of something, in this case insurance coverage, over a substantial amount of time. Inflation is a pretty basic statistical variable for which one should account. Does the Weiss report take inflation into account in reaching its conclusion regarding caps? It looks as if the Weiss report knows that to do a proper analysis one should take inflation into account. After all, it does so in analyzing insurance company payoffs.

For some inexplicable reason the Weiss report fails to do so in its analysis of the increase in insurance company premiums. There is no indication Weiss took inflation into account, despite the fact it does so in making a similar calculation for insurance company payoffs in other parts of the report. If I didn't know better, I would say such a glaring and telling omission was part of an effort to arrive at a predetermined conclusion.

The publication from which the Weiss report obtained its data is something called the Medical Liability Monitor. It is one of the best sources for medical malpractice premium information. Many legitimate reports use the data found in this publication to help explain the crisis. The most recent comprehensive rate survey in the Medical Liability Monitor, dated October 2002, had a headline that reads ''2002 rate survey finds malpractice premiums are soaring. Hard market wallops physicians. Average rate increase more than double those in 2001.''

It seems to me the methods the Weiss report uses are not only wrong but, in fact, misleading. The Weiss report is so seriously flawed, according to the Medical Liability Monitor, the experts who collect the data that Weiss manipulated, actually had to print the following disclaimer in a June 2003 issue to ensure this report was not used to mislead the public.

Let me read the most salient parts.

The Weiss ratings analysis of medical malpractice caps cites Medical Liability Monitor as the source of data Weiss uses to calculate average and median premiums for physicians during the last 12 years.

While we are an independent news publication and take no position on tort reform or other proposals to improve the medical liability climate, we feel it necessary to comment on the use of our statistics because some readers have expressed concern.

The medians and averages in the Weiss report are not the numbers we report in our annual rates surveys. Weiss may have taken our numbers—the amounts and increases of premiums paid by doctors State by State—and used them to arrive at their statistics, but it is impossible from their report to say definitely how our numbers have been used.

It is our view that it is impossible to calculate a valid ''average'' premium for physicians or for physicians in a particular State or territory, and we state that clearly in the executive summary of our rate survey.

But the editor of the Medical Liability Monitor goes further, advising the leaders it is misleading to use median annual premiums compiled from data from the Medical Liability Monitor to demonstrate the effect of noneconomic damage limits on medical liability rates. This is exactly what Weiss does. The report uses median annual premiums compiled with data from the Medical Liability Monitor to try to demonstrate the effect of noneconomic damage limits on liability rates. Not only is this wrong, it down right misleads the public.

I would be the first to confess I am not an expert on the subject but according to many experts, including the PIAA, it is impossible to calculate a valid and useful median premium using the numbers found in the Medical Liability Monitor for many reasons. One of the obvious reasons is a median is not a weighted average. Thus, the Weiss methodology, as far as we can tell, actually inflates the insurance carrier's premium increase by not weighing premiums according to market share. This is critically important because the highest rate probably has the lowest market share.

In fact, the Medical Liability Monitor does not report how many doctors have a particular premium, so a helpful weighted average is impossible to calculate based upon that data as the authors of the Weiss report will tell you.

In short, according to the very experts upon whom the Weiss report relies, the conclusion of the Weiss report on the effective economic damages are wrong, misleading, and should be avoided.

I think it is better to look at some legitimate studies. While folks should question the Weiss study, we can generally trust CBO. So let's look at some highlights from CBO.

Reading from pertinent parts, States with limits of $250,000 or $350,000 on noneconomic damages have an average combined highest premium increase of 15 percent compared to 44 percent to States without caps on noneconomic damages. In California, where the State has placed a cap on noneconomic damages, punitive damages, or rewards for pain and suffering at a quarter of a million, insurance rates have not shown the sharp increase experienced in other States.

Looking at my next chart which has been used by a number of proponents of the underlying legislation, it is very clear that major cities in States which have adopted some kind of caps on noneconomic damages are experiencing lower malpractice insurance rates for physicians. California and Colorado, where there are sensible restraints on noneconomic damages, whether you look at a specialty of internal medicine or general surgery or obstetrics, there is a dramatic difference between the rates in California and in Colorado compared to States such as New York, Nevada, Illinois, and Florida where there are no such caps.

The most dramatic example, I suppose, is in the area of obstetrics where in California the annual premium is $54,000; in Colorado, $30,000; compare these figures to a premium for obstetrics in Florida, which is $200,000 a year, Illinois is $100,000 a year, Nevada is $107,000 a year, and New York is just under $90,000 a year. These are actual 2002 premium survey data looking at selected specialties in States where there are caps versus States where there are no caps.

I repeat, once again, this legislation does not deny the victim a full recovery for all economic damages, plus on top of that, a quarter of a million dollars for pain and suffering, plus on top of that, punitive damages at twice the amount of economic damages or a quarter of a million, whichever is greater.

This is a bill that does provide for victims. In addition to that, it provides some reasonable restraint on lawyer's fees, which of course also benefit the victim because the dollars the lawyers don't get, the victims do.

We can have many legitimate arguments. I know my colleagues on the other side of the aisle seem to be terribly concerned about States' rights as it applies to this issue. I think that is certainly a reasonable argument to make. But it seems to me it borders on nonsensical to argue that caps on noneconomic damages have not had an impact on premiums, because clearly they have. The facts speak for themselves. All you have to do is look at the premiums for these specialists in States where there are caps on noneconomic damages and compare them to premiums in States where there are not. Clearly it makes an enormous difference.

Taking a look at California again, their underlying legislation, which is commonly referred to as MICRA, is the model for the bill which we hope to be able to proceed to. California has had very stable rates over the years going back to 1976 when MICRA was adopted, going right up to the present. If you look at the rest of the United States, California has had a 182 percent increase in medical malpractice liability insurance premiums over this quarter of a century period, but if you compare that to the rest of the country, there has been a 573 percent increase. Any way you look at it, the California law obviously has had a positive impact on making it possible for physicians to afford their liability insurance and therefore continue to offer health services for their people.

That takes us back to where I started yesterday. A year ago when the underlying bill was offered as an amendment, or a portion of it was offered as an amendment, we had a number of States in crisis. Today we have more States in crisis. Wyoming just yesterday changed from a state with problem signs to a state in crisis. Also, in the year since we last debated this issue, my own State of Kentucky, which was a State with problems a year ago, is now a State in crisis. We have to add both states to the red State list.

Connecticut. A year ago Connecticut was a State in trouble. Today, it is a State with a genuine crisis. So it will have to be added to the crisis State list today.

North Carolina. A year ago North Carolina was a State with problem signs. Today it is a State that is in crisis over this issue.

Arkansas. One year ago when we were considering legislation similar to this, Arkansas was a State with problems. Today, Arkansas is a State in crisis.

Missouri. A year ago, Missouri was in trouble. But today it is in crisis.

Finally, Illinois would have to be added today as a State in crisis.

So let's take a look at the map, where we stand today. As I can count them, there are only six States in America that are currently OK according to the AMA; that is, physicians are not avoiding choosing certain specialties or retiring early or closing their shops over the cost of their medical malpractice premiums. We now have 19 red States. Red States are States in crisis. I think we had 11 this time a year ago. Now we are up to 19. Then the rest of America is yellow. That is, States with problem signs. At the rate we are going, many of these yellow States will become red States in the coming months if we do not act to deal with this truly national problem.

I think the argument of States' rights occasionally makes sense, but this is a national issue, affecting health care for all Americans. This is really largely about the patients. Some people have described this as sort of a titanic struggle with doctors and insurance companies on one side and lawyers on the other. Frankly, I am not particularly interested in that struggle. I am sure it exists in a number of different ways. The real issue is whether or not patients are going to be cared for, whether or not there is going to be a medical professional within reasonable proximity of patients in order to deliver a service all Americans are entitled to. That is no longer the case in a significant part of our country.

In my State in eastern Kentucky we have had a number of horrendous occurrences as a direct result of medical professionals not being available because they went out of business. They simply could not afford to pay their medical malpractice insurance premiums and still be in business. So this is a national crisis.

Let me just say in closing, we are debating a motion to proceed. Reasonable people can differ about how to do something about this crisis, but I don't think there are many Senators coming out here, saying this is not a crisis. It is a crisis. Even those who are opposing the motion to proceed, I would expect most of them think we have a major problem here. One of the advantages of voting for the motion to proceed is to get us onto the bill so amendments can be considered. I would not even rule out the possibility that by the time we came to final passage of this legislation, it might look quite different. I might not like that, but I am not sure where the votes are unless we get onto the bill and have a chance to consider amendments and options to deal with this measure about the national health care crisis.

Two weeks ago we added a prescription drugs benefit to a reformation of Medicare. The House has acted. A conference will unfold in the coming weeks and we will on a bipartisan basis deal with one of the major health care issues confronting senior citizens, that is how to afford prescription drugs and whether or not they are going to have choices under the Medicare program.

Now we need to turn our attention to another major health care crisis, and that is the unavailability of health care in major portions of the country simply because physicians can no longer afford to pay their medical liability insurance premiums and still provide health care for patients. That is why we call this the Patients First Act of 2003.

I hope tomorrow, late morning, when we have the vote on cloture on the motion to proceed, that cloture will be invoked, that we will move on to this legislation, consider the various suggestions that have been made by Senators on both sides of the aisle as to how we ought to deal with this crisis. But let's act. Let's act. Let's make an effort to tackle one of America's great health care problems of the 21st century.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. HAGEL. Mr. President, I ask unanimous consent that I be allowed to address the underlying bill for no more than 10 minutes.

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

The Senator from Illinois.

Mr. DURBIN. Mr. President, I will not object, but I would like to amend that to be recognized after the Senator from Nebraska.

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

Mr. HAGEL. Mr. President, rapid increases in the cost of medical liability insurance are forcing many physicians to stop performing high-risk procedures, limiting the kind of patients they will see, moving to another State where the liability climate is more favorable, or, simply, they take the option of early retirement. When this occurs, who wins? Who benefits? No one. Everyone loses.

Twenty-six States, including my State of Nebraska, have instituted some sort of cap on noneconomic damages. However, some States have had their caps overturned by the courts and other States are barred by their State constitutions from enacting a cap. Medical liability and access to quality health care are national problems. Medical liability reform is needed to help preserve the ability of health care providers to obtain affordable malpractice insurance so we can remain in practice and deal with the health care needs of America. At the same time, we must ensure that victims of medical malpractice continue to have access to the courts and jury awards.

This is not an either/or issue. S. 11, the Patients first Act of 2003, is a responsible solution. It is a balanced approach to maintaining access to quality care while preserving the rights of both patients and providers.

S. 11 does not cap actual damages. S. 11 caps non-economic damages but defers to current or future state caps. It limits punitive damages to two times actual damages, or $250,000, whichever is greater, but does not preempt existing state caps. It does not preempt State law with respect to compensatory or punitive damages, regardless of the limit.

S. 11 limits attorney contingency fees so that awards go to victims, not to trial lawyers.

No provisions in the House-passed bill or in S. 11 would limit awards for actual damages.

This legislation is important to ensuring access to quality health care for our citizens, and retaining our healthcare workforce.

As an example of what providers face and the impact on patients, consider the fact that annual medical liability insurance premiums for OB-GYNS range from a low of $12,000 a year in Nebraska, to a high of $208,000 in certain areas of Dade and Broward Counties in Florida. Women in rural areas have historically been particularly hard hit by the loss of obstetric providers.

Practicing obstetrics is already economically marginal in rural areas due to sparse population, low insurance reimbursement for pregnancy services and growing managed care constraints. An increase in liability insurance rates will force rural physicians to stop delivering babies.

This is happening now. With fewer obstetric providers, women's access to early prenatal care will be reduced.

This is happening now.

Greater availability of prenatal care over the last several decades has resulted in this country's lowest infant mortality rates ever.

Providers' ability to maintain this standard will be threatened because the cost of insurance places a major additional strain on our maternal health care system.

Dr. Daniel Rosenquist, family practitioner in Columbus, NE who has been in practice 16 years, has delivered babies across Nebraska. However, if Nebraska's medical liability cap is overturned, he may have to give up that part of his practice. In the months before the cap was finally upheld, Dr. Rosenquist had to tell his patients that he wasn't sure if he would be able to continue seeing them.

Dr. Rosenquist is not alone. The Harris Interactive for Common Good Poll of April 11, 2002 states that 432 percent of physicians said they have considered leaving the medical profession because of changes brought about by the threat of malpractice liability.

Because of a liability cap, Nebraska is able to recruit physicians into rural areas by keeping medical malpractice insurance premiums at the fifth lowest in the Nation. It is important to note that even with a cap in place, medical liability premiums in Nebraska rose 36 percent in 2002.

Dr. Christopher Kent, one of four neurosurgeons in Lincoln, NE, who has come to view Nebraska as a great place

to practice medicine, initially came to Nebraska to practice because of its reasonable medical liability structure.

If Nebraska's cap were to be overturned, he says he would have to leave the State, probably within a year. One of his partners would also leave Nebraska and another would retire. This is equivalent to losing 75 percent of the neurosurgeons in Lincoln, and 15 percent of the neurosurgeons statewide. Dr. Kent and his colleagues have already begun restricting their practice, and worry that they will have to restrict care further if the cap is overturned.

According to a study by the Department of Health and Human Services' Agency for Healthcare Research and Quality, States that have enacted limits on non-economic damages in medical lawsuits have about 12 percent more physicians per capita than states without such caps.

Medical liability reform is about quality of care and access to care.

Caps on non-economic damages help keep premiums down, and keep doctors in practice all over our State. S. 11 will provide security to States like Nebraska facing the uncertainty of legal challenges to existing caps, and will result in a faster, fairer, simpler medical liability system that protects both patients and doctors.

The economic benefits of medical lability reform are substantial.

CBO estimates that if legislation such as S. 11 is signed into law, Medicare, Medicaid and the Federal Employees Health Benefits Programs would save $14.9 billion in Federal spending over the next 10 years.

State and local governments would save about $8.5 billion. State spending for Medicaid would decrease by $2.5 billion over that period—again putting that money where we need it the most, where health care is most urgent.

The Joint Economic Committee in a May, 2003 report, estimates an additional $16.7 billion will be saved over 10 years due to reductions in the practice of defensive medicine. According to a July 2002 Health and Human Services report, States with reasonable caps on noneconomic damages saw premium increases of 12 to 15 percent in 2002 compared to 44 percent in States without caps on noneconomic damages.

Dr. Daniel Kessler, a professor at the Stanford Business School, and Dr. Mark McClellan, a former Stanford University economist who is currently FDA Commissioner, in a February 2000 study, looked at spending cuts after tort reform, beyond claim payouts and insurer expenses.

They concluded that States adopting direct reforms exhibited reductions in hospital expenditures of 5 percent to 9 percent, but this did not result in higher patient mortality rates or an increase in serious medical complications.

If these savings were generalized to all medical spending, a $50 billion reduction in national health spending could be achieved through such reforms, in addition to that sense of confidence that would be increased across America because these dollars would be focused in areas that need the health care the most—productive uses for $50 billion.

I am proud to be an original cosponsor of this responsible legislation, S. 11, the Patients First Act of 2003. I urge my colleagues to give it serious consideration and support S. 11.

Thank you and I yield the floor.

The PRESIDING OFFICER (Mrs. DOLE). The Senator from Illinois.

Mr. DURBIN. Madam President, I thank my colleagues on the other side of the aisle and on the other side of this issue for coming to the floor because I hope the tone we have set in this debate indicates that regardless of which side of the aisle you are on, regardless of which side of the bill you are on, we understand that we are facing a national challenge.

There is entirely too much medical malpractice in our country today. The best doctors concede that. However, the insurance that is being charged to even good doctors is too unreasonable in many areas, depending on the specialty and where they choose to live. Frankly, there are a lot of people who will suffer if we don't do something about that. Obviously, the doctors themselves who have dedicated their lives to the medical profession want to see some solution to this. I do as well. But the patients who are served by them are also looking for us to do something constructive and positive to make certain that quality health care is available across America.

I don't personally believe S. 11 is up to that challenge. I am not even certain it is a step in the right direction. There has been lengthy debate about whether or not putting a limitation on the amount that can be awarded to a person who has been a victim of medical malpractice is going to bring down malpractice insurance premiums.

This bill, S. 11, suggests that rather than giving that decision to a jury—whether it is in Rhode Island or Illinois or Nebraska—that decision on how much an injured patient should receive will be made by a jury of 100 U.S. Senators. We will pass a bill that says: Regardless of what has happened to you, what happens to your family as a result of medical negligence and medical malpractice, you will be unable to recover anything more than $250,000 for your pain and suffering. Oh, yes, they will pay the medical bills. And if you have lost wages, those will be paid, too. But when it comes to pain and suffering, regardless of whether you are 6 years old, 60, or 96, there will be a limitation of $250,000 which can come your way.

Now, $250,000 in the abstract sounds like a large sum of money—until you sit down and consider the cases, the actual people who have been affected by medical malpractice.

In a few moments, I am going to talk about a number of them, some of whom I met for the first time today. When you hear their stories, I hope those who are following the debate will step back for a second and say: Wait a minute—as I have—is this right for the Senate, for those of us elected from 50 States across the Nation, to decide in each and every case what the maximum recovery will be for medical malpractice injuries? I think the answer is clearly no. That is why I am encouraging my colleagues to vote against the cloture motion, which is a motion which tries to bring this bill before the Senate.

What I believe—and others, I think, share this belief—is that we have a national challenge and a problem when it comes to medical malpractice. But it is a problem that will not be resolved until we deal with it responsibly and completely, until we look at all the facets of the problem.

This bill says it comes down to one thing: Injured victims of medical malpractice are recovering too much money for their injuries. If we can limit the amount of money they recover, then the system is going to be so much better.

I think that oversimplifies it. In fact, I think it really is an abuse of the situation rather than an effort to rectify it. That is why I am opposing it.

We had testimony a few weeks ago from the Bush administration, a doctor from the Department of Health and Human Services, saying that medical malpractice in America has reached epidemic proportions—epidemic proportions. There are those who estimate that as many as 100,000 Americans lose their lives each year because of medical malpractice—not because they are destined to die because of God's choice but, rather, because someone has made a very serious and fatal mistake in their medical treatment—100,000 a year.

We also have studies that have come out from Harvard University that suggest that only 1 out of every 50 cases of medical malpractice ends up in a lawyer's office with a claim against a doctor or hospital—1 out of 50. So I say to those who support this bill, if you do not look at the underlying incidence of medical malpractice in this country, simply limiting the amount that an injured person can recover is no guarantee you will not face an avalanche of cases coming at you for medical malpractice. We have to go to the underlying issues in how to deal with it.

It is interesting to me, as well, how many elements are being overlooked during the course of this debate. All the debate on the floor has been about doctors: States that do not have doctors, communities that do not have obstetricians to deliver babies, red maps brought before us to show State after State where doctors are facing problems.

But read this bill. This bill isn't just about doctors. This bill is about protecting HMOs, managed care insurance companies, pharmaceutical companies, medical device companies, and nursing

homes. So in all of this debate about the sad situations many doctors do face in America, no one has come to the floor to justify why, within this bill, there is protection for these special interests: HMOs, managed care insurance companies, which many times make decisions which can be as lethal and fatal as any decision made by any doctor.

I think most Americans know of what I am speaking. When an HMO that you are a part of or a managed care insurance company that your family is a part of makes a decision as to whether or not they will pay for a diagnostic test, a laboratory procedure, your hospitalization, or a surgery, when they decide how many days you can stay in the hospital, they are, in fact, dictating medical care in the name of profitability. They want to make more money. They would like to keep you out of the hospital as much as possible, reduce your costs as much as possible, and they make medical decisions.

It is interesting that today a report came out. It is a report that was published by Health Affairs, and those who prepared it are people from the American Medical Association based in Chicago: Matthew Wynia, Jonathan VanGeest, Deborah Cummins, and Ira Wilson. This report is entitled ''Do Physicians Not Offer Useful Services Because Of Coverage Restrictions?''

They surveyed doctors across America and asked them the question: How often have you decided not to offer a useful service to a patient because of health plan rules?

I have talked to doctors who have told me many times that is happening more often than they would like to admit.

Let me show you a chart which tells you what they found in asking doctors across America that question. They were asked this question: How often have you, as a doctor, decided not to offer a useful service to a patient because of health plan rules, insurance rules? In this case, ''very often,'' 2 percent; ''often,'' 6 percent; ''sometimes,'' 23 percent; ''rarely,'' 27 percent. Even if you take the ''very often,'' ''often,'' and ''sometimes,'' you have 31 percent of the cases. Almost a third of the time doctors are saying they are making decisions not to provide a useful service to a patient because the health insurance company tells them they will not pay for it and they cannot do it.

Now, that isn't part of this debate. No one has brought into this conversation the question as to whether or not HMOs, in the way they are treating doctors, are having some impact on medical malpractice and injuries to patients. No. What we are doing for HMOs is not holding them accountable but, rather, saying we are going to give them even more privileges under law. We are going to insulate them from the liability of these bad decisions. So the insurance companies, particularly the HMOs, are running rampant across the Senate when it comes to malpractice instead of being held accountable, as they should be, for their restrictions on good doctors making sound medical decisions.

This is another question asked of these doctors in this Health Affairs study that came out today: If ''sometimes'' or ''more often'' you decide not to offer a useful service because the insurance company tells you you can't, are you doing so more often, less often, or about as often as you were 5 years ago? Most of them say unchanged: 55 percent. But 35 percent say ''more often.''

So you have doctors who are increasingly finding insurance companies making decisions on what you, your mother and father, your wife or husband or child is going to receive in terms of medical care. Is that the answer to this issue, that we are going to say that HMOs will make these decisions, and when they are wrong, and people are injured, and these poor people then turn to a court and ask for some compensation for their injury, they will be limited not only in what they can recover from the doctor or the hospital but even the HMO insurance company? That is what this bill says. That is what this bill is designed to do: to insulate from liability even HMO insurance companies which are responsible for more and more doctors making medical decisions which they believe, based on their training and experience, are not the right decisions for their patients. I do not think that is fair. I do not think it treats people as they should be treated.

Let me mention a couple other items. We have a nursing shortage in America. It worries me. I am reaching an age when I am thinking about the day when I want to punch a button at a hospital or some other place to call a nurse and hope that someone shows up. But the likelihood that is going to occur is diminishing because we have a nursing shortage, and it is a serious shortage.

As America's population ages, we need more nurses to take care of us in convalescent homes and nursing homes and hospitals and other places. Sadly, those nurses are not as plentiful as they once were.

Let me tell you about a report from the Journal of the American Medical Association that relates to the issue of malpractice and the shortage of nurses. This is a report from October of 2002 from the Journal of the American Medical Association. They published the results of a study that, for the first time, showed that the number of patients who die in the hospital increases when nurses are assigned to care for too many patients. An estimated 20,000 people die each year in hospitals from medical mistakes attributed to nurses caring for more patients than they can handle.

This accounts for 20 percent of the nearly 100,000 deaths annually from medical mistakes. While a link between nurse staffing and quality of care seems like common sense, many hospitals downplayed the link until the study was published.

This is a troubling report as well. I read from a book entitled ''The Wall of Silence,'' written by Rosemary Gibson and Janardan Singh. This is a quote from the book:

> Experienced nurses as well as newly-minted nurses are leaving patient care at the bedside at a time when other job opportunities exist. Their knowledge and skills are valued in pharmaceutical companies, managed care organizations and information technology firms. How many are leaving? It is hard to say precisely. The Federal Government's Bureau of Health Professions issued a report showing that about 50,000 fewer nurses were using their licenses in 2000, as compared with 1996.

As our population ages, as the demand for nurses increases, the number of nurses in America diminishes. We have seen that when there are fewer nurses in a hospital, there is more likelihood of medical mistakes, medical malpractice, and medical injuries. Has that even been mentioned in the course of this debate? Has anyone talked about the HMOs and their impact on medical practice? Has anyone talked about the shortage of nurses and the fact that it is leading to more medical mistakes, leading to more lawsuits filed against doctors and hospitals. Instead what we have had in this debate is a strict debate, limited to the question of how much injured parties can recover once they face medical malpractice, once the injuries have occurred.

I would like to introduce in the debate now some real-life stories about people who have been victims of medical malpractice. As I mentioned earlier, some of them were kind enough to join Senator LINDSEY GRAHAM and myself earlier this morning when we held a press conference and introduced our version of a bill which we think is a more reasonable approach to dealing with the medical malpractice challenge we face in America.

The first person is Colin Gourley. Colin is on your left as you view this picture here in the striped shirt. This is his twin brother Connor. Nine-year-old Colin Gourley, from the State of Nebraska, suffered a terrible complication at birth as a result of a doctor's negligence. Colin has cerebral palsy. He cannot walk. He could not speak until he was 5 years old. He has irregular brain waves and the amount of time he has spent in a wheelchair has affected his bone growth. He has had five different surgeries, and he needs to sleep in a cast every night to prevent further orthopedic problems. His twin brother Connor survived birth without any injury.

A jury ruled that Colin was a victim of medical negligence. They decided that because of that medical negligence the Gourley family was entitled to receive $5.6 million. That was what was needed to compensate him for his medical care and for the lifetime of suffering and problems which

he will face. Last month, the Nebraska Supreme Court upheld a Nebraska law that severely cut this jury verdict to about one-fourth of the award. As a result, Colin will have to rely on the State of Nebraska and the Federal Government for assistance for the rest of his life.

The jury understood what the case was worth. The jury got to meet Colin, his brother, his two sisters, and mom and dad. The jury heard what happened that led to this terrible medical malpractice, and the jury decided in fairness that he and his family were entitled to $5.6 million. Yet the law came in and said: I am sorry. We have to limit you—a law similar to the one we are considering in the Senate this evening, a law which will say no jury in Nebraska nor Illinois nor North Carolina is going to make that decision. This decision will be made by a jury of 100 United States Senators, and we will decide, in the case of Colin, that no matter what his life may be, whether it is 5, 10, 20, 50, or 80 years, the maximum amount we will pay for his pain and suffering is $250,000.

What may have sounded like a large amount of money at the beginning of this conversation, as we understand as we consider each and every case, becomes an amount which is hardly adequate to take care of what Colin is going to face, as well as his family.

Let me introduce you now to Kim Jones. This is a picture taken before Kim's medical malpractice. As you can see, she is a lovely, proud mother from King County, WA. She was 30 years old and she remains severely brain damaged and in a comatose state today after undergoing routine tubal ligation surgery following childbirth at the Washington State Medical Center. After the operation, the hospital staff failed to notice that Kim had stopped breathing since her vital monitors had been improperly removed. Though successfully resuscitated, Kim suffered multiple seizures and was given seizure control medication that actually worsened her condition. She was later taken by helicopter to another medical facility.

Today Kim is unable to control her bodily functions. She has no discernable mental function and is being cared for at a convalescent center. Kim's father filed a lawsuit against the hospital and the anesthesiologist. The case is still pending.

Kim is standing there at a better time before the medical injury with her daughter. Now she is in a nursing home or convalescent home for the rest of her natural life. What is it worth? After the medical bills are paid, after her lost income is paid, what is it worth to her, to her daughter, to her parents? According to this bill, we know exactly what it is worth. It is worth no more than $250,000 for the pain and suffering she will endure for the rest of her life.

Now let me introduce you to a young lady who made quite an impact on us this morning. She told her terrible story. This is Sherry Keller from Conyers, GA. Sherry is shown in her wheelchair. That is where she was today when she came to speak to us. She stood up and said: I am from Conyers, GA, and I am a registered Republican. I want to make that clear.

I said: We have Republicans and Democrats and Independents. Then she told her story.

Sherry Keller received a complete hysterectomy. Her surgeon relied upon staples rather than sutures to hold her incision closed. Upon having the staples removed, Sherry's incision began to bleed. The surgeon began cleansing the wound. Unfortunately, the incision opened. I won't go into the graphic details. But the doctor in that situation—this happened at the doctor's office—apparently panicked and left her alone in the room for 35 minutes when the doctor went to call a wound specialist. She left her lying on an examination table. The doctor continued to see other patients while the specialist was on the way and left Sherry in that examining room for 35 minutes. Sherry went into shock from loss of blood, lost consciousness, and fell off the exam table. There was no one with her. Her head hit the counter as she fell. She came to but in the process damaged her spinal cord and rendered her an incomplete quadriplegic. She dragged herself out in that condition into the hallway to get the attention of a nurse or doctor to come to her aid. The doctor called for an ambulance but gave directions that she should be transported only. She, the doctor, left instructions that a doctor would go to the emergency room to dress the wound later.

Sherry was then left in the emergency room for 2½ hours waiting for a doctor to treat her wound. As a result of that fall in the office, Sherry will never walk again. As she was not employed outside the home, she has no lost income for her injury. Her damages were virtually all medical bills and pain and suffering. Here she is, a woman, some 35 years of age, who faces a lifetime in a wheelchair now because of malpractice.

This law we are considering would pay her medical bills but say that the total amount of compensation for her for the pain and suffering she and her family will go through is limited to $250,000. Some Senators as jurors have decided that in her case $250,000 is adequate, thank you.

I think a jury has a right to consider that case. A jury has a right to consider whether that doctor is guilty of malpractice and whether this woman and her family are entitled to more than $250,000. The fact that she was at home raising her children, because of this bill, will be used against her. She has no job where she earns a paycheck, but she has a real job as far as America is concerned; she was raising her family.

And now look at this situation. This bill will actually penalize her for being a stay-at-home mother with her family. For a Senate that is supposed to be dedicated to family values, it is hard to understand how Sherry's case tells that story.

The next person I would like you to meet is Evelyn Babb of Tyler, TX. This case is similar to many you may have read about. She is a bright, happy-looking person in this picture. She needed arthroscopic surgery on her right knee for a torn lateral meniscus. Her doctor marked her right knee to be operated on with an X. However, the hospital staff negligently prepared her left knee for surgery. Without verifying whether the staff had properly prepared the patient, the doctor proceeded to operate on the knee which the staff had prepared. He began performing the partial lateral meniscectomy before he realized he was operating on the wrong knee. The staff then prepared the other knee, and the doctor performed the operation as previously planned.

Due to the unnecessary surgery on the one knee, Mrs. Babb's recovery was considerably longer and more painful than it would have been. She has severe pain and swelling in her left knee and a lingering infection. She continues to suffer from pain, has difficulty walking, and has a markedly decreased range of motion in her knee.

As an elderly woman of 75, Mrs. Babb will suffer no loss of income, however, and there will be few, if any, additional medical expenses because there is nothing that could be done to improve her condition. Virtually all of the damages she could recover for this obvious malpractice would relate to the pain and suffering she would endure. This bill has decided how much her case is worth: no more than $250,000, period.

When you look at that situation, a person who is retired, with no active income, and with limited medical bills, but a serious medical outcome, it is an indication of the unfairness of this underlying bill.

This case I will tell you about now involves Heather Lewinsky from Pittsburgh, PA. Seventeen-year-old Heather Lewinsky's face remains scarred for life after a Pittsburgh plastic surgeon performed radical surgery to correct a skin disorder near the left corner of her mouth when she was 8 years old.

The doctor claimed to have done this procedure on children many times before when, in fact, neither he nor any doctor in the United States had ever done the surgery to treat a condition such as Heather's. Following the operation, Heather was left with horrific facial scarring and a terrible stroke-like tugging at the corner of her mouth.

The doctor attempted to fix the problem with two additional surgeries, which made it even worse, forcing her to undergo 10 more operations with other doctors between the third and tenth grades.

The pain, swelling, and recuperation with each procedure were excruciating. Heather and her family filed a lawsuit

against the doctor who only paid a small fraction of the jury verdict because he had insufficient insurance coverage.

This is an indication of a young lady who is scarred for the rest of her life. What is permanent disfigurement worth if it is the result of medical malpractice? A point will be reached when no more surgeries will be indicated; they won't add much to her improvement. She may not have lost wages, but she is scarred for life. As far as this bill is concerned, permanent disfigurement because of medical malpractice is worth $250,000, not one penny more.

The last case I want to talk to you about is a case that involves Alan Cronin of California. In the year 2000, Alan Cronin, then 42 years old, went into the hospital for a routine hernia surgery. Alan was married with three children at the time—two of them still at home. He goes in for a routine hernia surgery. After the surgery, two doctors failed to diagnose an acute infection following the routine hernia repair. The doctors treated him as though he had the flu rather than inspecting the surgery site. He became septic and suffered toxic shock. Once the doctors finally opened the surgery site, the pus and sepsis were so overwhelming that they told Alan's family that he had a 98-percent chance of dying. Gangrene had set in and all of Alan's limbs were amputated. When he awoke from his coma, he no longer had arms or legs.

Alan was a customer service representative for a medical equipment manufacturer. Workers' compensation paid for all of his medical bills, including future expenses. He also had a private disability policy that was used as an offset against future economic damages.

In speaking with Alan about the cap on noneconomic damages, he says that there are so many things that you don't think of as necessities, and $250,000 could not begin to cover those expenses. Alan, 42 years old, has had the amputation of his arms and legs from medical malpractice. How much is the suffering and pain that he will endure in the next 30, 40 years of his life worth? We know in the Senate. It is worth $250,000 and not one penny more.

Incidentally, there is another provision in the bill. Because Alan had the foresight to work for a company that provided him with health insurance that covered some of his medical bills after the medical malpractice, and because he also had a private disability policy that will help him with some of his expenses as he tries to struggle through rehabilitation and rebuilding his life, that information, according to the bill, should be brought up in the trial. As a former trial lawyer, I can tell you it is being brought out so as to encourage the jury to diminish any award they are going to give to Alan Cronin. Because he had the foresight to pay for health insurance and a private disability policy, he would be penalized in a court of law by the disclosure of this insurance and this disability policy.

That isn't done today in any court in America, but it would be done under this bill. S. 11 has decided that is a fair way to deal with medical malpractice. I think most Americans would disagree. What they believe is, if you put a cap or limit on the recovery of a person who is a victim of medical malpractice, the malpractice insurance premiums may come down. They hope if they come down, the threat to the lifestyle and future careers of doctors is going to be diminished. Yet when you look at the studies—the Weiss study, for example—you find the opposite is true.

States with limitations on what can be recovered in court had a higher percentage increase in malpractice premiums between 1991 to 2001 than States without caps. So not only is this proposal in S. 11 fundamentally unfair, it is totally ineffective. What we are doing is seeing, frankly, this battle between the White House and the people who are gearing up for some Presidential campaign and the American trial lawyers. That is what this is about. It is not about malpractice premiums, bringing them down. It is not about the incidence of malpractice and reducing it. Frankly, it is about a political battle which should be secondary to the more important issues before us.

S. 11, as it has been brought to us today, is a bill against which I have led the fight. I am sorry I have to do it in one respect, but I am proud to do it in another. I am sorry because this should not be the bill we are considering. We ought to be coming before the American people with a bill that addresses this problem in its entirety and in a fair way. We ought to bring into this conversation medical providers across America. We should sit down and have an honest and open conversation about how to reduce medical injuries and medical errors. That would be good for everyone. I am sure doctors could tell us ways to do that.

Let me give you an example of what we have tried to do in the past. We decided at one point that we would create a national registry to try to find out how often we have these incidents of problems. With that national data bank, we would say to hospitals that before you hire a doctor on your staff, you can check to see whether he has had his license suspended or has been sued successfully for malpractice. In the 1980s, we established that—my colleague, Ron Wyden from Oregon, was then a Congressman who proposed the legislation. He thought if this data bank were present, we could find the limited number of doctors who are most responsible for malpractice and make certain that they either change their ways or get out of the practice of medicine. It was certainly a good idea.

Sadly, there haven't been many people who have used it. Consider this fact:

> The data bank is an effective information tool only if hospitals and other health organizations actually report adverse actions involving a health care professional. Federal law requires this information to be reported. But hospitals are not complying. Since the data bank was established, more than 60 percent of hospitals have never reported any adverse action [against a doctor that occurred on the premises.] It was expected that hospitals would report more than 1,000 disciplinary actions every month, yet fewer than 1,000 are reported in a year.

Managed care organizations, which are protected by this bill from liability—the HMOs and managed care organizations which, again, receive preferred treatment by the Senate under this bill—are not doing much better.

> From September 1, 1990, to September 30, 1999, [the managed care organizations in America] reported only 715 adverse events to the data bank. Eighty-four percent of them have never reported any adverse action. The investigative arm of the Federal Department of Health and Human Services, the Office of the Inspector General, notes that ''with close to 100 million individuals enrolled in [managed care organizations and HMOs] and hundreds of thousands of physicians and dentists associated with them, fewer than a thousand adverse action reports over nearly a decade of service, for all practical purposes, are reported.

So the efforts we put in place to track medical malpractice, to try to weed out the bad actors, to try to take the doctors away who perform some of these acts of malpractice have been in vain.

Hospitals, HMOs, managed care organizations, have refused to report the bad actors. Yet our answer on how to deal with that situation is S. 11. We are going to limit the amount of money victims can recover. Is this totally upside down?

Should we not start with the premise that we want to limit the amount of malpractice itself and medical error in America and then follow through to the next and obvious question: When doctors are going to buy insurance, how can we help them secure reasonably priced malpractice insurance policies? That, of course, would mean bringing in the malpractice insurance companies and reinsurance companies.

Incidentally, there is one thing I said yesterday that we are going to look into. It was my understanding from reports we received that there were five reinsurance companies available to U.S. insurers. A call today to the Illinois State Medical Society said they work with 9 or 10. I want to make sure the record is corrected and reflects the fact that at least we are trying to come to the right number of reinsurance companies. Regardless of whether it is 5 or 50, the reinsurance companies have to be part of this conversation as to how we are going to reduce the cost of malpractice insurance for doctors and hospitals across America.

The third point, and equally important, and I speak to this one as a

former trial lawyer myself, is that the legal profession has to be part of this conversation. We have to say those lawyers who would consider filing a frivolous lawsuit are going to face severe penalties. They will have to pay compensation of cost and fees associated with those cases, and if, in fact, they are found to have done it repeatedly, we can prohibit them from that field of practice completely.

I add, based on my personal experience, it would take an absolute fool as a lawyer to entertain a medical malpractice case that really did not have a chance of success and that could be considered frivolous. Those cases in my State of Illinois are extremely expensive. You start with a certification by a doctor that you actually have a justifiable cause of action before you file your complaint. An important consideration in taking these cases up is whether or not you can move them forward to recover for the plaintiff who is injured. If you do not think you have a chance, you have to tell that sad news to the client who sits in your office, and I have done that.

Frankly, you have to honestly tell many people who are seriously injured: I do not think you have a case on which you can recover.

We have to bring together, if we are serious about medical malpractice, the doctors who can speak for their profession, nurses who can help us understand how we can bring more medical professionals to the job to reduce the likelihood of medical injuries, HMO insurance companies that have to be told they can no longer dictate sound medical practice, where doctors are told what they have to do regardless of whether they think it is right professionally. We have to bring in the insurance companies to make certain the rates they charge are reasonable, and lawyers have to be brought in as well so they are involved in responsible conduct which is focused more than anything else on recovery for the patient or claimant involved. That is what this is about.

The idea that by limiting recovery for the victims we have talked about here is going to solve the problem just will not work.

Let me use this chart as an illustration as well. Here are two States in the Midwest: One I am very familiar with, my State of Illinois, and a neighboring State, Michigan. They are comparable States in makeup of the population in rural areas and urban areas. They are big States by most standards.

Michigan has caps and limitations on how much a person can recover in court. Illinois does not. Here we take a look at the professional liability insurance that is being paid in these two States as of October of last year. We will see in the State of Michigan, OB/GYNs on average are paying more than in the State of Illinois that does not have caps. With surgery, it is the same story. With internal medicine, it is the same story. Michigan, with caps, has higher medical malpractice insurance rates than the State of Illinois without caps.

The belief that in passing this bill and establishing caps across America we are going to bring down malpractice insurance premiums I do not think is a reasonable conclusion, which is borne by the evidence presented here, and this comes from an analysis of the medical liability monitor data, the same monitor data used by both sides of the debate.

I understand the Senator from Utah is here and would like to speak. I close at this point by saying what I said at the outset, and I repeat today, I value very much the medical profession. They have meant so much to me and my family. I have entrusted the care of my greatest treasures on Earth—my wife and children—to great doctors, and I thank God they were there when we needed them.

I want them to continue in practice. I want them to feel good about what they do for a living. I do not want them looking over the shoulders at lawyers who are filing frivolous lawsuits. I do not want them facing 35-percent increases in malpractice premiums they cannot cope with, that they cannot pass on to patients, that force them to make decisions that, frankly, are not in the best interest of good medicine.

Today, during the course of our press conference with these victims of medical malpractice, one of the staff in the back of the room fainted. When he fainted, we stopped everything and somebody said: Call a doctor. How many times have we heard that said? We say it because we all know in those dire emergency situations and in everyday situations, we need the medical profession.

I said at the outset of this debate, and I repeat, I stand ready to sit down with anyone in good faith who wants to deal with the medical malpractice crisis facing America. Let us deal with this in its entirety and in an honest fashion. Let us ask everyone to make a sacrifice—the doctors, the lawyers, and the insurance companies—and then I think we can come up with a bill that is worthy of the Senate.

For us to deliberately limit the amount of money available to these victims with tragic stories, which I have brought to the Senate today, is fundamentally unfair. It is as unfair to those victims as those malpractice premiums are unfair to many of the doctors who are paying them today.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Madam President, I rise to speak about the medical liability and medical crisis threatening our great Nation. Over the years, I have pressed for legislation to protect our health care delivery system from the ravages of an out-of-control medical liability system.

Many times we have come close to enacting legislation, and a giant opportunity stands before us today. I hope we do not let it slip through our fingers once more.

I remember as a young lawyer in the early days of my practice in Pittsburgh, PA, the law basically was, if you met the standard of practice in the community, there was no case because everybody knew that medical science is not an exact science. Once they adopted the doctrine of informed consent in its various forms, it meant that every case goes to the jury, regardless; every case that has a bad result, even though the doctor did everything in his or her power to effectuate a decent result. And we have had this medical liability catastrophe upon our hands ever since.

I can remember as a defense lawyer, my advice to some doctors was that they needed to do everything they possibly could to make sure there was absolutely no way they overlooked anything with regard to any person's complaint. If a person came in to them with a common cold, they could no longer say: Take two aspirin every 6 hours, drink all the liquids you can, and in 7 days you will be better. Or: Don't do anything and in 7 days you will be better. No, they have to give vascular and respiratory examinations, blood tests, et cetera. As a result, what used to be a $5 bill in those days, or at most $15 or $20, is far more today. Of course, I believe unnecessary defensive medicine such as that has driven our country to its knees from a medical liability standpoint.

Today, defensive medicine increases health care costs by $60 to $108 billion per year according to the Department of Health and Human Services report of last year.

As I have noted previously, out-of-control medical liability litigation is needlessly increasing the cost and decreasing the quality of health care for every American. It is preventing patients from accessing high-quality health care or, in some cases, any care at all because doctors are being driven out of practice.

I was pleased that President Bush announced his desire to address medical liability legislation reform last summer when he spoke of the need for reform in his State of the Union Address and when he called on us to pass meaningful medical liability reform legislation in this Congress. I am pleased that our majority leader, Dr. FRIST, has brought the Patients First Act forward to be debated today.

Our colleagues, Senator ENSIGN from Nevada, who introduced this bill, and Senator MCCONNELL from Kentucky, deserve special recognition and thanks for their work on this bill as well.

Of course, this was not the first time we have addressed this issue. As many of us will recall, we passed medical litigation relief language with the Commonsense Product Liability and Legal Reform Act in 1995. Unfortunately, it was stripped from that bill in conference.

I am sorely disappointed that in the ensuing 8 years we have not addressed this problem. As a result, the problem has continued to fester like an infection that will not heal. Worse yet, this infection is spreading to all parts of our country.

This map which has been utilized throughout this debate, and I think properly so, with data supplied by the American Medical Association, shows the States that currently are experiencing a medical liability crisis and those that are showing signs of a developing crisis. The 19 red States are crisis States. Nineteen of the 50 States are crisis States. The 26 yellow States are showing problem signs. Only 5 States are currently OK. The red ones are in crisis. The yellow ones are about to be in crisis. The white States are currently OK generally because they have passed medical liability litigation reform legislation like S. 11.

To contrast this for my colleagues, I must note that on a map with last year's data, only 12 States were in crisis. In March, it was up to 18. Now it is 19. The problem is growing and it reaches from coast to coast.

There are very unfortunate consequences to this crisis—doctors forced to quit practicing, trauma centers closing, babies being born by the roadside, and, yes, people dying. These are all due to out-of-control litigation and soaring medical liability insurance premiums.

The crisis is particularly acute in the farming and ranching communities of rural America where obstetricians and family practitioners, some of whom have been delivering babies for 25 years, are quitting their obstetrical practice. As a result, there is an increased shortage of obstetricians in the rural west, including in my home State of Utah.

Studies by both the Utah Medical Association and the Utah chapter of the American College of Obstetricians and Gynecologists underscore the problem. According to the Utah Medical Association:

> 50.5 percent of family practitioners in Utah have already given up obstetrical services or never practiced obstetrics. Of the remaining 49.5 percent who still deliver babies, 32.7 percent say they plan to stop providing OB services within the next decade. Most plan to stop within the next five years.

The Utah study examined the causes of the crisis also:

> Professional liability concerns were given as the chief contributing factor in the decision to discontinue obstetrical services. Such concerns include the cost of liability insurance premiums, the hassles and costs involved in defending against obstetrical lawsuits and a general fear of being sued in today's litigious environment.

Although many blame out-of-control litigation, others believe that the downturn in the economy caused the crisis. In an attempt to identify the cause, in February Senator GREGG and I held a joint hearing of the HELP and Judiciary Committees. We heard from a lawyer who believes the downturn in the economy and problems with State insurance regulations are responsible. But, in addition, we heard from the Texas State insurance commissioner and from the president of Physician Insurance Association of America, representing provider-owned or operated insurance companies that provide insurance for the majority of American doctors.

One reason they do is not because the insurance companies are so awful. It is because the insurance companies will not handle this type of coverage any more. The reason they will not is because of the exposures they are facing. So they have turned now to provider-owner and operated insurance companies.

These gentlemen face this crisis and its consequences every day. Their data and their studies, as well as those from the Department of Health and Human Services, show that increasingly frequent frivolous lawsuits and skyrocketing awards are responsible for rapidly rising premiums.

Have the recent downturns in the economy and the stock market affected medical liability premiums? Possibly. But this does not appear to be a major cause of the current crisis.

Look at this chart. This is a chart showing how insurance companies that offer medical liability coverage allocate their assets. As this chart shows, between 1997 and the year 2001, insurance companies invested conservatively, primarily in bonds—that is corporate in red, Government in green, which is the middle line, and municipal bonds in purple. A minority of funds, only about 10 percent, happens to be invested in equities, which is shown in the yellow.

This conservative investment strategy minimizes the effect that changes in the stock market have on insurance premiums. In fact, there is good evidence that increasing medical liability awards are responsible for increasing premium costs.

This pie chart with data from the Physicians Insurance Association of America shows the outcome of medical liability cases. The area in the orange, almost 68 percent of the pie, represents medical liability cases that were dropped or dismissed. In other words, a vast majority of cases are frivolous to begin with. In those cases, the plaintiff received no award because no harm was found. Yet these frivolous lawsuits cost money, an average of at least $25,000 per case, and those costs increase the costs of medical liability insurance.

This next chart shows the growth in median—that is the blue line and the average in red—medical liability claim payments between 1989 and the year 2001. Prior to 1995, median and average claim payments increased readily, as we can see. But the rate of growth for both increased dramatically after 1995.

Finally, this next chart shows the growth in million dollar ''mega verdicts'' claim payments equal to or greater than $1 million between 1985 and 2001.

In 1985, less than 1 percent of all awards exceeded $1 million. In 2001, over 8 percent of awards were $1 million or higher. The data is very clear. A high percentage of medical liability claims are frivolous. Average and median claim payments are increasing rapidly and the percentage of mega awards, those greater than $1 million, increased dramatically as shown on this particular chart.

It seems clear to me that out-of-control medical liability litigation is driving the increase in premiums, not the economy and not a problem with the insurance industry which some would try to make it. It is not just the doctors but all Americans who are paying the price. This is a national problem and one that requires a national solution.

In my letter of March 12 to Budget Committee Chairman NICKLES and Ranking Democrat CONRAD, I emphasized the important implications of medical liability litigation on the Federal budget. In that letter, I wrote:

> The Federal Government pays directly for health care for members of the armed forces, veterans, and patients served in the Indian Health Service. The Federal Government provides reimbursement for the Medicare and Medicaid programs. According to the Department of Health and Human Services' March 3, 2003, report . . . the Federal Government spends $33.7 billion–$56.2 billion per year for malpractice coverage and the costs of defensive medicine.

That is $33.7 billion to $56.2 billion a year just for malpractice coverage in these areas of Federal Government medicine.

That report states:

> reasonable limits on noneconomic damages would reduce the amount of taxpayers' money the Federal Government spends by $28.1 billion to $50.6 billion per year.

Now I continued to write:

> In my view, Federal legislation that would decrease costly frivolous medical liability lawsuits and limit awards for noneconomic damages is necessary, not only to ensure patient access to health care, but to curb increasing Federal health care costs. Because of the substantial and important budgetary implications, particularly to the Medicare and Medicaid Programs, we request that the budget resolution include language calling for medical liability legislation reform.

I am pleased to report the budget resolution we passed in the Senate recognized the tremendous impact of medical liability costs. The budget resolution included $11.3 billion in savings over 10 years as a result of medical liability reform based on CBO calculation. The Medicare Program alone would save $7.9 billion while Medicaid would save $2.9 billion. The remaining savings would occur in the Federal Employees Health Benefits Program and the Department of Defense.

What if we had that money to help with the poor? It would certainly do a lot of good, more good than is being done by spending it on medical liability.

But it is not only the Federal Government that is affected. Medical liability litigation directly and dramatically increases health care costs for all Americans.

What is more, skyrocketing medical litigation costs increase health care costs indirectly by changing the way doctors practice medicine. In an effort to avoid frivolous suits, doctors often feel compelled to perform diagnostic tests that are costly and unnecessary. This defensive medicine is wasteful. Unfortunately, for doctors, it has become a necessity.

I hate to admit it, but I am partly responsible for that myself because, knowing that many doctors are going to be sued unnecessarily and improperly, I advised them to do what they can to protect themselves. Consequently, this defensive medicine is leading to a lot of unnecessary defensive medicine. And they have to do it or they face unnecessary litigation.

According to a recent Harris poll, fear of being sued has led 79 percent of doctors to order more tests than are medically needed; 74 percent refer patients to specialists more often than necessary; 51 percent recommend invasive procedures that they thought were unnecessary; 41 percent prescribe more medications, including antibiotics, that they did not think were necessary.

Defensive medicine increases health care costs. But the real problem inherent in the current medical liability system and the resulting process of defensive medicine is that it also puts Americans at risk. Every test and every treatment poses a risk to the patient. Every unnecessary test, procedure, potentially puts a patient in harm's way.

According to the Harris poll, 76 percent of the physicians are concerned that malpractice litigation has hurt their ability to provide quality care for their patients.

That brings us to the main question. What can we do to address this crisis today? The answer is, plenty. There are excellent examples of what works. The March 2003 Department of Health and Human Services report describes how reasonable reforms in some States have reduced health care costs and improved access to, and the quality of, care. According to this report, over the last 2 years the States with limits of $250,000 or $300,000 on noneconomic damages premiums have increased an average of 18 percent compared to 45 percent in States without such limits.

In 1975, California enacted the Medical Injury Compensation Reform Act, MICRA. Again, I will refer to this chart. This graph shows that MICRA slowed the rate of increase in medical liability premiums dramatically, and it did so without affecting negatively the quality of health care received by the State's residents.

The red on the chart is States that have gone up 573 percent from 1976 to the year 2000. In California they have increased by only 182 percent. As a result of MICRA, California has saved billions of dollars in health care costs, and Federal taxpayers have saved billions of dollars in the Medicare and Medicaid Programs.

The March 2003 report goes on to state:

> A leading study estimates that reasonable limits on non-economic damages such as California has had in effect for 25 years, can reduce health care costs by 5–9% without ''substantial effects on mortality or medical complications.'' With national health care expenditures currently estimated to be $1.4 trillion if this reform were adopted nationally, it would save $70-$126 billion in health care costs per year.

Now, in our joint HELP and Judiciary Committee hearings in February, we heard from those who believe insurance reform is a cure for this crisis. These individuals believe the Federal Government rather than the States should regulate insurance. Those who advocate Federal insurance regulation apparently believe the States and the State insurance commissioners are not able to accomplish this alone. They suggest that insurance companies are colluding to increase premiums. In all honesty, some of them are getting out of the business because of the risks and exposure they face.

There has been little, if any, evidence during or after our hearing to support these allegations. In fact, we heard that the State insurance commissioners monitor and regulate insurance business practices very closely. The State laws are based on the National Association of Insurance Commissioners model rating laws that include the following language:

> No insurer or advisory organization shall attempt to monopolize or combine or conspire with any other person to monopolize an insurance market or engage in a boycott . . . of an insurance market.

And:

> No insurer . . . shall make any arrangements with any other insurer . . . which has the purpose or effect of unreasonably restraining trade or lessening competition in the business of insurance.

Moreover, insurance companies are precluded from increasing premiums to make up for past losses. It seems to me insurance reforms that some have proposed not only miss the mark badly, they would do nothing to address the cause of the crisis and would prevent State insurance commissioners from performing their jobs.

I have to say I came away from the hearing convinced, and I remain convinced, that out-of-control medical litigation is the major cause of the crisis and we have to do something to stop it. The current medical litigation system represents and resembles a lottery more than a justice system. This system harms patients in many ways. All Americans deserve the access to care, the cost savings, and the legal protections that States such as California provide their residents. This problem has reached crisis proportions, and it is high time we end it.

The task before us is to design a system that protects both the patient and the provider. S. 11, the Patient First Act of 2003, which I am proud to cosponsor, includes provisions that have been shown to work that are fair to all concerned. So S. 11 would encourage speedy resolution of claims by providing a reasonable statute of limitations. The bill provides for unlimited awards for economic damages, and it limits awards for noneconomic damages to $250,000.

Moreover, S. 11 does not preempt State limits on awards for damages, noneconomic or otherwise, even if the State limits are higher than those imposed by S. 11. The Patient First Act limits attorney's fees, thereby reducing the costs of medical liability litigation and channeling award money to where it belongs, the injured patient.

Normally I am against that, limiting the attorney fees, but in this particular case we have to do something. Women are going to be without obstetricians. Many people are going to be without surgeons and many will be without specialists. Young people are not going to go into the profession. Young outstanding geniuses who would make great doctors do not want to go into the profession.

In addition, S. 11 provides for evidence of collateral source payments to be introduced in any health care lawsuit. Juries would be made aware of existing health insurance or other sources that compensate individuals for injuries. No longer would Americans compensate an individual twice for the same injury.

While there is much to commend S. 11, one provision we should consider adding is the carefully crafted catastrophic exception to the limit on awards for noneconomic damages. A carefully worded catastrophic exception can provide that individuals who have particularly severe injuries as a result of extremely egregious acts of negligence receive an award for noneconomic damages that would be greater than the limit. Nine States have included such a provision in their statutes.

Having said that, I must say that S. 11 is a very good bill and I believe that it will accomplish our primary goal of ensuring that Americans have access to health care.

What I like most about the ''Patients First Act'' is that it is true to its name.

The bill puts the patient first.

Not the doctor.

Certainly not the lawyer.

You see, it is the patient who is threatened the most by the medical liability litigation crisis.

It is the patient who eventually pays for the increased health care costs and it is the patient that suffers most when he or she cannot access needed care.

The medical liability litigation crisis threatens the economic health of our country and the personal health of every American. It is like a festering

wound, spreading like an infection throughout the country. It is time that we cured this infection by treating it with a proven remedy. S. 11, the Patients First Act of 2003 is the proven remedy Americans need and deserve. I urge my colleagues to join me in supporting this very important legislation.

Madam President, I began these remarks by stating that, as someone who had experience in this field, I have witnessed an unfortunate transition; a transition from the days when the standard of practice in the community was the rule in most communities, which seemed to me to be a fair rule, to a rule of the doctrine of informed consent, which means the doctor has to so inform the patient that the patient knows all of the risks involved. Well, the patient would have to go to medical school to know all of the risks and it would take so much of the doctor's time to advise a patient of those risks that none of us could afford it.

There are always risks in surgery and there are always risks in a number of clinical procedures. Consequently, because no doctor can ever really meet those standards, every one of those cases go to trial. In this country, jurors don't realize by giving outrageous awards that are not justified in these medical liability cases, they are basically spreading that cost to everybody in society.

If we do not act, babies will not be delivered with the utmost care in the future. Americans will not have access to trauma care. Americans will not have access to the top surgeons.

And if we do not act, unnecessary and costly defensive medicine will continue. I have to say, I have witnessed the increased use of costly CAT scans and MRIs in cases where patients could very easily have been treated at a very low cost in comparison. You can go right on down the line in almost everything else. It is getting so that young people in this country cannot afford to have children because it costs so much, and it is all driven by this medical liability situation. I think that is pathetic. I think it is pathetic for anybody to stand on the floor and say this is not a problem of tremendous concern and, literally, say that it is the insurer's fault.

That just is not the case. In all honesty, it doesn't take a rocket scientist to figure out what the problem is. I hate to say it, being a lawyer and having been a trial lawyer. The problem is caused by many in our profession who are bringing these frivolous suits. I have to tell you that I have seen lawyers bring frivolous medical liability suits for one reason and that is because it costs between $50,000 and $100,000 to defend those suits. Many of these insurance companies, rather than take the risk of a runaway jury or a forum shopping situation, even within in a state, will pay the defense costs to get out of the case even though the case has no merit.

Settling 20 of these frivolous cases per year, makes a pretty good living for an attorney, just forcing the insurance companies to pay defense costs because the insurance company doesn't want to take the risk of a runaway jury verdict in a runaway community.

I think what jurors need to know is that in many respects, by allowing outrageous verdicts in some of these cases where there has been no negligence, they are basically running this system right into the ground. That is what has happened.

As I say, I would have a catastrophic provision in this bill if I could, that basically would take care of particularly egregious, gross negligence type cases. There are reasons for bringing litigation from time to time. There are good reasons to weed out those doctors who should not be in the operating room, those doctors who really are incompetent, those doctors who do not do what is right.

But those are the exceptions, not the rule. We are finding that far too many good doctors are leaving the profession because they cannot stand this intolerable situation anymore. The country cannot stand it, either.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, this legislation, S. 11, is not a serious attempt to address a significant problem being faced by physicians in some States. It is the product of a party caucus rather than a bipartisan deliberation of a Senate committee. It was designed to score political points, not to achieve a bipartisan consensus which is needed to enact major legislation. For that reason, it does not deserve to be taken seriously by the Senate.

We must reject the simplistic and ineffective responses proposed by those who contend that the only way to help doctors is to further hurt seriously injured patients.

Unfortunately, as we saw in the Patients' Bill of Rights debate, the Bush administration and congressional Republicans are again advocating a policy which will benefit neither doctors nor patients, only insurance companies. Caps on compensatory damages and other extreme tort reforms are not only unfair to the victims of malpractice, they do not result in a reduction of malpractice insurance premiums. Not only does this legislation fail to do what it claims but it would do many things that its authors are attempting to conceal.

In reality, this legislation is designed to shield the entire health care industry from basic accountability for the care it provides. While those across the aisle like to talk about doctors, the real beneficiaries will be the insurance companies and large health care corporations. This amendment would enrich them at the expense of the most seriously injured patients, men and women and children whose entire lives have been devastated by medical neglect and corporate abuse.

This proposal would shield HMOs that refuse to provide needed care, drug companies whose medicine has toxic side effects, and manufacturers of defective medical equipment.

In the last 2 years, the entire Nation has been focused on the need for greater corporate accountability. This legislation does just the reverse. It would drastically limit the financial responsibility of the entire health care industry to compensate injured patients for the harm that they have suffered. When will the Republican Party start worrying about the injured patients and stop trying to shield big business from the consequences of its wrongdoing? Less accountability will never lead to better health care.

According to professor Sara Rosenbaum, a nationally respected expert on health care law at the George Washington University School of Public Health:

> This measure is so vast in scope that it reaches every conceivable health care claim against every health care corporation or manufacturer of health care products . . . In this sense the measure extends far beyond its popular billing as one related to the crisis facing physicians and other medical professionals in individual practice.

In testimony on the companion bill to S. 11 before the House Commerce Committee, she stated that the bill was written so broadly that it would shield health care companies from claims as varied as billing fraud, providing tainted blood to patients, fixing the prices of drugs, deliberately overcharging Medicare or Medicaid for health services, making defective implants and violating nursing home safety rules. This legislation is attempting to use the sympathetic family doctor as a Trojan horse concealing an enormous array of special legal privileges for every corporation which makes a health care product, provides a health care service, or insures the payment of a medical bill. Every provision of this bill is carefully designed to take existing rights away from those who have been harmed by medical neglect and corporate greed.

This legislation would deprive seriously injured patients of the right to recover fair compensation for their injuries by placing arbitrary caps on compensation for noneconomic loss in all of these cases. These caps only serve to hurt those patients who have suffered the most severe, life-altering injuries and who have proven their cases in court.

They are the paralyzed, the brain-injured, and the blinded. They are the ones who have lost limbs, organs, reproductive capacity, and in some cases even years of life. These are life-altering conditions which deprive a person of the ability to engage in many of the normal activities of day to day living. It would be terribly wrong to take their rights away. The Bush administration talks about deterring frivolous cases, but caps by their nature apply only to the most serious cases which have been proven in court.

A person with a severe injury is not made whole merely by receiving reimbursement for medical bills and lost wages. Noneconomic damages compensate victims for the very real, though not easily quantifiable, loss in quality of life that results from a serious, permanent injury. It is absurd to suggest that $250,000 is fair compensation for a person paralyzed for life.

Caps are totally arbitrary. They do not adjust the amount of the compensation ceiling with either the seriousness of the injury, or with the length of years that the victim must endure the resulting disability. Someone with a less serious injury can be fully compensated without reaching the cap. However, a patient with severe, permanent injuries is prevented by the cap from receiving full compensation for their more serious injuries. Is it fair to apply the same limit on compensation to a person who is confined to a wheelchair for life that is applied to someone with a temporary leg injury?

Caps discriminate against younger victims. A young person with a severe injury such as paralysis must endure it for many more years than an older person with the same injury. Yet that young person is prohibited from receiving greater compensation for the many more years he will be disabled. Is that fair?

Caps on noneconomic damages discriminate against women, children, minorities, and low-income workers. These groups do not receive large economic damages attributable to lost earning capacity. Women who are homeowners and caregivers for their families sustain no lost wages when they are injured, so they only receive minimal economic damages. Noneconomic damages are particularly important to these vulnerable populations.

In addition to imposing caps, this legislation would place other major restrictions on seriously injured patients seeking to recover fair compensation. At every stage of the judicial process, it would change long-established judicial rules to disadvantage patients and shield defendants from the consequences of their actions.

It would abolish joint and several liability noneconomic damages. This means the most seriously injured people may never receive all of the compensation that the court has awarded to them. Under the amendment, health care providers whose misconduct contributed to the patient's injuries will be able to escape responsibility for paying full compensation to that patient.

The bias in the legislation could not be clearer. It would preempt State laws that allow fair trdatment for injured patients, but would allow State laws to be enacted which contained greater restrictions on patients' rights than the proposed federal law. This one-way preemption contained in Section 11(b) shows how result-oriented the legislation really is. It is not about fairness or balance. It is about protecting defendants.

The amendment preempts State statutes of limitation, cutting back the time allowed by many States for a patient to file suit against the health care provider who injured him. Under the legislation, the statute of limitations can expire before the injured patient even knows that it was malpractice which caused his or her injury.

It places severe limitations on when an injured patient can receive punitive damages, and how much punitive damages the victim can recover. Under the bill, punitive damages can only be awarded if the defendant acted ''with malicious intent to injure'' or ''deliberately failed to avoid unnecessary injury.''

This is far more restrictive than current law. It prohibits punitive damages for ''reckless'' and ''wanton'' misconduct, which the overwhelming majority of States allow. In the very small number of cases where punitive damages would still be allowed, it would cap them at twice the amount of economic damages, no matter how egregious the defendant's conduct and no matter how large its assets.

It imposes unprecedented limits on the amount of the contingent fee which a client and his or her attorney can agree to. This will make it more difficult for injured patients to retain the attorney of their choice in cases that involve complex legal issues. It can have the effect of denying them their day in court. Again the provision is one-sided, because it places no limit on how much the health care provider can spend defending the case.

If we were to arbitrarily restrict the rights of seriously inured patients as the sponsors of this legislation propose, what benefits would result? Certainly less accountability for health care providers will never improve the quality of health care. It will not even result in less costly care. The cost of medical malpractice premiums constitutes less than two-thirds of 1 percent—66 percent—of the Nation's health care expenditures each year. For example, in 2001, health care costs totaled $1.42 trillion, while the total cost of all medical malpractice insurance premiums was $7.3 billion. Malpractice premiums are not the cause of the high rate of medical inflation.

This chart clearly reflects that we spend $1.42 trillion a year in total personal health care expenditures. It is a very large amount per individual. If we are ever able to get the cost of health care per individual down to a reasonable amount there would be real savings. But that isn't what this is about. This is about $7.3 billion, and that amounts to just one-half of 1 percent of all medical costs. Medical malpractice premiums do not contribute to the overall rise. We ought to address the cost of health care. That isn't what this bill is about.

Over the last 15 years, medical costs increased by 113 percent. The total amount spent on medical malpractice insurance rose just 52 percent over that period, less than half the rate of inflation for health care services. The increase is rising at virtually one-half of what other health care services are rising.

The White House and other supporters of caps have argued that restricting an injured patient's right to recover fair compensation will reduce malpractice premiums. But there is scant evidence to support their claim. In fact, there is substantial evidence to refute it.

In the past year, there have been dramatic increases in the cost of medical malpractice insurance in States that already have damage caps and other restrictive tort reforms on the statute books, as well as in States that do not. No substantial increase in the number or size of malpractice judgments has suddenly occurred which would justify the enormous increase in premiums which many doctors are being forced to pay.

Comprehensive national studies show that the medical malpractice premiums are not significantly lower on average in States that have enacted damage caps and other restrictions on patient rights than in States without these restrictions. Insurance companies are merely pocketing the dollars which patients no longer receive when ''tort reform'' is enacted.

Let's look at the facts. Approximately half of the States have a cap on medical malpractice damages. Most have had those statutes for a substantial number of years. The other half of the States do not have a cap on malpractice damages. The best evidence of whether such caps affect the cost of malpractice insurance is to compare the rates in those two groups of States.

Based on data from the Medical Liability Monitor on all 50 States, the average liability premium in 2002 for doctors practicing in States without caps on malpractice damages was $31,926, virtually the same as the average premium for doctors practicing in States with caps, which was $30,521.

There are many reasons why insurance rates vary substantially from State to State. This data demonstrates that it is not a State's tort reform laws which determine the rates. Caps do not make a significant difference in the malpractice premiums which doctors pay. This is borne out by a comparison of premium levels for a range of medical specialties.

The average liability premium in 2002 for doctors practicing internal medicine was less—2.8 percent—for doctors in States without caps on malpractice damages—$9,552—than in States with caps on damages—$9,820. Internists actually pay more for malpractice insurance in the States that have caps.

The average liability premium in 2002 for general surgeons was almost identical for doctors in States without caps—$33,016—than States with caps—$33,157. Surgeons are paying the same regardless of the State's tort laws.

The average liability premium for OB/GYN physicians in 2002 in States without caps—$53,163—exceeded the rate for doctors in States with caps—$48,586—by less than 10 percent, a relatively small difference.

Shown on this chart are the figures for: internal medicine, general surgery, OB/GYN, and the physicians in States without caps on damages and the physicians in States with caps on damages. A fair reading of that would indicate there is virtually little that would reflect itself in lower malpractice insurance rates for those States with caps.

This evidence clearly demonstrates that capping malpractice damages does not benefit the doctors it purports to help. Their rates remain virtually the same. It only helps the insurance companies earn even bigger profits. As Business Week Magazine concluded after reviewing the data ''the statistical case for caps is flimsy.'' That is from their March 3, 2003 issue.

Since malpractice premiums are not significantly effected by the imposition of caps on recovery, it stands to reason that the availability of physicians does not differ between States that have caps and States that do not. AMA data shows that there are 233 physicians per 100,000 residents in States that do not have medical malpractice caps and 223 physicians per 100,000 residents in States with caps. Looking at the particularly high cost speciality of obstetrics and gynecology, States without caps have 29 OB/GYNs per 100,000 women while States with caps have 27.4 OB/GYNs per 100,000 women. Clearly there is no correlation.

If a Federal cap on noneconomic compensatory damages were to pass, it would sacrifice fair compensation for injured patients in a vain attempt to reduce medical malpractice premiums. Doctors will not get the relief they are seeking. Only the insurance companies, which created the recent market instability, will benefit.

A National Association of Insurance Commissioners study shows that in 2000, total insurance industry profits as a percentage of premiums for medical malpractice insurance was nearly twice as high—13.6 percent—as overall casualty and property insurance profits—7.9 percent. Do we understand that now? This is the National Association of Insurance Commissioners. Their study showed, in the year 2000, that the insurance industry profits as a percentage of premiums for medical malpractice insurance was twice as high as casualty and property insurance profits. The profits from the premiums for medical malpractice insurance were twice as high. This is the National Association of Insurance Commissioners study.

In fact, malpractice was a very lucrative line of insurance for the industry throughout the 1990s. Recent premium increases have been an attempt to maintain the high profit margins despite sharply declining investment earnings. That is what is at the root cause here.

Insurance industry practices are responsible for the sudden, dramatic premium increases which have occurred in some States in the past 2 years. The explanation for these premium spikes can be found not in legislative halls or in courtrooms, but in the boardrooms of the insurance companies themselves.

There have been substantial increases in the last 2 years in a number of insurance lines, not just medical malpractice. Insurers make much of their money from investment income. Interest earned on premium dollars is particularly important in medical malpractice insurance because there is a much longer period of time between receipt of the premium and payment of the claim than in most lines of casualty insurance.

The industry creates a ''malpractice crisis'' whenever its investments do poorly. The combination of a sharp decline in the equity markets and record low interest rates in the last 2 years is the reason for the sharp increase in medical malpractice insurance premiums. What we are witnessing is not new. The industry has engaged in this pattern of behavior repeatedly over the last 30 years. When ''tort reform laws'' are enacted, the insurance companies pocket the resulting savings to bolster their profits.

Last month, Weiss Ratings, Inc., a nationally recognized financial analyst, conducted an in-depth examination of the impact of capping damages in medical malpractice cases. This is a nationally recognized financial analyst. Their conclusions sharply contradict the assumptions on which this legislation is based. Weiss found capping damages does reduce the amount of money that malpractice insurance companies pay out to injured patients. However, those savings are not—those savings are not—passed on to doctors in lower premiums. That is the conclusion.

This is what the Weiss report, issued on June 3 of this year, states:

> Since the insurers in the states with caps reaped the benefit of lower medical malpractice payouts, one would expect that they would reduce the premiums they charged doctors.

At the very minimum, they should have been able to slow down the premium increases. Surprisingly, the data show they did precisely the opposite. Between 1991 and 2002, the Weiss analysis shows that premiums rose by substantially more in the States with damage caps than in the States without caps. The 12-year increase in the median annual premium was 48.2 percent in the States that had the caps, and only 35.9 percent in the States that had no caps. In the words of the report:

> On average, doctors in states with caps actually suffered a significantly larger increase than doctors in states without caps. . . . In short, the results clearly invalidate the expectations of caps proponents.

There it is. Those States with the caps, 48.2 percent median premium increase; States without caps, 35.9 percent. That is from the study by Weiss Rating, Inc. It is not a study that is made up by those of us who are expressing opposition.

Doctors, especially those in high-risk specialties, whose malpractice premiums have increased dramatically over the past 2 years, do deserve premium relief. That relief will only come as a result of tougher regulation on the insurance industry.

When insurance companies lose money on their investments, they should not be able to recover those losses from the doctors they insure. Unfortunately, that is what is happening.

Doctors and patients are both victims of the insurance industry. Excess profits from the boom years should be used to keep premiums stable when investment earnings drop. However, the insurance industry will never do that voluntarily. Only by recognizing the real problem can we begin to structure an effective solution that will bring an end to unreasonably high medical practice premiums.

I conclude with a quotation from the analysis of medical malpractice premiums by Weiss Ratings, Inc. Weiss Ratings, as I said, is not speaking from the perspective of a trial lawyer or a patient advocate, but as a hard-nosed financial analyst that has studied the facts of malpractice insurance ratings. Here are their recommendations to us based on those facts:

> First, legislators must immediately put on hold all proposals involving non-economic damage caps until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs. Right now, consumers are being asked to sacrifice not only large damage claims, but also critical leverage to help regulate the medical profession—all with the stated goal that it will end the med mal crisis for doctors. However, the data indicate that similar state legislation has merely produced the worst of both worlds: The sacrifice by consumers plus a continuing—and even worsening—crisis for doctors. Neither party derived any benefit whatsoever from the caps.

Mr. DURBIN. Will the Senator yield for a question?

Mr. KENNEDY. I also reference a really excellent article in U.S. News and World Report from June 30 that shows on a chart what has been happening with premiums going from $2.9 billion to $4.9 billion and, on the other hand, points out insurers' payments after the jury verdict was $147 billion in 1993 and in the year 2001, $172 billion—so basically a fairly flat line across almost a 10-year period, a dramatic increase in the premiums and virtually flat in terms of the payments.

I am glad to yield.

Mr. DURBIN. If the Senator from Massachusetts would yield for a question, I would ask him, since he has been our leader in the Senate on the issue of a Patients' Bill of Rights to ensure that patients across America have their rights against HMOs and managed care companies—I ask the Senator from Massachusetts, is he aware

that despite the copious debate on the floor about the crisis facing physicians across America, S. 11 provides a limitation on liability not just for doctors and hospitals but also for HMO insurance companies, managed care organizations, pharmaceutical companies, and manufacturers of medical devices?

Mr. KENNEDY. The Senator is exactly right. It is not only limited to those groups the Senator has cited, but there is a strong belief that it would also apply protection for billing fraud, tainted blood to patients, fixing of prices of drugs, deliberately overcharging Medicare and Medicaid for health services, as well as making defective implants, and violating nursing home safety standards.

We don't hear much from those who are supporting this about why all of these various groups need this kind of protection. It is a catch all, not dealing with what was stated by many of those who were speaking in favor. This is a catch all for anything to do in any way, under any pretense, with the health care industry.

Mr. DURBIN. May I ask the Senator from Massachusetts another question through the Chair. There is a section in this bill I would like to call to his attention, section 13. I would like to read it to the Senator and ask him to respond, since he has been the sponsor of a Patients' Bill of Rights, so that once and for all HMOs and managed care companies will be held responsible and accountable for medical decisions they make that injure patients. I ask the Senator if he would respond and tell the Senate on the record what it means to include in S. 11 a section 13, with the following language—sense of Congress:

It is the sense of Congress that a health insurer should be liable for damages for harm caused when it makes a decision as to what care is medically necessary and appropriate.

I ask the Senator from Massachusetts, does this sense of Congress language guarantee that those who are harmed by health insurers who make bad decisions about diagnostic procedures, stays in the hospital, necessary surgery—is this language some refuge and comfort for them that finally now they will have their day in court and now, with this sense of Congress, they can hold these health insurance companies accountable?

Mr. KENNEDY. It really insults the intelligence of the average family, and the average family is far too bright and smart not to understand what this says and what it does not. As implicated in the Senator's question, this is a sense of the Senate of something we should be doing by legislation which we have attempted to do with the Patients' Bill of Rights.

This sense of the Senate is meaningless. It isn't even worth the paper it is written on, because of all the other provisions included in the legislation which the Senator has spoken to so effectively during the course of the debate.

This is sort of a catch all, a ''make them feel good,'' section, for some to be able to say: Look, they have language in here that it is the sense we all feel this way. But, of course, it says this in a piece of legislation which will effectively undermine the protections for working families, for their parents, and for their children.

We have many things that can be done to provide help to some of those who have the particular specialties which need attention, but the idea that you have these two lines of a sense of the Senate to effectively say: We have done all of these bad things, and we have put them in law, but we want a sense of the Senate to make you feel good and show that we are actually protecting the average family in this country—as the Senator well knows, it isn't worth the paper it is printed on.

Mr. DURBIN. If I may ask one last question of the Senator?

Mr. KENNEDY. If I may just add, as the Senator remembers—I hope the American people do—we had weeks of debate on the floor on the Patients' Bill of Rights. As the Senator remembers, what underlined that whole debate was that we ought to put the well-being and the health care interests of the patients of this country ahead of the bottom line of the HMOs. This was a debate in which the American people really participated. It was sidetracked because the administration refused to allow States to make the ultimate decision about compensation for individuals. That was in the final compromise which this administration refused.

So for all those who want to talk about States rights issues on this and the States know best—all those who make that argument—they somehow miss the importance of the real protections for people.

Mr. DURBIN. My last question to the Senator: If this sense of the Congress is not worth the paper it is written on, as the Senator has said, is it fair to conclude that since the HMOs and managed care companies prevailed before when the Senator from Massachusetts offered his Patients' Bill of Rights to protect individuals from insurance companies making medical decisions, is it fair to conclude that if S. 11 were enacted as written, limiting the liability of these HMO and insurance companies, these companies would win again, that we would reward them again for bad conduct, despite the sense of the Senate, sense of Congress, section 13 of this bill?

Mr. KENNEDY. I think what you could say is that this is the anti-Bill of Rights for the American consumer because it goes in just the opposite way. Rather than guaranteeing protections, it undermines whatever protections are out there. This is a battle we have been fighting over and over again in recent years, making sure the most basic protections for our consumers and families in the health care area are not undermined.

As the Senator has pointed out, this is going in the opposite direction.

Mr. DURBIN. I thank the Senator.

Mr. KENNEDY. I thank the Senator.

The PRESIDING OFFICER (Mr. ALEXANDER). The Senator from Nevada.

Mr. ENSIGN. Mr. President, I wish to respond to a few of the items just laid out in the Senate and try to point out what I think are glaring inaccuracies.

First of all, the Weiss report we have heard so much about from the last two speakers uses numbers from the Medical Liability Monitor. The Medical Liability Monitor just provides the numbers. They are not a group that is pro tort reform or anti tort reform. This is what the editor, Barbara Dillard, says about the numbers that the other side of the aisle is using to somehow skew what the premiums are doing in those States that have enacted tort reform. Let me read some of the most salient parts:

The Weiss ratings analysis of medical malpractice caps cites the Medical Liability Monitor as the source of data Weiss uses to calculate ''average'' and ''medium'' premiums for physicians during the last 12 years. While we are an independent news publication and take no position on tort reform, or other proposals to improve the medical liability climate, we feel it is necessary to comment on the use of our statistics because some readers have expressed concern. The median and averages in the Weiss report are not the numbers we report in our annual rate surveys. Weiss may have taken our numbers, the amounts and increases of premiums paid by doctors State by State, and used them to arrive at their statistics. But it is not possible from the report to say definitely how our numbers have been used. It is our view that it is impossible to calculate a valid ''average'' premium for physicians, or for physicians in a particular State or territory, and we state that clearly in the executive summary of our rate survey.

But the editor of the Medical Liability Monitor goes further. She advised the leader's office that:

It is misleading to use median premiums compiled with data from the Medical Liability Monitor to demonstrate the effect of noneconomic damage limits on liability rates.

This is exactly what Weiss does. That is the report they have been quoting here. The report uses median annual premiums compiled with data from the Medical Liability Monitor to try to demonstrate the effect of noneconomic damage limits on liability rates. Not only is this wrong, it downright misleads the public.

Let me refer to some of the other issues they were talking about. Half of the States have enacted medical liability reform. My State did that a year ago. It has caps. If you look at my State, as far as the numbers, it would look like it hasn't worked. It takes a minimum of probably 8, 10, 12, or 15 years to go through the courts to find out whether the caps are going to be upheld. If the insurance companies are unsure whether the caps are going to be upheld or not, there is no predictability there because they can reach way back—once it is held unconstitutional, they can go back and try those cases and get those awards.

That is why in California it took so long—from 1975 until the mid-1980s—to

find out whether the law was going to work. Colorado and California have now had their laws in place long enough to stabilize rates. Let's look at those two States, in major cities, compared to other cities around the country.

Here are Los Angeles and Denver. We will start with the general surgery. It is almost $37,000 in Los Angeles for the medical liability premiums for the year; that is for a general surgeon. In Denver, it is around $34,500. New York is about $51,000. Las Vegas was $70,000. It is a lot higher this year in Las Vegas. In Chicago, it is $68,000. In Miami, it is $174,000. The cities in the gray on the chart are States without medical liability reform. The two in the white have had medical liability reform in place long enough for them to have predictability.

This whole debate isn't about hurting patients; it is about helping them to have access to quality care. In my State, we had a level I trauma center close for 10 days because of a crisis, where the specialists who were treating patients there could not afford the medical liability insurance anymore. So they had to say: We cannot come in there and practice because we cannot afford the insurance. The Governor of our State, within a week, called a special session of the legislature. They enacted, in a bipartisan way, caps. Unfortunately, like a lot of the caps in the country—and they use a lot of these statistics—they are similar to the caps in my State where they have loopholes that you can drive a truck through, which makes the legislation pretty much, as far as a court of law is concerned, ineffective. That is why there is a move in my State to close those huge loopholes down to where just the most serious cases actually have unlimited pain and suffering type of awards.

In our State, the way they reopened the level I trauma center in that special session of the legislature—not only did they enact a $350,000 cap for the general population but for the level I trauma center they put it under the State. Guess what. Our State has $50,000 caps total—economic, pain and suffering, medical, the whole thing. That is the only way they could get the level I trauma center back open. Why did they do it? They knew there was a crisis. People had died, and more would die if they didn't reopen the trauma center.

Well, how bad does it have to get in the U.S. for us to say there is a crisis? When will the other side realize how bad the situation is in America? We are losing specialists. People are leaving the practice of medicine—especially those specialties and subspecialties in which we already have a shortage in many areas; and new people are not going into these areas because they see the writing on the wall. They see it is going to be too expensive for them to go out and practice.

I have a good friend from Las Vegas, Dr. Spoon. We were talking a couple months ago. One of his favorite things to do in his practice—he is an obstetrician—is to deliver babies, especially those high-risk pregnancies. He got so much enjoyment from bringing them to the point where they were successful. His insurance company made him stop performing high-risk deliveries, and they also cut him down from 250 or 300 deliveries a year, and he can deliver no more than 125 babies a year.

Southern Nevada is the fastest growing metropolitan area in the country. Yet we are losing OB/GYNs and new ones are not coming in. So what happens in that area is women are having serious trouble locating OB/GYNs to deliver their babies.

I want to try to talk a little bit about the bill and what it really does do and try to clear up some of these issues. First, to go back to premiums. It was said that in places such as California premiums and caps on economic damages—caps on pain and suffering don't work. According to the CBO, they do work. H.R. 5, which is virtually identical to the bill we have today, would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law. Premiums for medical malpractice insurance ultimately would be an average of 25 to 30 percent below what they would be under current law.

The Congressional Budget Office is nonpartisan, and everybody is supposed to respect the numbers they put out around here. They certainly don't have any pro or con as far as tort reform is concerned. There are others such as the U.S. Department of Health and Human Services that say States with limits of $250,000 or $350,000 on noneconomic damages have average combined highest premium increases of 12 to 15 percent—that is average combined highest premium increases—compared to 44 percent in States without caps on noneconomic damages.

The Joint Economic Committee of the Congress says that tort reform will reduce overall spending on health care savings by between $67 billion and $106 billion over the next 10 years.

I wish to talk a little bit about what kinds of economic damages. That has been criticized. We don't cap economic damages. What can you get in economic damages under this bill? You can get all lost wages and benefits. Lost earning capacity. They say it hurts children. You get a child who gets hurt because of malpractice and you can calculate what that child would have had over the next 60, 70 years.

Mr. DURBIN. Will the Senator yield for a question?

Mr. ENSIGN. They may not have the education to know what their total potential was but it is 60 or 70 years' worth of earnings they can get in economic damages. That can be significant. I will freely admit it is not what Barry Bonds would get if he got hurt, or LaBron James, the new basketball player. They would obviously get a lot more money because they have the potential of making so much more money. But this child would still get a significant amount.

Let me go through these points, and then I will yield for a question.

All medical expenses would be covered under this bill: long-term care, assisted living devices, child care, household services, lost time, special medical damages, value of care, counsel, advice, aid, comfort, counsel for children, parents, and spouses. All of those are possible under economic damages in this bill.

The final point I wish to make is this: Does this capping hurt patients? We just have to look at Colorado and California and ask: Are there people out there being hurt? I submit there are a lot more people being hurt and going to be hurt in States such as Nevada where the doctors are leaving, where the doctor will not be in that emergency room or will not be able to deliver a baby, especially in those high-risk pregnancies.

This one case in Florida is a very good example. I actually met this gentleman. He is a physician himself. He was not performing duties as a physician at this time, he was a parent of an injured child. His name is Dr. Frank Shwarin. His 4-year-old child in Naples, FL, fell and hit his head on the side of the swimming pool. This was in July of 2002. The father is named Frank and Craig is the son. He rushed him to the nearest hospital only to find that none of the neurosurgeons on call would treat patients under 18 years of age. Why? Because they could not get medical liability coverage to treat, even in an emergency situation, a pediatric neurosurgery case. They had to medevac his son a couple hours away. Fortunately, because the father is a doctor, he was able to keep his son alive during that time.

A woman testified before the Senate that when the level I trauma center crisis happened in my State, her father died when that trauma center was closed because he had to be sent to another emergency room, and an emergency room is not a trauma center. They do not have the kind of expertise to treat severe trauma. As a result, her father died.

We cannot guarantee he would not have died in the trauma center, but we can guarantee he would have had the best possible care and the best chance of living. That is what I believe this debate has come down to: The system is out of balance now. It is not working. To correct this imbalance, we have to start reining in some of these frivolous, outrageous jury awards.

I yield for a question.

Mr. DURBIN. Mr. President, I thank the sponsor of the legislation for coming to the Chamber. I want to give him an opportunity to complete his statement, and perhaps at the end of that statement, if he and I can engage in dialog or debate, that would be fair. I do

not want to interrupt his train of thought during his presentation.

Mr. ENSIGN. That would be fine. I have a couple other issues to go through. There are a few other cases I would like to bring to the attention of our colleagues.

First, because we need to put a real face on this issue—we need to put a face on the patients, and I think it is legitimate to put a face on the other way. I think it is legitimate to put a face on somebody who has had a claim of malpractice and actually had malpractice committed against them, and it is also fair to put faces on those people who now are having trouble finding the kind of health care they need.

This is a balancing act, there is no question about it. There is no perfect answer to this situation. I wish there were. The fact is, the current system is driving health care providers out of the practice of medicine, hospitals are closing down, and we need to correct the situation so that when we seek health care in an emergency situation or in a nonemergency situation, we will have the kind of care we need.

A friend of mine in Las Vegas has Parkinson's disease and goes down to Loma Linda—I told this story earlier today—to see his subspecialist in neurology to treat this disease. He had some fairly radical surgery where they actually separate parts of the brain. He has had very good success with it. He had a specialist talked into moving his practice to Las Vegas shortly before the medical malpractice crisis hit in Las Vegas. Once that hit the news, the guy said: Sorry, I live in California where we have caps. I cannot go to Las Vegas and pay $250,000 a year for my practice for medical liability coverage. I cannot afford to do it. Why would I do that when I have a good practice here, we have caps, and it is working well in California?

He wanted to move to Las Vegas. He was ready to go with his family. He liked the quality of life in Las Vegas. He did not go simply because he cannot afford to take that kind of economic hit. So people in Las Vegas have to drive down there.

Most of the time those are not emergency cases, but for those cases that are an emergency, it is just a shame.

People say this is a State issue. I would counter that this is the United States of America, and we are supposed to be able to live where we want to live, and now we are saying to people: No, you cannot go there because of medical liability premiums, you cannot afford to open up your practice because of medical liability premiums. People should be able to find the kind of health care they need wherever in the United States and live the quality of life and obtain the best health care they can possibly get based on what is available in the area. I do not think outrageous premiums should be the limiting factor.

Let me close with this point, Mr. President. Earlier there was debate about punitive damages and that we are protecting big companies. Under this bill, we do protect companies that make medical devices if they have followed FDA regulations. In other words, the manufacturer would not be liable for punitive damages if it satisfied FDA's rigorous approval process and if the harm to the patient did not result from the company's violation of an FDA regulation. If they played by the rules that the Government set down, we protect them in this bill from noneconomic—we do not protect them from economic or from medical expenses. But if they violate the FDA rules, then they are not protected. I think that is fairly reasonable. That is why we think this bill is a reasonable compromise, is a reasonable approach to solving what I believe is an out-of-control system.

I will be happy to yield for questions.

Mr. DURBIN. Mr. President, I thank the sponsor of the legislation. I would like to ask him this question. Virtually every example the Senator has given, every compelling example he has given for this legislation involves doctors paying malpractice premiums. Yet as he has written this legislation, it goes far beyond providing limitation of liability for doctors. It includes limitation of liability for HMOs, managed care, pharmaceutical companies, medical device manufacturers, and nursing homes.

Can the Senator from Nevada explain to me why he has not come before us and argued on behalf of HMOs and why their exposure to liability for wrongdoing is a source of concern and leads to, he thinks, the need for legislation?

Mr. ENSIGN. Mr. President, we know we live in a litigious society. We are sue happy today. Everything is somebody else's fault, and we immediately go to court. Because of the nature of our courts, it is easier to settle. When we settle, it drives up the cost for all of us. A lot of the cases never make it because it is too expensive to take the case all the way to court.

A lot of companies especially are self-insured for certain amounts of money. It is easier for them to calculate the cost of going to court, and what happens in the long run is that all of us pay for that in higher premiums. When we have higher premiums, it is pretty simple. We end up with a situation where employers cannot afford it. A lot of small employers especially are dropping their health insurance coverage and we are ending up with 41 million uninsured in this country and a big part of that is the cost, not only of the premiums to doctors but just the whole cost of defensive medicine that we have to practice today because of the fear of being sued.

Mr. DURBIN. So if the Senator from Nevada will yield for another question, through the Chair, is the Senator from Nevada going to bring for us then more evidence, as he has when it comes to doctors, as to the insurance crisis facing drug companies in America, which as I understand are the most profitable corporations in America with an average annual return of 18 percent on capital, about 6 times the rate of return of the Fortune 500? Is he going to tell us about the liability exposure of HMOs that really necessitate this protection which he is building into his proposed law, S. 11? Is he going to tell us about the medical device corporations that have made faulty products which are causing problems across America and how their exposure and liability necessitate this need to limit their accountability and cap the recovery of innocent people who are victims of their misconduct?

Mr. ENSIGN. If the Senator would vote for us to go forward with the bill tomorrow when we have a cloture vote, we will have a lot of time to debate this. We can amend it and go forward with this debate. So I hope he will join us in voting for cloture because I do have a lot of evidence to justify the various provisions in the bill.

The bottom line is we all know that today it costs around $900 million to bring a single new drug to the market. I am not here to defend the pharmaceutical companies or any other company.

Mr. DURBIN. That is what the bill of the Senator does.

Mr. ENSIGN. No. What I am here to say is we have a problem with our health care system today and we need to fix it. If we can go forward with this bill, if there are amendments the Senator thinks can improve this bill, let's at least move to it so that we can amend it, put the amendments forward, and have a healthy debate. We can take a week, or whatever it takes, to do that so that we can go forward and try to fix some of the glaring problems. If the Senator thinks there are some problems with the bill, let's bring forth amendments and try to fix it.

Mr. DURBIN. If the Senator will yield for another question, I am curious. What the Senator has just suggested is a good basis for establishing what we might even call a Senate committee where we could have Members of the Senate come together, consider evidence, and offer amendments before the bill comes to the floor. If I am not mistaken, the Senate bill already provides for committees. Why is it that this bill, of such consequence, should not go through a Senate committee system so that the very aspects that we have just discussed can be openly debated and amended and come up with a work product that might be of real value to this country?

Mr. ENSIGN. I say to my friend and colleague that it is obvious why. We could not get a bill to the floor. The Senator knows that and everybody here knows that. It is just like last year when the Senator was in the majority, there were at least two bills that I remember, the Energy bill, as, well as the prescription drug bill, that were brought to the floor that were not brought through committee. They were

brought directly to the floor by the majority leader at the time. It is not a common procedure, but it is a procedure that has to be done every once in a while to bring up important legislation that cannot go through committee and my colleagues know cannot get through committee.

The way the Senate works is so different than the House, and the Senator knows that. We both served in the House of Representatives. The House of Representatives does almost all their work in the committee. We can do a lot of our work on the floor and produce a pretty darn good product by bringing it to the floor, amending the bill on the floor, and that is what I think we should do.

Mr. DURBIN. If I could ask the Senator from Nevada, the sponsor of this legislation, another question, he has spoken about his own home State of Nevada and the problems they have faced. In the last 2 days, there has been a lot of discussion on the Senate floor about the medical malpractice crisis in this country that involves an increasing incidence of medical malpractice. In fact, the Bush administration says it has reached epidemic proportions.

I ask the Senator from Nevada, what in his bill, S. 11, would deal with the problem in his home State of Nevada, reported by Business Week on March 3 of this year, in which they reported that in his home State of Nevada, which adopted a $350,000 cap on recovery last year, it was discovered that two doctors in his State were responsible for $14 million of the $22 million in claims awarded in Nevada in 1 year? What in this legislation would make certain that those doctors, guilty of malpractice, would be held accountable for their wrongdoing and would be removed from practice if, in fact, they are not meeting the standards of professional conduct?

Mr. ENSIGN. Mr. President, I say to my colleague that it is a great point. I practiced veterinary medicine and I understand how professional boards work. I understand that with professional boards there is a self-policing that is assumed. It is supposed to happen with lawyers. It is supposed to happen with accountants. It is supposed to happen with veterinarians. It is supposed to happen with physicians. The big problem today with professional boards is they are afraid to do something with somebody's license because if they do, they can be held personally liable. That happens time and time again.

All of the professional boards go through this; that as badly as they would love to jerk somebody's license, unless it is so clear and the evidence is so outrageous of what they have done to deserve their license being jerked, it just does not happen. Frankly, it should happen more. There are incompetent doctors. There are incompetent lawyers. There are incompetent veterinarians. More of them should have their license jerked in that case, and I wish they were empowered a little more and maybe protected a little more to do that.

Mr. SESSIONS. Will the Senator from Nevada yield for a question?

Mr. ENSIGN. I am happy to yield for a question.

Mr. SESSIONS. I say to Dr. Ensign, we appreciate his leadership on this matter and know that he is a professional himself, and he is familiar with these liability issues. The Senator talked about two doctors in Nevada being responsible for $14 million of the $22 million in punitive damages. I guess what I want to ask the Senator is that in this way we operate with punitive damages, is not the real truth that when two doctors get hit with big verdicts that the premiums from all the innocent doctors in Nevada go up? It is not just the bad doctor who pays—it is supposed to punish him—but the insurance company pays it, does it not, and then they pay for that by raising the premiums on everybody else?

Mr. ENSIGN. The Senator from Alabama brings up a very true point, but also the Senator from Illinois is correct in that we do need to do a better job of policing the physicians. They need to do a much better job of that. That is why I brought up the point of the boards. The point is, though, if we vote for cloture tomorrow, maybe we can work this out. Maybe we can come up with something that could be addressed, or at least give suggestive language to the States to be able to work this out. It is so clear that if we can invoke cloture—for the general public, that means that we can proceed to the bill. The vote tomorrow is just whether we can proceed to the bill. All of this is just pre-debate on whether we are going to proceed to a bill that is so critical to the future health care in this country.

Mr. SESSIONS. The Senator is exactly correct. I certainly agree, as a Federal prosecutor—and I prosecuted some physicians and other professionals in the medical business for bad behavior, but the odd thing about the way our tort system works, people think the doctor who gets sued is being punished, but really the doctor has insurance which he is required to have in order to practice in a hospital—virtually everybody has to have some, no matter how much it costs—and they do not end up being punished. Every physician in the community is punished, are they not? Is that not an odd thing that we are dealing with in current law?

Mr. ENSIGN. I do not know if the Senator can see this chart—maybe we can have that chart turned just slightly so the Senator from Alabama can see it, but it brings up the exact point. The States that have capped noneconomic damages in the white, California and Colorado, represented by Los Angeles and Denver, in those States let's go down to the OB/GYNs, $54,000 in Los Angeles for the annual premiums for the medical liability insurance, $30,000 in Denver. Go over to New York; it is almost $90,000; in Las Vegas, $108,000. I guarantee that number in Las Vegas is old because friends of mine who are OB/GYNs say they are paying anywhere from $130,000 to $150,000 a year. Chicago, $102,000 and Miami is over $200,000 a year. The cities in gray, representing the states in gray, have no tort reform that has been on the books. Nevada has it but it has not been on the books long enough. It will take 6, 8, 10 years. Los Angeles and Denver have had their laws on the books long enough to work.

Because they have enacted what we want to do today, we see these premiums.

I yield the floor.

The PRESIDING OFFICER (Mr. TALENT.) The Senator from Alabama.

Mr. SESSIONS. I will share my thoughts. I believe this bill is a good way to go about at the present time dealing with what is a health care crisis in America—the surging costs of insurance and liability. I wish we were not in the Senate having to deal with it. I have some great friends in the tort business, good lawyers, and they have learned over the years how to utilize the system to maximize verdicts and maximize recoveries. They have been successful.

Things have gotten out of sync. They need to be brought into sync. We can do it a number of different ways. We can do it State by State. The truth is over half of the medical care in hospitals in America today, and a very large percentage of what doctors do every day, is paid for by the Federal Government in Medicaid. It is our tax money. We are paying it. Part of the need they have for higher pay and higher reimbursement rates is because of the malpractice insurance they must pay.

Caps on damages have worked. Last week I was in the small town of Russellville in Alabama where I practiced law for a year or so. It is pretty far off the beaten path. A bright young doctor gave me a couple of ideas about reforming medical care unrelated to this issue. He told me he had come from California. His premiums in Alabama were substantially higher, and growing each year, than his colleagues he left in California. He did not expect that. We have little or no caps. We have some caps in Alabama, but not the kind in California.

I talked to a physician friend of mine, a wonderful person I go to church with, Dr. Conrad Pierce, former president of the OB/GYN Association. And he talked about the $100,000 liability premiums that OBs pay. He said, Jeff, you can get by in a city if you are delivering a couple hundred babies a year, but if you deliver 50 or 100 babies, this is $1,000 per delivery. It represents your health care premium. That is a big deal.

Mr. ENSIGN. If the Senator will yield, is the Senator aware that, for instance, in Las Vegas, they are limiting

the number of babies they are allowed to deliver to 125. What your friend was talking about is right, they used to deliver 250 to 300. Now they limit how many they can deliver.

Mr. SESSIONS. That is the result we are dealing with. All kinds of factors are occurring that are impacting adversely health care as a result of the premiums.

As my friend pointed out, in some rural areas you only deliver 50 or 60. It is not precisely how many babies delivered by a doctor that determines the premiums paid. You pay a basic premium if you deliver any at all. So the low numbers drive out physicians in rural areas who do not deliver that many babies.

It is a big deal. We have seen medical malpractice insurance jump by 81 percent over the past 2 years alone. It has driven people out of business.

The Physicians Insurance Association of America shows a fourfold increase from the period of 1991 to 2002 in the percentage of jury awards that exceed $1 million. We have a fourfold increase in the percentage of jury awards that exceed $1 million. Some say the reason these premiums have gone up is because insurance reserves are not producing the returns they used to produce. I don't think it is disputed that we have a substantial increase in the large verdicts around the country. That does drive the market.

In West Virginia, Charleston Area Medical Center lost its Level I Trauma Center status, leaving West Virginia University Ruby Memorial Hospital as the only Level I Trauma Center in the State. The inability of this facility to find neurosurgeons and orthopedists created a situation in which critically injured patients had to be medevac'ed out of the State.

Open the newspaper and you will read of similar crises in Pennsylvania, Nevada, Mississippi, and other areas. Rural areas are hit hardest by the increasing costs. This places additional burdens on those who can least afford it.

In my home State, I was in the town of Atmore, not too far from where I grew up. The Atmore Community Hospital was forced to close its obstetrics unit because it could not afford the 282 percent increase in malpractice insurance from $23,000 to $88,000. When you deliver a limited number of children, $88,000 is a substantial cost against you. Now expectant mothers must travel either to the hospital in Brewton, 30 miles away, or to Mobile or Pensacola, FL, an hour away, eliminating availability of health care.

Another rising crisis in my State has been brought to my attention involving the nursing home industry. It was a stunning statistic. At the request of the American Health Care Association, Aon Risk Consultants conducted an actuarial analysis that found there was a substantial increase in premiums, an extraordinary increase from 1995 to 2002 for nursing homes, meaning that the cost for settling and defending malpractice claims increased from $320 a bed in a nursing home to $4,410 per bed, over a tenfold increase in the insurance premiums paid. This was first brought to my attention by an individual I know in my hometown of Mobile who shared those numbers with me. It is consistent with his personal experience. I was shocked. We are looking at $4,000 per-bed cost annually for liability insurance per nursing home bed. That is very significant.

I hope as we go forward we can move beyond obstruction and a filibuster to be able to offer amendments, if people think they can make it better, that we can do things that would be realistic and effective. I think we can do that. This bill has a good core right now. I intend to support it and I intend to vote for it and I intend to vote to move it up for debate.

The odd thing about malpractice in America today and the lawsuits that get filed are, as I suggested to my able friend from Nevada, Senator ENSIGN, we think we are punishing doctors who make a mistake and we sue them for punitive damages. This historically was not a big part of litigation in America, but in the last 20 or 30 years punitive damages have become a staple in litigation. If a doctor makes a mistake, they sue him for the mistake, they sue him for the compensation, damages, pain and suffering of the patient, and they invariably add it was done recklessly, wantonly, or without due regard of care and that he is, therefore, responsible for punitive damages. Those punitive damages are added on to it as a punishment to that doctor. But already the doctor in the basic recovery is above the deductible he had on his insurance policy. He has already paid that out of his pocket. So whether it is $1 million or $10 million or $500,000 in punitive damages, that is paid for by the insurance system that we set up. And who pays into that insurance system? All the doctors in the community.

I absolutely agree with Senator ENSIGN that we need tighter controls on physicians by the medical associations, just as I believe—and have believed for a long time—we need tighter controls by the legal professional community, of which I have been a part. We do not do enough there.

But, regardless of that, you are still going to have negligence. You are still going to have these kinds of recoveries. If not capped, they continue to shift the payment from the person who did wrong to the innocent doctors and physicians out there who will all see their premiums increase substantially.

I have visited hospitals in my State on a regular basis. I visited probably 30 hospitals in the last 3 or 4 years. I ask them about how their liability insurance premiums are doing. They tell me they tripled in the last several years, invariably—more than double consistently, they tell me, over the last 3 or 4 years. Each one is somewhat different but the premiums have gone up at an extraordinary rate.

I think this Congress, faced with a demand for improving health care and health care delivery to more people, and at the same time trying to do so with contained cost, ought to look at one aspect of the medical system that produces little or no benefit and that is the amount of money paid out through this system.

Yes, I do believe that lawsuits make some physicians more careful. I do think it has led to the altering of practices for better health care. I do not believe all lawsuits are bad. I do not believe all recoveries are bad. I think it is good sometimes if physicians get hit and popped and sent a message. I think the embarrassment of the lawsuit itself has a substantial impact on this physician and other physicians in the community. But whether the recovery is $500,000 in punitive damages, $250,000 or $2 million is not the point. That physician is not really going to be paying it. The other physicians in the community will be paying it.

I think we will get the same impact in terms of improving health care if we allow lawsuits to go forward but we don't allow them to turn into jackpot justice where one patient, one victim, one injured patient who sues gets $10 million and another one gets $500,000 or zero for virtually the same circumstance. Too often that has happened. This is not a systematic way we are dealing with malpractice in America. And who is paying for it? John Q. Citizen, the Federal Government, in terms of Medicare and Medicaid moneys we send out.

I think we can do better. I think this bill is a step in the right direction. My friend from Illinois is a skilled lawyer. There is no doubt in my mind his remarks on this bill will represent the best comments that can be made in opposition to it. But overall I think it is a net plus. It is the right step to take. We are going to need to do something about these costs. I do not believe the benefits in improved health care are anything like the costs that are being incurred by physicians. They do not consider the amount of care being denied American citizens as a result of physicians choosing another course.

Finally, I read in the newspaper about Dr. Sumpter Blackman from Camden, AL, a small town I grew up in of not much more than 1,000 people with a small hospital with about 20-some-odd beds. Dr. Blackman is the main physician there.

It was reported that he may have to give up his practice; that he could not get insurance. One of the companies had changed and he was not able to get other insurance. The rates were extraordinarily high. He was wondering whether or not he should stay in the business.

I could say to the Members of this Senate, with no doubt, if you took a poll of the people in Camden, AL, and the environs and asked who was the

most important person in that community to them, Dr. Sumpter Blackman would win that hands down.

He was my mother's physician. He takes care of people there. He knows them. He is an excellent physician. He is talking about retiring early as a result of lawsuits. I think this has gone beyond just talk and debate and big insurance companies and rich companies and poor victims and doctors. I think it is a health care issue. We cannot afford to lose people such as Dr. Sumpter Blackman from the medical profession. He has saved the lives of thousands in his long career there in Camden, AL, and there are a lot more like him. They are thinking maybe this business just isn't worth it; I put aside some money and maybe I will just go off somewhere and do something else and not have to worry about this and worry about getting insurance.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank the Senator from Alabama for his kind words. He and I disagree on many issues but respect one another very much. I am sure there will be an issue somewhere along the way on which we agree. We are both waiting, and after 6 or 7 years the day may come. We will announce it.

Mr. SESSIONS. If the Senator will yield, I think we do agree we need to work to improve our legal system to make it the best we possibly can. How do we do that? Sometimes we disagree but I respect the Senator from Illinois and his skill.

Mr. DURBIN. I consider that a rhetorical question but I respect the Senator from Alabama.

Let me say there was a statement made earlier by the sponsor of this legislation that tells the whole story. When he came to illustrate the savings in malpractice premiums from States with caps and States without caps, he said to us, I think the CONGRESSIONAL RECORD will reflect what I am about to say is accurate, that the reason he only chose Los Angeles and Denver to illustrate that States with caps lower malpractice premiums was because it takes a long period of time for the caps to be reflected in the premiums charged to doctors. In his words, he said 8 to 12 to 15 years before premiums come down.

I think perhaps he may be right. Perhaps he may not be right. Over a period of 8 to 15 years it is hard to measure what is going to have an impact on malpractice premiums. It could be the investment success of the insurance company as much as a cap or any other thing. But it tells an important part of the story. If we are facing a medical malpractice insurance crisis today in America, what is being proposed, limiting the recovery of medical malpractice victims, putting a cap on the amount of money they can take home from a lawsuit, is, in fact, not going to provide relief to doctors or hospitals facing these high premiums today. In fact, it may be 8, 10, 12, or 15 years, according to Senator ENSIGN, the sponsor of this legislation. I think that should give pause to every Senator who believes they can vote for this legislation, see it enacted, go home to doctors in their community and say we have met our obligation. I do not think that is a fact.

There is another side of the story here that is worth at least pointing to. When I asked the Senator from Nevada why he included more than just doctors in this bill, more than just hospitals in this bill, why did he go on to include health care organizations such as insurance companies, HMOs, managed care organizations, why did he include pharmaceutical companies, medical device manufacturers, nursing homes, why are all of them being brought into the debate if our concern is whether or not there will be enough doctors around to deliver babies, he basically said we are trying to reduce the cost to the health care system. I assume if you limited recovery to zero dollars, you could reduce it even more. This bill limits it to $250,000 in noneconomic losses. He gave an illustration of the fact that economic losses include lost wages. Then he went on to say that if a child were injured and would be unable to be employed, for example for the rest of his life, they would have to try to make some calculation as to the lost wages.

I might remind my friend from Nevada that his bill requires objective verifiable losses. How do you calculate that for a 6-year-old boy, such as the one I talked about yesterday, who will literally have no work life, no work experience the rest of his life on Earth? How do you calculate that in objective verifiable ways, as to his future lost wages?

The importance of that, of course, is that is only one of two things he can be compensated for—medical losses as well as loss of income. So the calculation is very difficult under the exact language of the bill written by the Senator from Nevada.

I take exception to a comment made during the course of this debate by my friend from Alabama. He has made this comment before. He referred to what he called ''jackpot justice.'' He referred to verdicts that really are of little or no benefit, as he said, to society.

I suggest to him that we have statistics. Virtually both sides inundated the record with statistics. But these come from the National Association of Insurance Commissioners. Here is what they tell us.

The number of new medical malpractice claims declined by 4 percent between 1995 and 2000. During that 5-year period of time, new medical malpractice claims declined by 4 percent.

If we were talking about a proliferation of claims or lawsuits, the record suggests it is not the number. But, of course, some will argue how much is being awarded to those that are being filed. I would concede that the general awards have gone up. It reflects a number of things. It reflects inflation in medical care, and the cost of medical care. Everybody knows that is a fact. The cost of prescription drugs, the cost of doctors' care, and the costs of hospitals have all gone up. That is reflected when a verdict or an award is given to someone who has been injured. You would expect under normal circumstances for a person who is aggrieved or injured by medical malpractice on a year-to-year basis to see that award going up, understandably so. But how about the big awards, ones over $1 million?

According to Business Week, and their March 3, 2003, issue, which I quoted earlier—Business Week is hardly a liberal publication—in 2001 there were only 895 out of 16,676 payouts exceeding $1 million, about 1 percent. That is up from 506 in 1996.

In a 5-year period of time, the number of awards over $1 million went from 506 to 895.

From the debate on the floor you would conclude that the number was much larger.

I take exception especially to a reference to these awards and settlements in larger numbers as ''jackpot justice.''

I will not bring out the photographs. But earlier I mentioned some of the people who have been victims of medical malpractice.

Heather Lewinsky of Pittsburgh, PA, a 17-year-old who has gone through a series of plastic surgeries and will be deformed and scarred for the rest of her life by medical malpractice—would a verdict in her case be a jackpot? I don't think so.

Evelyn Babb, a 75-year-old woman from Tyler, TX, went in for a simple knee surgery and the surgeon operated on the wrong knee. As a result, this 75-year-old lady lost her mobility and will be suffering with pain for the rest of her natural life. Would a verdict in her case be ''jackpot justice''?

Sherry Keller from Conyers, GA, a graphic case which I talked about earlier, a lady who went into her doctor's office after a hysterectomy and had a terrible situation where her womb was reopened because of bleeding and she went into shock—the doctor left her alone in the room, she fell off the examination table striking her head as she fell to the floor, eventually leading to a situation of being a quadriplegic. If she received an award, this mother and homemaker, of $500,000, has she hit the jackpot?

I don't think so.

Colin Gouley from Nebraska came with his family to see us today. This little 9-year-old boy, whose life has been compromised dramatically, will have a difficult time doing things we pray that every child can do, such as read, write, engage in conversation, walk, and run. He will never have that chance. A jury in Nebraska thought that his damages from malpractice committed against him was worth

more than $5 million. So did Colin Gouley hit the jackpot with a $5 million verdict if he has a lifetime of being in a wheelchair because of medical malpractice? Is this ''jackpot justice''?

Kim Jones, 30 years old, went in for a simple tubal ligation and ended up in a comatose state in a nursing home for the rest of her life. Is an award in her case a jackpot? Did she hit it big if they gave her enough money for someone to care for her the rest of her life? Frankly, she will never be able to care for her daughter again.

Or Alan Cronin, 42 years of age, who went into a hospital in California for a routine hernia surgery and ended up with an infection so serious that it lead to gangrene in all of his limbs and amputation of both arms and legs—Alan Cronin, would he be the winner of a jackpot if those who were responsible for his losing his arms and his legs had to pay and compensate him not only for his medical bills and lost wages but also for his pain and suffering?

That is the part of the calculation which those who bring the bill to the floor have not spoken of. They talked about the challenges facing doctors. We conceded that. In some areas of the country, malpractice insurance is too high. Don't overlook what this bill does. It closes the door and removes the jury from the decision about fair compensation for people who have been injured through no fault of their own.

That is why I think those who are pushing this bill will probably be unsuccessful tomorrow. People on this side of the aisle, and Republicans as well, believe this bill, S. 11, goes too far. This is excessive. This is not setting out to simply solve the problem. This is setting out to make a political point—that we are going to go after those who would be so bold as to file a lawsuit.

In the pages of this bill, you will see a limitation on what attorneys can be paid if they represent one of these clients or one of these patients I have mentioned—people who have lost their limbs, people who are no longer able to function as normal human beings. If they go to hire a lawyer to represent them in a case of malpractice, this law will restrict how much their lawyer can be paid.

If you believe in justice, wouldn't you also argue that those who defend the doctors and defend the hospitals should have their attorney's fees limited as well? Wouldn't that be fair? Isn't that justice with a blindfold? No. The blindfold is raised on one side. It is a wink and a nod to the defense industry representing the doctors and the hospitals. But when it comes to these poor people with limited economic resources fighting for compensation for injuries that are no fault of their own, this bill limits the amount of money that can be paid to those lawyers.

I will tell you that without the contingency fee system, most of these poor people I have described today will never ever have their day in court. No attorney will be able to represent them.

Do you recall not too many months ago that sad story in North Carolina, I believe at a major university, where there was supposed to be a heart-lung transplant and they mistakenly brought the wrong blood and tissue type organs to be transplanted and a mistake was made? It was clearly not the mistake of the family or the little girl who was involved. Discovering this error, they tried to implant an additional set of organs—heart and lung—to save her after this serious mistake was made.

I can tell you that this little girl, who sadly died because of that malpractice, would have recovered little or nothing for that wrongful death under this legislation.

Where do you point to in terms of lost wages for a little girl who died during the course of the surgery? Where is the pain and suffering in a wrongful death lawsuit? Yet that is what it comes down to.

Those sponsors of this bill are prepared to close the courthouse door and say that for her family, they do not have the opportunity to get a lawyer because the contingency fee is limited, and once they have that lawyer there is little or nothing they can recover despite clear evidence of medical malpractice.

That isn't fair. It isn't American. It isn't just. We are talking about rewarding people who have been seriously and egregiously injured.

I hope my colleagues will join me tomorrow in voting against the motion for cloture. We should not proceed to this bill. This bill should proceed to a committee. It should go to a committee for a long period of study of compromise, of amendment, of a good-faith effort on both sides involving the medical profession, and the insurance industry which gets a windfall from this bill, as they do virtually every bill that comes through here, as well as the legal profession; and a bill that will end up in a resolution of the problems facing our doctors and medical providers whom we value very much, but I don't believe they would stand behind such a product that is so fundamentally unfair.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

MORNING BUSINESS

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business.

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

ADDITIONAL STATEMENTS

A TRIBUTE TO ROZ WYMAN

● Mrs. FEINSTEIN. Mr. President, 50 years ago today a young and dynamic woman was elected as a member of the Los Angeles City Council. She was just 22 years old, making her the youngest council member in the city's history.

The fact that such a record has been held for so long is in itself remarkable. But then again, we are talking about a truly remarkable woman, Rosalind Wyman.

For many years now, Roz has worked tirelessly, for her family and friends, for the city she loves, for the State of California, for the Democratic Party, and for women everywhere.

There is a wonderful photo of Roz when she was only 2 years old, smiling up at a portrait of Franklin Roosevelt. Her mother, Sarah, was a precinct captain for FDR's first Presidential campaign, running the operation out of the family's drugstore on 9th Street and Western Avenue in Los Angeles.

Roz's father, Oscar, worried that such a partisan stance would cost them customers, but Sarah believed that electing Roosevelt was much more important.

Small wonder, then, that Roz developed a deep and abiding passion for political activism and the Democratic Party. Her first campaign was working on behalf of Congresswoman Helen Gahagan Douglas, in her ill-fated 1950 Senate race against Richard Nixon, when he unfairly portrayed her as ''the Pink Lady.''

Then, 2 years later, Roz made history by becoming the youngest person ever elected to the L.A. City Council, and only its second woman member. She went on to serve in that body for the next 12 years, on the finance and budget committees, and eventually becoming president pro-tempore.

As another woman who entered California politics in the 1950s, I can assure you that it was quite a different world back then. It was still very much a male club. In both Los Angeles and San Francisco, one was hard-pressed to find a women's bathroom anywhere near the chambers.

Something else Roz inherited from her mother was a love for baseball. In fact, there is nowhere that Roz Wyman would rather be than at Dodger Stadium, at the home plate corner of the Dodger dugout, where she has had her seats for over 40 years now.

It is no exaggeration to say that the Dodgers would not have come to Los Angeles without the vision, fortitude, and sheer determination of Roz Wyman. Just ask Tommy Lasorda, who said: ''What this lady did for baseball in this city, they should erect a monument to her.''

Today, it is hard to believe how polarizing the effort was to bring the Dodgers from Brooklyn in the late 1950s. Yet Roz, believing that a professional sports team was just what L.A.

needed to cement its image as a major American city, braved death threats and earned many political enemies in order to see this come about.

One year after coming to L.A., however, the Dodgers went on to win the World Series, as they did again in 1963, 1965, 1981, and 1988, along with three National League Championships in the 1970s. No one today could imagine the city without one of baseball's greatest franchises.

One of the other defining moments in the modern history of Los Angeles, which placed the city firmly on the map as one of America's premier cities, was when it hosted the Democratic Convention in 1960.

And here, too, Roz Wyman played a vital, even pivotal role. She was an ardent Kennedy supporter, having supported him in 1956, in his unsuccessful bid for the Vice Presidential nomination.

She understood the natural connection between Hollywood and Washington, and before many others recognized Kennedy's enormous charisma and appeal, along with the growing importance of television to electoral politics.

And with her late husband, Eugene, who served as chairman of the California Democratic Party, they proved to be extraordinarily effective fundraisers and campaigners. They were responsible for enlisting the likes of Frank Sinatra to sing by the swimming pool, as Kennedy worked his political magic with the delegates.

It is easy to forget that back then, party conventions were not the largely scripted events that they are today. There was real drama—nothing was inevitable—and delegates could change their vote at the last minute.

Such was Roz's influence with the Kennedy campaign, that she was able to convince Robert Kennedy to change the venue for JFK's fabled ''New Frontier'' speech from the Sports Arena to the grander Memorial Coliseum next door.

She went on, 8 years later, to work closely on Robert Kennedy's bid for the White House, which ended so tragically in Los Angeles.

During the 1970s, both with her husband Gene and after his unexpected passing, Roz was a highly effective advocate for the Democratic Party, raising awareness on a wide array of issues.

I first met Roz when I was mayor of San Francisco and she served as convention chair and chief executive officer of the 1984 Democratic National Convention, the first woman—Democrat or Republican—ever selected to run a Presidential Convention. In that position she oversaw the entire planning and management of the convention and its $13 million budget.

We soon became close friends, forming a bond that has grown ever stronger over the years. She was already a living legend, already a star of our party, and she did an absolutely stellar job, not just for the Democratic Party but for the city of San Francisco.

President Clinton recognized Roz's contribution, back in 2000, when he said: ''She reminds me of my ties to my roots. Her loyalty to our party and our candidates is something I hope I can emulate for the rest of my life.''

I share President Clinton's sentiments—and I, too, hope that I can emulate Roz Wyman. A pioneering force in American politics, she is my Field Marshall, my trusted adviser, and most importantly to me, my very dear friend.●

LOCAL LAW ENFORCEMENT ACT OF 2003

● Mr. SMITH. Mr. President, I speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred in Tulsa, OK. On September 11, 2001, a 29-year-old Pakistani was hospitalized after he was badly beaten and kicked by three men. The racially motivated attack happened outside of a service station as the victim was visiting a friend who worked there. The victim suffered a broken jaw and lost several teeth during the attack. He was hospitalized for several days in a Tulsa hospital.

I believe that government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.●

HONORING STUDENT RECIPIENTS OF GATES MILLENNIUM SCHOLARSHIP

● Mr. NELSON of Nebraska. Mr. President, today it is my great honor to recognize three outstanding Nebraska students who recently were named Gates Millennium Scholars by the Bill and Melinda Gates Scholarship Foundation.

David Sanchez-Aparicio, from Oaxaca, Mexico, is the son of Benito and Juana Sanchez. Since he was a child, David's scholastic interest has been in computer technology. While a student at Lincoln High School in Lincoln, NE, David took part in the Information Technology Focus Program, specializing in computer programming, networking, and multimedia production. David played tennis and ran track, focusing on the 800-meter race. David also spent his time working at BryanLGH Medical Center in the cafeteria. In addition to rigorous coursework and extracurricular activities, David, whose mother passed away 2 years ago, has spent much of his high school career helping his father care for his younger siblings. David's teachers note that he is a quiet, yet diligent student who is dedicated to his studies and his family. David will attend the University of Nebraska-Lincoln in the fall where he plans to major in computer engineering.

Codah Gatewood, 18, is the youngest of three children and a member of the Navaho, Omaha, and Santee Sioux tribes. His parents are Edison Gatewood and Belva Gatewood. Since he was a young boy, Codah's primary academic interest has been architecture. As a child, he would create intricate buildings with Legos; at Lincoln High School, he learned to use computer-aided-design, CAD, in technical design and architecture classes before tackling advanced architecture and engineering. Codah won an academic letter during his senior year of study for his mastery in pre-calculus, differentiated physics, advanced architecture, and applied economics. In his free time, Codah volunteers at the Indian Center of Lincoln, assisting in powwows and dinners. He also likes to experiment with mobile electronics on his car, frequently updating his own website with his success in modifications. Codah's teachers describe him as a self-reliant and high-ranking scholar. For his commitment to academic excellence, Codah has also earned a University of Nebraska Davis Scholarship, awarded to the most academically talented racial minority students. He will attend the university this fall.

Huong Le, 18, came to Lincoln from Long An, Vietnam, 11 years ago with her parents, Vinh Le and Luong Nguyen, and sisters and brother. Long An is a small province in the Mekong Delta of South Vietnam. Huong spoke very little English when she arrived in Lincoln, but began to master the language while a student at Everett Elementary School. Huong was nominated for the Gates scholarship by her Lincoln High School chemistry teacher, who taught her a rigorous advanced chemistry course and saw promise in her passion for science. The following summer, Huong participated in a sophisticated research project, coordinated by the University of Nebraska, involving organic and biochemical processes of insects. While at Lincoln High School, she also played tennis for 4 years and was a member of the Asian Caucus, Upward Bound, and Youth Leadership Lincoln. Huong has also volunteered at the Lincoln Buddhist Temple, Lincoln Action Program and United Way. Huong plans to take English composition and calculus classes as part of the Summer of Promising Scholars Program. Huong will pursue a degree in pharmacy from the University of Nebraska.

The Gates Millennium Scholarships aim to reduce the financial barriers for African-American, Hispanic, Native and Asian-Pacific students with high academic and leadership promise. They also increase representation of minority students in the targeted disciplines.

The Gates Foundation will pay for the students to attend any college with any undergraduate major, and for a graduate education in mathematics, science, engineering, education, or library science.

I am proud to represent these promising young students who are dedicated to excellence in the classroom and in the community. I am confident that these talented leaders will excel at the University of Nebraska and beyond. The city of Lincoln and the State of Nebraska are fortunate to have these three students as part of their community.●

HONORING THE LIGHT OF THE WORLD CHRISTIAN CHURCH

● Mr. BAYH. Mr. President, it is with great pride that I rise today to honor the Light of the World Christian Church of Indianapolis. This congregation, under the leadership of Bishop T. Garrott Benjamin Jr., is opening a new worship facility this weekend. The 3,000-member congregation has come together to raise the funds necessary for a truly impressive church. The new facility will feature a congregation hall capable of seating 1,200, a chapel for weddings and funerals, and amply space for classrooms and offices. But what I would most like to recognize is the persistence and dedication demonstrated in achieving this goal by Bishop Benjamin and the benefit he has provided our community as a result.

In addition to providing spiritual guidance, the church provides numerous family services including the well-known Respect Academy that emphasizes teaching children self-respect as well as respect for others. The church's programs and services affect nearly 2,000 young people each year. The influence the church has on the lives of the children at such an important time in their lives is invaluable.

Bishop Benjamin, now in his 34th year as pastor, has made his struggles in life the mission and driving force behind many of the youth programs offered at the Light of the World Christian Church. At the age of 5 Bishop Benjamin was abandoned by his parents and was raised entirely by his grandmother. He says it was his own experience that made him so distinctly aware of the value of a nurturing spirit in a young child's life and that has made him so proud of the youth programs sponsored by his church.

I would like to take this opportunity to commend the Light of the World Christian Church for nearly 140 years of service to the Indianapolis community. I know that my colleagues will join with me in congratulating the congregation, and especially Bishop Benjamin, for their accomplishments and in wishing them continued success as they enter a new and promising future.●

HONORING THE LIFE OF E.W. KELLEY

● Mr. BAYH. Mr. President, it is with great sadness that I rise today to honor the life of my friend, E.W. Kelley, who passed away on July 4, 2003, after a long-fought battle with prostate cancer. Mr. Kelley was known around the world for his philanthropy and generosity, yet remained a modest man who never sought the fame that came with his great gifts.

Among his many projects, Mr. Kelley helped found the Jerusalem YMCA to help foster peaceful coexistence and even friendship among the city's residents. He was also a past-president of the Boy Scouts of America Council and was involved with the United Way. In 1997, he donated more than $23 million to Indiana University's School of Business, where he had graduated nearly 60 years before.

Born in 1917, Estel Wood Kelley grew up near Sharpsville, IN, before attending Indiana University's School of Business. Mr. Kelley made a name for himself in business marketing, creatively introducing America to countless products that have become integral parts of domestic life today. In 1961, he became the youngest vice president ever at General Foods, and in 1967 was named ''Marketer of the Year'' by Advertising Age magazine. However, it is his philanthropic work and the numerous lives he touched through it, for which he will be remembered best.

E.W. Kelley served as a shining example for business executives everywhere, humbly giving back to hometown institutions and international organizations alike in order to improve the lives of those around him and those he would never meet. His legacy of giving will continue through his many scholarship awards, including the Kelley Scholarship Program at Indiana University, which provides full tuition to 15 business undergraduate students each year. Mr. Kelley eschewed any special attention connected with his gifts, saying that the reason he donated to causes like Indiana University was simply ''to give back to society what society helped me get.''

The sense of loss to all those who knew E.W. Kelley and were affected by his generosity in Indiana, the Nation, and throughout the world is tremendous. He is survived by his wife, Wilma Lippert Kelley, and their children, E.W. Kelley II, Wayne L. Kelley and K. Kelley Germaine.

It is my sad duty to enter the name of my friend Estel Wood Kelley into the CONGRESSIONAL RECORD.●

TRIBUTE TO CAROL COTTRILL, TINA SLUSHER, AND ROBERT SALLEY

● Mr. BUNNING. Mr. President, I rise today to pay tribute to three of Kentucky's finest physicians. Drs. Carol Cottrill, Tina Slusher, and Robert Salley are exemplars in the field of medicine because they spend several months of each year providing medical care to children in developing and underprivileged countries.

Drs. Cottrill, Slusher, and Salley performed an implantation of a new mechanical heart valve for a young girl from the village of Eku, Nigeria. Dr. Slusher first examined Sussana Olesenekwu in a 168-bed Baptist hospital near her village in Nigeria. Upon realizing the gravity of Olesenekwu's heart condition, Dr. Slusher worked with urgency to find a U.S. hospital and surgeon willing to do the surgery quickly and for free. Dr. Cottrill, a children's heart specialist, and Dr. Salley, a heart surgeon, joined Dr. Slusher in donating their time and skill to perform a surgery largely unavailable in Nigeria. Dr. Cottrill is even allowing Olesenekwu to recover in her home. Aided by Medtronic, which contributed the mechanical heart valve, and St. Joseph's Hospital, which incurred the remaining costs, these exceptional doctors saved Olesenekwu's life.

Open-heart surgery is almost nonexistent in Nigeria. Though the country has a population of approximately 130 million, it has just one facility that performs only a few surgeries each year. In Nigeria the surgery would cost $3,000 to $4,000, and most families earn less than $10.00 a week. Drs. Cottrill, Slusher, and Salley's altruistic and selfless donations of time and skill are unparalleled.

Drs. Cottrill and Salley both live and practice in Lexington, KY, and Dr. Slusher is a native of Bell County, KY. Their commitment to improving the lives of those less fortunate are an inspiration to many. Their contributions have truly made the world a better place. Drs. Cottrill, Slusher, and Salley are tributes to Kentucky. They are Kentucky at its finest. I thank the Senate for allowing me to recognize Dr. Carol Cottrill, Dr. Tina Slusher, and Dr. Robert Salley and voice their praises.●

CELEBRATION OF THE 100TH ANNIVERSARY OF THE GEORGETOWN FIRE COMPANY

● Mr. CARPER. Mr. President, I rise today to celebrate the 100th anniversary of the Georgetown Fire Company. Founded in 1903, the Georgetown Fire Company is only one of fifteen Delaware fire companies to achieve a century or more of service a testament of the hard work and dedication of those who have been part of this venerable organization.

Several fire companies in Delaware, particularly around rural communities, were formed in the wake of disasters. That was the case for nearby Milton, which founded its fire company in 1901. But residents and town leaders in Georgetown formed their own fire company before a major fire broke out.

On April 11, 1903, the commissioners of the Town of Georgetown advised the

town's people by posting in the local newspaper, The Sussex Journal, that there would be a meeting that evening for the purpose of creating a fire company. In this posting, they stated that the formation of a fire company would decrease the cost of fire insurance within the town. There were fourteen charter members of the Georgetown Fire Company. Until that day, the community had relied solely on so-called bucket brigades and a hand-drawn ladder wagon.

Today, the fire company owns the most modern of technology and fire-fighting equipment, and what started off as a small squad of locals with minimal training has evolved into a company that today has almost 100 members, 50 of whom are active. The remaining members are life members, limited service members or honorary members, all of whom continue to help protect Georgetown. Originally located in the old fire hall building on The Circle in 1930, they moved to their new building on South Bedford Street in 1966. There, the doors are opened one evening each February for an annual fundraiser for the fire company, the legendary ''Oyster Eat,'' which attracts people from throughout the Delmarva peninsula and beyond.

I rise today to recognize all the members of the Georgetown Fire Company, past and present, and their contributions to their beloved community. This is a historic event, especially for a non-profit organization based solely on volunteerism. I congratulate you all and thank you for your service to the people of Georgetown and to all of Southern Delaware.●

TRIBUTE TO MAJOR ROBERTA KEARNEY CHANG

● Mrs. MURRAY. Mr. President, I rise today to recognize a great American and a true military heroine who has honorably served our country for over 20 years in the Army Medical Service Corps: MAJ Roberta Kearney Chang. As a resident of Bellevue, WA, MAJ Chang began her career at Fort Benning, GA, home of the Army's infantry, as a medical platoon leader. There, she earned the coveted Parachutist Wings and Expert Field Medical Badge. Following in her father's footsteps, the late First Lieutenant Robert M. Kearney, United States Army, Retired, she quickly rose through the ranks and served at Army bases throughout the world.

MAJ Chang had two overseas tours, one in Honduras, Central America, and one in the Republic of Korea. In Honduras, she participated in humanitarian missions to provide aid and medical care to the people of this country. In Korea, she successfully completed two consecutive company commands for the 121st Evacuation Hospital and Headquarters, 18th Medical Command. MAJ Chang was handpicked to become an instructor at the U.S. Army Academy of Health Sciences, Fort Sam Houston, TX. In this capacity she taught health care administration subjects to over 5,000 officers annually. MAJ Chang also served as the senior patient administrator for the Command Surgeon, United States Army Reserve Personnel Command. She counseled and assisted hundreds of reservists that were injured as a result of service in Operation Desert Storm. Her knowledge of the intricacies of the physical disability system for both the active duty and reserve component soldiers is unsurpassed, and she is considered an expert trainer in these areas. She served as a health care operations officer and the head of communications and customer service at the TRICARE Mid-Atlantic, Lead Agent Office Norfolk, VA for final assignment TRICARE Mid-Atlantic serves over 1 million military beneficiaries.

In each assignment, MAJ Chang excelled and met every challenge, and was rewarded with greater responsibilities and opportunities. Her talent for teaching and mentoring personnel, as well as her creativity and skill in management, were instrumental in providing army medicine the fine cadre of hospital administrators serving today. Above all, she is a stellar officer and leader who always put the welfare of her staff and patients first. MAJ Chang is a committed health care professional, and is an active member of the American College of Healthcare Executives and the American Health Information Management Association. MAJ Chang always went the extra mile to serve her country and her fellow man. Her performance reflects greatly on herself, the United States Army, the Department of Defense, and the United States of America. I extend my deepest appreciation to MAJ Roberta Kearney Chang on behalf a grateful Nation for her over 20 years of dedicated military service. Congratulations, MAJ Chang, and let me be the one of the first to welcome you home to Washington State.●

DICK KNIPFING's 40TH ANNIVERSARY IN NEW MEXICO BROADCASTING

● Mr. DOMENICI. Mr. President, I rise to pay tribute to a friend and public servant of New Mexico, Dick Knipfing of Albuquerque.

A few years ago, a New Mexico research company conducted a statewide poll on the popularity of certain well-known people. My name was one of the most recognized, but I wasn't No. 1. The person best known and best liked by New Mexicans was Dick Knipfing.

He is not a politician. He has never been Governor, Senator, mayor, or on any city council. Dick is something more special to everyday citizens—he has been a nightly guest in their living rooms for 40 years.

In July 1963, Dick started as a reporter for the CBS affiliate in Albuquerque. He did it all. He shot and edited his own film, wrote his own scripts, and got to know some of the most influential people in New Mexico. Eventually, Dick became an anchor. Over the course of his career, he moved to the ABC affiliate, then to the NBC station, and back to ABC. This month, he celebrates his 40th anniversary in broadcast journalism at channel 13, the CBS station where it all started.

Since Dick returned to Channel 13, a station whose news had been in the ratings cellar, the station rapidly shot into head-to-head competition with other New Mexico news channels. There is one big reason—Dick Knipfing.

New Mexicans trust Dick as a veteran newsman. He is respected by his colleagues. He has been inducted into the Silver Circle Society by the National Academy of Television Arts and Sciences, one of the organization's highest honors for a television journalist.

Dick Knipfing is revered by viewers because they easily discern that he is devoted to bringing them a comprehensive and accurate look at the day's major news events. Viewers have welcomed him into their homes, either as a reporter or anchor, because he has shown them that he cares very deeply for New Mexico and its people. Dick, and his wonderful wife, Charlene, have made Albuquerque and New Mexico their home, and integrated themselves into activities to make it a better place to live.

Like tens of thousands of New Mexicans, my wife Nancy and I have grown accustomed to Dick's face and his voice. As he marks his 40th anniversary in broadcast journalism, we hope there will be 40 more years of Dick Knipfing to represent the best in broadcasting.●

GREATER MIDWEST AFFILIATE OF THE AMERICAN HEART ASSOCIATION

● Mr. LEVIN. Mr. President, I am pleased to recognize the creation of the Greater Midwest Affiliate of the American Heart Association. This new affiliate which was founded on July 1, 2003, covers seven States, including my State of Michigan.

Heart disease is still the No. 1 killer in America. The American Heart Association is the second largest funding source for research and prevention of heart disease behind only the Federal Government. Its mission is to reduce disability and death from cardiovascular diseases and stroke. To this end, they work within local communities to educate people on prevention and identification of heart disease.

The merger which creates the Greater Midwest Affiliate strengthens the potential for positively influencing the health and welfare of Americans by advancing groundbreaking medical research and spreading lifesaving education on heart disease to people of all ages. I am sure my colleagues join me in applauding the Greater Midwest Affiliate of the American Heart Association as they renew a commitment to

create healthier communities and make stronger, longer lives possible for more Americans.●

IN RECOGNITION OF THE 21ST ANNUAL METRO DETROIT YOUTH DAY

● Mr. LEVIN. Mr. President, I would like to recognize an important event that will soon be held in my home State of Michigan. On July 9, 2003, community residents, business owners, and area youth will gather at Belle Isle to celebrate the 21st Annual Metro Detroit Youth Day.

Metro Detroit Youth Day was founded to improve relations between youth and other community members in the metropolitan Detroit area. Before its creation 20 years ago, a series of altercations had occurred between Detroit area youth and several grocery store owners. Since that time, Youth Day has provided an opportunity for all community members to work and play together and has drastically reduced the level of violence in the area. Youth Day includes games, meetings with celebrities, motivational speakers, sports events, and a wide variety of other activities designed to promote unity within the Detroit community.

I am pleased to recognize Metro Detroit Youth Day as an example of a proactive community effort that has promoted positive change. I am sure that my Senate colleagues will join me in saluting this event and in wishing Metro Detroit Youth Day continued success in the future.●

IN RECOGNITION OF MARQUETTE COUNTY

● Mr. LEVIN. Mr. President, I am pleased to recognize an outstanding county in my home State of Michigan for receiving a prestigious community recognition award. Marquette County, which is located in the beautiful upper peninsula of Michigan, was recently named an All-America City by the National Civic League.

The National Civic League has presented the All-America City Award annually for the last 54 years. The award recognizes outstanding communities such as Marquette for their excellence in combining grassroots efforts with local government and businesses' community programs to address critical local issues. This year Marquette County was selected in recognition of its efforts to increase access to health care, create a countywide nonmotorized trail system, and build support for at-risk youth in the community.

Marquette County was one of only 10 communities nationwide to be awarded the distinction of All-America City. The selection was made out of a pool of more than 700 applicants and 30 finalists. A 10-person jury comprised of nationally recognized public and civic affairs experts evaluated Marquette County based on a 10 category model developed by the National Civic League. Criteria include significant evidence of results which have improved the community within the last 3 years, extent of public participation, evidence of collaboration between multiple jurisdictions, and creative usage of available resources.

In addition to being an active and caring community, Marquette County includes some of the nation's most beautiful beaches, waterfalls, and wildlife. Thousands of tourists each year are attracted by the breathtaking scenery and numerous outdoor leisure activities such as golf, skiing, canoeing, hiking, and fishing.

I take great pride in congratulating Marquette County for the award of All-America City. This award is well deserved and is a source of pride for everyone in my home State of Michigan. I know my Senate colleagues will join me in saluting Marquette County and wishing its citizens continued success in the years to come.●

NEBRASKA'S TOM ALLAN

● Mr. NELSON of Nebraska. Mr. President, Tom Allan wasn't born in Nebraska, but that didn't stop him from falling in love with my State or from making the entire State feel like part of his family. Tom traveled the highways and byways for over 40 years, seeing the beauty of Nebraska, making friends, and sharing his experiences through his often humorous and always insightful news articles. When he passed away recently there were Nebraskans in every city, town, and village that mourned him and fondly remembered their favorite Tom Allan stories.

Tom Allan was born in Scotland and moved to Nebraska when he was only 9 years old. After graduating from high school and Ottawa College he served his Nation honorably in World War II with tours in the Philippines and Alaska. He retired as a major in the Nebraska National Guard.

He began working for the Omaha World Herald in 1947 and became the paper's roving reporter in 1959. He traveled more than a million miles and wore out 20 cars while filing stories from every community in the State. He covered the occasional big news story, but Tom Allan specialized in simple stories that touched the heart. For readers in Omaha, Tom brought to life the unique people and small towns that can't be found on a map.

Tom Allan outran tornados, trekked through the Amazon jungle, and even stood in for a U.S. Ambassador in Finland. He covered the State fair with such regularity that he was honored with ''Tom Allan Day'' at the Nebraska State Fair in 1997. His humor and humility were clear when he wrote, ''I'd rather they'd just given me a fat-hog blue ribbon and let it go at that.''

In that same column Tom described his job as the privilege of discovering what is over the next hill and who is around the next bend in the road along the byways of Nebraska. On behalf of all Nebraskans, I would like to thank Tom Allan for the privilege of his company and for the wonderful stories he shared with all Nebraskans for over 50 years. We will always remember his love for the State of Nebraska, and we are grateful that through his stories he taught us about Nebraska and helped us understand ourselves.

Tom Allan passed away on June 27, 2003.●

RECOGNITION OF THE MAGDALENA RIDGE OBSERVATORY

● Mr. DOMENICI. Mr. President, I rise to congratulate the Office of Naval Research for the successful design review to begin development of the next great astronomical telescope. The Navy is the preeminent authority in the areas of Precise Time and Astrometry, and distributes Earth Orientation parameters and other Astronomical Data required for accurate navigation and fundamental astronomy. Now they are managing an international team to build the Magdalena Ridge Observatory, MRO, on a 10,000 foot mountain in central New Mexico. The Navy, along with the Air Force, Army, and a consortium of universities from the United States and the United Kingdom, will break ground on October 20 this year.

This month, the prestigious scientific journal, Physics Today, published a superbly written article that explains the MRO. The project will create a unique array of mirrors that can take pictures of bright celestial objects with a resolution equivalent to a huge telescope measuring 400 meters in diameter.

I ask that a copy of the article be printed in the RECORD.

The article follows.

NEW MEXICO PLANS OPTICAL INTERFEROMETER AND FAST-SLEWING TELESCOPE

How does a minor university land a major observatory? In New Mexico Tech's case, it helped that the university has access to a high, dark site, that the Magdalena Ridge Observatory (MRO) will have national security applications, and that the project has allies in Congress.

''We had a coalition of universities looking for an observatory,'' says Van Romero, vice president for research at New Mexico Tech (officially the New Mexico Institute of Mining and Technology), which has around 1800 students and 110 faculty members. New Mexico Tech and its partners—New Mexico State University, New Mexico Highlands University, and the University of Puerto Rico—learned that the US Army's neighboring White Sands Missile Range wanted better missile tracking capability and the Air Force Research Laboratory in Albuquerque was interested in developing adaptive optics. ''We seemed to have a critical mass—universities, along with more than one military user,'' says Romero. Representative Joe Skeen and Senator Pete Domenici, both New Mexico Republicans, supported creating the MRO because the potential for education outreach, adaptive optics research, and world-class astronomy ''all came together in a happy confluence of ideas,'' says Stephen Traver, a legislative fellow in Domenici's office who used to work for the now retired

Skeen. Domenici led the way in winning a congressional markup for the $48 million observatory.

The observatory's future home is on a ridge in the Magdalena mountains near Socorro, about 130 kilometers south of Albuquerque. Besides the clear skies and roughly 3200–meter-high perch, the site's advantages include that it is near both White Sands and New Mexico Tech, it has room for the observatory to expand, and it has a road and other infrastructure already serving ecological and atmospheric studies and the university's lightning lab (see box).

The MRO will consist of an optical-infrared interferometer with eight to ten 1.4-meter telescopes in a reconfigurable Y-shaped array up to 400 meters long plus a single 2.4-meter telescope. Groundbreaking is scheduled for 20 October.

STARS AND SCUDS

The MRO array will have a large number of bigger elements distributed over a wider range of baselines than any other optical interferometer in the works, says Chris Haniff, whose University of Cambridge group is involved in the project. MRO's angular resolution, he adds, ''will be a factor of a hundred higher than the Hubble Space Telescope. That means that for any class of astronomical object, you can see more detail.''

''One of the exciting things we think we will be able to do is to look at the central engines of active galactic nuclei,'' says David Westpfahl, project scientist for the MRO interferometer. ''All the models have a massive object at the center, such as a black hole, and an accretion disk and polar outflow, but the detailed shape and arrangement of these things are still being worked on. We hope to be able to resolve several of these objects and decide among the models.'' The MRO interferometer will also be used to deduce the relative rotational axes of stars in clusters, which could shed light on the importance of turbulence in star formation, and to study other aspects of star birth, as well as star aging and planet formation.

Fast slewing is the special feature of MRO's single telescope. It will be able to zip to a particular part of the sky at 10° per second. The slewing was initially incorporated to accommodate the US Army. The MRO offers a good look at target missiles fired from Fort Wingate in western New Mexico, says Tomas C. Chavez, chief of test technology at White Sands. ''We could collect phenomenology data during the target's boost and coast phases to help home in on the target with an interceptor.'' Adds Romero, ''This is a match made in heaven. The army wants to use [the telescope] during the day and early morning, we want to use it at night.'' The 2.4-meter mirror was donated by the air force. Originally intended for classified space-based research, it has hardware added to keep it from sagging in Earth's gravitational field.

Astronomers will take advantage of the fast slewing, too. ''One big use of the telescope will be 'alert response to transient astrophysical phenomema,''' says project scientist Eileen Ryan. ''An example would be to find the optical counterpart of gamma-ray bursts.'' For that, the telescope would automatically interrupt other observations when it receives signals from Swift, a satellite NASA is supposed to launch in December. The MRO telescope, Ryan adds, will be bigger and will slew faster than other ground-based telescopes currently hunting for GRBs (see Physics Today, July 2002, pages 24 and 25). Mostly, though, the 2.4-meter telescope will be devoted to studying ''small Solar system bodies—asteriods, comets, and Kuiper Belt objects,'' says Ryan. ''We want to use the telescope to ask how fast asteroids are spinning. How big are they? What are their shapes?

POSSIBLE WITH PORK

What with the MRO being funded directly by Congress, the project often gets labeled as pork. Says Romero, ''Without this type of funding, we would not be able to build it. But we think this is a facility that funding agencies like NASA and NSF will take the opportunity to fund research at.'' And, unusual for a federally funded project, New Mexico Tech and its partners will foot the running costs, estimated at $2 million a year. If all goes as planned, the single telescope would see first light in 2005, and the interferometer could be up and running a couple years laters.●

MESSAGES FROM THE PRESIDENT

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

EXECUTIVE MESSAGES REFERRED

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

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

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–3008. A communication from the President of the United States, transmitting, pursuant to law, a report that provides the aggregate number, locations, activities, and lengths of assignment for all temporary and permanent U.S. military personnel and U.S. individual civilians retained as contractors involved in the antinarcotics campaign in Colombia, relative to Plan Colombia; to the Committee on Appropriations.

EC–3009. A communication from the Secretary of Defense, transmitting, the report of a retirement; to the Committee on Armed Services.

EC–3010. A communication from the Staff Director, Office of Regulatory and Management Services, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Land Uses; Revenue Producing Visitor Services in Alaska'' (RIN0596-AB57) received on June 25, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3011. A communication from Director, Office of Surface Mining, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''West Virginia Regulatory Program'' (WV-097-FOR) received on June 24, 2003; to the Committee on Energy and Natural Resources.

EC–3012. A communication from the Staff Director, Office of Regulatory and Management Services, Department of Agriculture, transmitting, pursuant to law, a rule entitled ''Forest Land Enhancement Program'' (RIN0596-AB95) received on June 25, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3013. A communication from Staff Director, Office of Regulatory and Management Services, Department of Agriculture, transmitting, pursuant to law, a rule entitled ''Notice, Comment, and Appeal Procedures for National Forest System Projects and Activities'' (RIN0596-AB89) received on June 25, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3014. A communication from Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Update of Rev. Proc. 96-30'' (Rev. Proc. 2003-48) received on June 24, 2003; to the Committee on Finance.

EC–3015. A communication from Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Business Purpose Under Section 355—Fit & Focus—Capital Allocation Purpose'' (Rev. Rul. 2003-75) received on June 24, 2003; to the Committee on Finance.

EC–3016. A communication from Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Assumption of Partner Liabilities'' (RIN1545-BB83) received on June 24, 2003; to the Committee on Finance.

EC–3017. A communication from Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''2003 Section 43 Inflation Adjustment'' (Notice 2003-43) received on June 24, 2003; to the Committee on Finance.

EC–3018. A communication from Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''2003 Marginal Production Rates'' (Notice 2003-44) received on June 24, 2003; to the Committee on Finance.

EC–3019. A communication from Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Applicable Federal Rates—July 2003'' (Rev. Rul. 2003-71) received on June 24, 2003; to the Committee on Finance.

EC–3020. A communication from Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Guidance Regarding Election Under Section 953(d)'' (Rev. Proc. 2003-47) received on June 24, 2003; to the Committee on Finance.

EC–3021. A communication from Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''CRP Cost-Share Payments'' (Rev. Rul. 2003-59) received on June 24, 2003; to the Committee on Finance.

EC–3022. A communication from Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Compliance Initiative for Nonresident Aliens and Foreign Corporations'' (Notice 2003-38) received on June 24, 2003; to the Committee on Finance.

EC–3023. A communication from Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Revenue Ruling: Mass Obsolete Ruling'' (Rev. Rul. 2003-67) received on June 24, 2003; to the Committee on Finance.

EC–3024. A communication from Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Annual Report Concerning the Pre-Filing Agreement of the Large and Mid-Size Business Division for the Calendar Year 2002'' (Ann. 2003-43, 2003-26) received on June 24, 2003; to the Committee on Finance.

EC–3025. A communication from Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Correction to Rev. Rul. 2003-50 — BLS Department Store Indexes for March 2003'' (Ann. 2003-44) received on June 24, 2003; to the Committee on Finance.

EC–3026. A communication from the Regulations Coordinator, Department of Health and Human Services, Administration for Children and Families, transmitting, pursuant to law, the report of a rule entitled ''Child Support Enforcement Program Federal Tax Offset'' (45 CFR Part 303) received June 25, 2003; to the Committee on Finance.

EC–3027. A communication from the Chief, Regulations Branch, Department of Homeland Security, transmitting, pursuant to law, a rule entitled ''Confidentiality of Commercial Information'' (RIN1515-AD29) received on June 24, 2003; to the Committee on Finance.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

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

By Mr. SCHUMER:

S. 1370. A bill to amend the Fair Credit Reporting Act to provide for disclosure of credit-scoring information by creditors and consumer reporting agencies; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. BUNNING (for himself and Mr. BREAUX):

S. 1371. A bill to permit a special amortization deduction for intangible assets acquired from eligible small businesses to take account of the actual economic useful life of such assets and to encourage growth in industries for which intangible assets are an important source of revenue; to the Committee on Finance.

By Mrs. FEINSTEIN (for herself and Mr. ENSIGN):

S. 1372. A bill to amend the Elementary and Secondary Education Act of 1965 to specify the purposes for which funds provided under subpart 1 of part A of title I may be used; to the Committee on Health, Education, Labor, and Pensions.

By Mr. HOLLINGS:

S. 1373. A bill to authorize and direct the Secretary of Commerce, through an independent commission within the Department of Commerce, to protect consumers by regulating the interstate sale of insurance, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. DURBIN (for himself and Mr. GRAHAM of South Carolina):

S. 1374. A bill to provide health care professionals with immediate relief from increased medical malpractice insurance costs and to deal with the root causes of the current medical malpractice insurance crisis; to the Committee on Finance.

By Ms. SNOWE (for herself and Mr. KERRY):

S. 1375. A bill to provide for the reauthorization of programs administered by the Small Business Administration, and for other purposes; to the Committee on Small Business and Entrepreneurship.

By Mr. REID (for himself and Mr. ENSIGN):

S. 1376. A bill to include the Department of Energy and the Nuclear Regulatory Commission as employers for the purposes of whistleblower protection; to the Committee on Energy and Natural Resources.

By Mr. BINGAMAN (for himself and Mr. DOMENICI):

S. 1377. A bill to authorize a Native American language demonstration program at the University of New Mexico at Albuquerque, in consortium with the Linguistic Institute for Native Americans; to the Committee on Indian Affairs.

By Mr. DORGAN:

S. 1378. A bill to transfer to the Secretary of the Interior authority to revise the Missouri River Master Water Control Manual; to the Committee on Environment and Public Works.

ADDITIONAL COSPONSORS

S. 11

At the request of Mr. ENSIGN, the name of the Senator from Illinois (Mr. FITZGERALD) was added as a cosponsor of S. 11, a bill to protect patients' access to quality and affordable health care by reducing the effects of excessive liability costs.

S. 184

At the request of Mr. DODD, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 184, a bill to amend section 401(b)(2) of the Higher Education Act of 1965 regarding the Federal Pell Grant maximum amount.

S. 253

At the request of Mr. CAMPBELL, the name of the Senator from Texas (Mrs. HUTCHISON) was added as a cosponsor of S. 253, a bill to amend title 18, United States Code, to exempt qualified current and former law enforcement officers from State laws prohibiting the carrying of concealed handguns.

S. 296

At the request of Mr. CAMPBELL, the name of the Senator from Colorado (Mr. ALLARD) was added as a cosponsor of S. 296, a bill to require the Secretary of Defense to report to Congress regarding the requirements applicable to the inscription of veterans' names on the memorial wall of the Vietnam Veterans Memorial.

S. 333

At the request of Mr. BREAUX, the name of the Senator from Georgia (Mr. CHAMBLISS) was added as a cosponsor of S. 333, a bill to promote elder justice, and for other purposes.

S. 346

At the request of Mr. LEVIN, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 346, a bill to amend the Office of Federal Procurement Policy Act to establish a governmentwide policy requiring competition in certain executive agency procurements.

S. 518

At the request of Ms. COLLINS, the names of the Senator from New Jersey (Mr. LAUTENBERG) and the Senator from Louisiana (Ms. LANDRIEU) were added as cosponsors of S. 518, a bill to increase the supply of pancreatic islet cells for research, to provide better coordination of Federal efforts and information on islet cell transplantation, and to collect the data necessary to move islet cell transplantation from an experimental procedure to a standard therapy.

S. 560

At the request of Mr. CRAIG, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 560, a bill to impose tariff-rate quotas on certain casein and milk protein concentrates.

S. 569

At the request of Mr. ENSIGN, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of S. 569, a bill to amend title XVIII of the Social Security Act to repeal the Medicare outpatient rehabilitation therapy caps.

S. 661

At the request of Mr. SCHUMER, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 661, a bill to amend the Internal Revenue Code of 1986 to equalize the exclusion from gross income of parking and transportation fringe benefits and to provide for a common cost-of-living adjustment, and for other purposes.

S. 736

At the request of Mr. ENSIGN, the names of the Senator from Nebraska (Mr. NELSON) and the Senator from North Dakota (Mr. CONRAD) were added as cosponsors of S. 736, a bill to amend the Animal Welfare Act to strengthen enforcement of provisions relating to animal fighting, and for other purposes.

S. 764

At the request of Mr. CAMPBELL, the name of the Senator from Rhode Island (Mr. REED) was added as a cosponsor of S. 764, a bill to extend the authorization of the Bulletproof Vest Partnership Grant Program.

S. 847

At the request of Mr. SMITH, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 847, a bill to amend title XIX of the Social Security Act to permit States the option to provide Medicaid coverage for low income individuals infected with HIV.

S. 894

At the request of Mr. WARNER, the names of the Senator from Mississippi (Mr. LOTT), the Senator from Michigan (Mr. LEVIN), and the Senator from Nebraska (Mr. HAGEL) were added as cosponsors of S. 894, a bill to require the Secretary of the Treasury to mint coins in commemoration of the 230th Anniversary of the United States Marine Corps, and to support construction of the Marine Corps Heritage Center.

S. 982

At the request of Mrs. BOXER, the names of the Senator from California (Mrs. FEINSTEIN), the Senator from Delaware (Mr. CARPER), the Senator from Ohio (Mr. DEWINE), and the Senator from Arkansas (Mr. PRYOR) were added as cosponsors of S. 982, a bill to halt Syrian support for terrorism, end its occupation of Lebanon, stop its development of weapons of mass destruction, cease its illegal importation of

Iraqi oil, and hold Syria accountable for its role in the Middle East, and for other purposes.

S. 1001

At the request of Mr. BIDEN, the name of the Senator from Maryland (Mr. SARBANES) was added as a cosponsor of S. 1001, a bill to make the protection of women and children who are affected by a complex humanitarian emergency a priority of the United States Government, and for other purposes.

S. 1120

At the request of Mr. BAUCUS, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 1120, a bill to establish an Office of Trade Adjustment Assistance, and for other purposes.

S. 1172

At the request of Mr. FRIST, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 1172, a bill to establish grants to provide health services for improved nutrition, increased physical activity, obesity prevention, and for other purposes.

S. 1177

At the request of Mr. HATCH, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 1177, a bill to ensure the collection of all cigarette taxes, and for other purposes.

S. 1196

At the request of Mrs. HUTCHISON, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 1196, a bill to eliminate the marriage penalty permanently in 2003.

S. 1245

At the request of Ms. COLLINS, the name of the Senator from Kansas (Mr. ROBERTS) was added as a cosponsor of S. 1245, a bill to provide for homeland security grant coordination and simplification, and for other purposes.

S. 1303

At the request of Mr. BROWNBACK, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. 1303, a bill to amend title XVIII of the Social Security Act and otherwise revise the Medicare Program to reform the method of paying for covered drugs, drug administration services, and chemotherapy support services.

S. 1316

At the request of Mr. BROWNBACK, the name of the Senator from Nebraska (Mr. NELSON) was added as a cosponsor of S. 1316, a bill to treat payments under the Conservation Reserve Program as rentals from real estate.

S. 1317

At the request of Mr. SMITH, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 1317, a bill to amend the American Servicemember's Protection Act of 2002 to provide clarification with respect to the eligibility of certain countries for United States military assistance.

S. 1345

At the request of Mrs. MURRAY, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1345, a bill to extend the authorization for the ferry boat discretionary program, and for other purposes.

S. 1368

At the request of Mr. LEVIN, the names of the Senator from Louisiana (Mr. BREAUX), the Senator from Iowa (Mr. HARKIN), the Senator from Wisconsin (Mr. FEINGOLD), the Senator from Washington (Ms. CANTWELL), and the Senator from Washington (Mrs. MURRAY) were added as cosponsors of S. 1368, a bill to authorize the President to award a gold medal on behalf of the Congress to Reverend Doctor Martin Luther King, Jr. (posthumously) and his widow Coretta Scott King in recognition of their contributions to the Nation on behalf of the civil rights movement.

S. CON. RES. 40

At the request of Mrs. CLINTON, the name of the Senator from North Carolina (Mrs. DOLE) was added as a cosponsor of S. Con. Res. 40, a concurrent resolution designating August 7, 2003, as ''National Purple Heart Recognition Day''.

S. RES. 140

At the request of Mr. CAMPBELL, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. Res. 140, a resolution designating the week of August 10, 2003, as ''National Health Center Week''.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mrs. FEINSTEIN (for herself and Mr. ENSIGN):

S. 1372. A bill to amend the Elementary and Secondary Education Act of 1965 to specify the purposes for which funds provided under subpart 1 of part A of title I may be used; to the Committee on Health, Education, Labor, and Pensions.

Mrs. FEINSTEIN. Mr. President, I rise today to introduce a bill with Senator ENSIGN to ensure that Title I funds are directed towards instructional services to teach low-income students.

Title I provides assistance to virtually every school district in the country to serve children attending schools with high concentrations of low-income students, from preschool through high school.

It has been the ''anchor'' of Federal assistance to schools, since its origin in 1965. And while it has always been Congresses intent for Title I funds to be used for instruction and instructional services, the Federal Government has never provided a clear definition of what instructional services should entail.

This lack of Federal guidance has become especially clear now, as States scramble to comply with the new and expanded Title I accountability standards established in ''No Child Left Behind.''

While State Administrators of Title I are directed by law to meet these specific requirements, they have been given little guidance as to how to ensure that they are in compliance with the law.

I believe that the Federal Government is responsible for making this process as clear to States, as possible. In my own view, as it relates to Title I, we haven't lived up to our end of the bargain.

During consideration of ''No Child Left Behind,'' I worked hard to get my bill defining appropriate Title I uses included in the Senate version of the bill.

Unfortunately, during conference consideration, my bill was stripped out and in its place language directing the General Accounting Office, GAO, to report on how States use their Title I funds was inserted.

In April, GAO released the report that Congress directed them to submit on Title I Administrative Expenditures.

What GAO found is that while districts spent a relatively small amount—no more than 13 percent—of Title I funds on administration that ''because there is no common definition on what constitutes administrative, or indirect, expenditures'' the accounting office couldn't precisely measure how much of their Title I funds were used for administration.

Because Title I funds are not defined consistently throughout the States, the accounting office created their own definition by compiling aspects of State priorities to complete the report.

You see, the very reason I worked to define how Title I funds should be used—to create consistency and distribution priority nationwide—became the definitive aspect preventing GAO from effectively drawing conclusions in their report.

My bill takes some strong steps by balancing the needs for States to retain Title I flexibility and providing them with the guidance needed to administer the program uniformly throughout the country.

My bill does two things: It defines Title I direct and indirect instructional services and sets a standard for the amount of Title I funds that can be used to achieve the academic and administrative objectives of this program.

It ensures that the majority of Title I funds are used to improve academic achievement by stipulating that ''a local educational agency may not use more than 10 percent of [Title I] funds received. . . . for indirect instructional services .''

By limiting the amount of funds that schools can spend on administrative or indirect services, school districts are restricted from shuffling the majority of Title I to pay for non-academic services, but it also gives the districts flexibility to use the remaining funds for the indirect costs of administering Title I distribution.

The second component of my bill defines direct and indirect services so that all States apply the same standards for Title I use nationwide.

Examples of permissible Direct Services are: Employing teachers and other instructional personnel (including employee benefits); intervening and taking corrective actions to improve student achievement; extending academic instruction beyond the normal school day and year, including summer school; providing instructional services to pre-kindergarten children for the transition to kindergarten; purchasing instructional resources such as books, materials, computers, and other instructional equipment and wiring to support instructional equipment; professional development; developing and administering curriculum, educational materials and assessments; transporting students to assist them in improving academic achievement.

Examples of indirect services limited to no more than 10 percent of Title I expenditures are: business services relating to administering the program; purchasing or providing facilities maintenance, janitorial, gardening, or landscaping services or the payment of utility costs; and paying for travel to and attendance at conferences or meetings, except for travel and attendance necessary for professional development.

Current law on Title I is much too vague.

It says, ''A State or local educational agency shall use funds received under this part only to supplement the amount of funds that would, in the absence of such Federal funds, be made available from non-Federal sources for the education of pupils participating in programs assisted under this part, and not to supplant such funds.''

Basically, it says that Title I funds are to be used for the ''education of pupils.'' That is just too nebulous.

The U.S. Department of Education has given States a guidance document that explains how Title I funds can be used.

Under this guidance document, only two uses are specifically prohibited: 1. Construction or acquisition of real property; and 2. payment to parents to attend a meeting or training session or to reimburse a parent for salary lost due to attendance at ''parental involvement'' meeting.

I believe we should give the Department, States and districts clearer guidance in law.

My reasons for introducing this bill are two-fold: First, I believe that States must use their limited Federal dollars for the fundamental purpose of providing academic instruction to help students learn.

Secondly, I believe that it is nearly impossible to do so without providing a clear definition of what is considered an instructional service.

I am not suggesting that it is the fault of the school districts for not focusing their Title I funds on academic instruction. They are simply exercising the flexibility that Congress has given them.

What I am saying is that if Congress also intended for those funds to educate our neediest children, Federal guidance must be given to ensure that it happens.

It is my view that Title I cannot do everything. Federal funding accounts for a small percentage of total funding for elementary and secondary education and Title I is even a smaller percentage of total support for public schools.

That is why I am trying to better focus Title I funds on academic instruction, teaching the fundamentals and helping disadvantaged children achieve success.

Schools must focus their general education budget to pay for expenses that fall outside of the realm of direct educational services and retain the majority of Federal funds to improve academic achievement for poor children.

It is time to better direct Title I funds to the true goal of education: to help students learn. This is one step toward that goal.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1372

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Title I Integrity Act of 2003''.

SEC. 2. DIRECT AND INDIRECT INSTRUCTIONAL SERVICES.

Subpart 1 of part A of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.) is amended by adding at the end the following:

''SEC. 1120C. DIRECT AND INDIRECT INSTRUCTIONAL SERVICES.

''(a) IN GENERAL.—

''(1) USE OF FUNDS.—Notwithstanding any other provision of this Act, a local educational agency shall use funds received under this subpart only for direct instructional services and indirect instructional services.

''(2) LIMITATION ON INDIRECT INSTRUCTIONAL SERVICES.—A local educational agency may not use more than 10 percent of funds received under this subpart for indirect instructional services.

''(b) INSTRUCTIONAL SERVICES.—

''(1) DIRECT INSTRUCTIONAL SERVICES.—In this section, the term 'direct instructional services' means—

''(A) the implementation of instructional interventions and corrective actions to improve student achievement;

''(B) the extension of academic instruction beyond the normal school day and year, including during summer school;

''(C) the employment of teachers and other instructional personnel, including providing teachers and instructional personnel with employee benefits;

''(D) the provision of instructional services to prekindergarten children to prepare such children for the transition to kindergarten;

''(E) the purchase of instructional resources, such as books, materials, computers, other instructional equipment, and wiring to support instructional equipment;

''(F) the development and administration of curricula, educational materials, and assessments;

''(G) the transportation of students to assist the students in improving academic achievement;

''(H) the employment of title I coordinators, including providing title I coordinators with employee benefits; and

''(I) the provision of professional development for teachers and other instructional personnel.

''(2) INDIRECT INSTRUCTIONAL SERVICES.—In this section, the term 'indirect instructional services' includes—

''(A) the purchase or provision of facilities maintenance, gardening, landscaping, or janitorial services, or the payment of utility costs;

''(B) the payment of travel and attendance costs at conferences or other meetings;

''(C) the payment of legal services;

''(D) the payment of business services, including payroll, purchasing, accounting, and data processing costs; and

''(E) any other services determined appropriate by the Secretary that indirectly improve student achievement.''.

By Ms. SNOWE (for herself and Mr. KERRY):

S. 1375. A bill to provide for the reauthorization of programs administered by the Small Business Administration, and for other purposes; to the Committee on Small business and Entrepreneurship.

Ms. SNOWE. Mr. President, I rise today to introduce the ''Small Business Administration 50th Anniversary Reauthorization Act of 2003,'' a bill to reauthorize the U.S. Small Business Administration, SBA, and its programs for the next three years. While reauthorization legislation is a significant event, this year it is particularly auspicious since we are celebrating the 50th anniversary of the agency—a full half century of helping to create, assist, and guide small businesses.

As the Chair of the Committee on Small Business and Entrepreneurship, I began developing this legislation just after assuming the leadership of the Committee in January. The bill I introduce today is the product of considerable effort and vetting, and I am very pleased to be joined by the Committee's Ranking Member, Senator KERRY, in this process. Through his contributions and those of other Members of my Committee, this is truly bipartisan bill.

Over the past several months, we have held a series of hearings and roundtables to examine virtually every aspect of the SBA and the wide array of programs and services it provides to the country's small enterprises. As we started that process, we looked back on the SBA's history to learn from its past in order to set a path for its future.

More than 50 years ago, congressional efforts began to focus on the specific needs of small businesses—to create a ''level playing field''—and to develop Federal small business assistance programs. One of the objectives was to

ensure that small businesses could develop management and marketing skills to compete with big business for their share of government contracts.

In May of 1953, the Small Business Act was introduced, and it became law on July 30 of that year with President Eisenhower's signature. Since 1953, Congress and the various administrations have responded to the needs of small businesses by creating a fair but competitive environment for those who choose entrepreneurship. The SBA has evolved from a direct lender and provider of management assistance to a nationwide delivery system of resources offering a complete menu of small business tools, professional counseling assistance, business education and training programs, Federal procurement opportunities, and loan guaranty programs.

Today, the agency faces enormous challenges. Each year, there are 3 to 4 million new businesses start-ups—one in 25 adult Americans is taking steps to start a business. One quarter of existing small business owners intend to form another business. And, small businesses account for approximately two-thirds of the net new jobs in our country. So while the SBA has had a tremendous impact on the success of small businesses over the past 50 years, it is critical that we ensure the agency is well positioned to produce even better results in the next 50 years.

My goal in developing this bill has been to ascertain what works among SBA programs, why it works, and apply that approach to other programs so there is more consistent success within the SBA portfolio of products and services. In the end, I hope this bill will lead to a renewed SBA, rededicated to improving the environment or leveling the playing field for small business ownership in America.

While the particulars of this bill are extensive, I want to highlight three of its most critical, key areas—

In terms of financing programs for small businesses, during this reauthorization process, I have focused extensively on improving the credit and venture capital resources that the SBA provides for small enterprises. These programs—including the 7(a), 504, and Microloan programs as well as the SBIC, New Markets Venture Capital, and Surety Bond programs provide vital capital for America's small businesses. In addition, looking just at the lending programs, they alone are responsible for helping small businesses create and retain more than 1.3 million jobs in just the past 3 years!

That is why I held two Committee roundtables on these financing programs so I could hear firsthand from small business, lenders, and the SBA about ways these programs can increase access to capital for small businesses. To start, we are proposing to continue the growth of the financing programs through reasonable increases in their authorization levels. The bill also increases the amount that small businesses can borrow subject to the SBA's guarantee, so that the SBA's loan sizes will keep pace with what it actually costs to start and operate a small business in today's economy. And we make improvements to the SBA's loan programs that will benefit fast-growing contributors and vital elements of our economy including women-owned and veteran-owned businesses and small business exporters.

Moreover, the bill addresses access to capital by helping SBA's lending partners. A new initiative that holds great promise will allow for the pooling of small business loans not guaranteed by the SBA. This pilot program was recommended by participants at our roundtable on April 30, 2003, and has been under consideration by the SBA. By pooling these non-guaranteed loans together and offering them as securities on the secondary market with a partial SBA guarantee on the pool, banks will be able to free-up capital for additional small business lending. As a result, they will be able to provide even greater resources for small businesses struggling to secure the necessary capital to start up, operate, and grow.

Similarly, the new National Preferred Lenders Pilot Program will allow qualified SBA lenders to be licensed on a nationwide basis. Currently, Preferred Lenders must qualify in every region where they do business, which is both cumbersome and costly. This initiative will streamline that process for the premier lenders who qualify for a nationwide license and enable them to provide capital more efficiently and effectively to small businesses across the nation.

In addition, the bill includes a proposal by Senator KERRY to permit nonprofit child-care centers to qualify for 504 loans. I believe the growing need for child care in this country warrants testing this idea as a pilot program, even as I continue to have reservations about this initiative's effect on the availability of loans under the 504 program for other for-profit borrowers and the expansion of this loan program to non-profit entities. Accordingly, we have limited the loan volume under the pilot to 7 percent of the overall 504 loans to ensure that this initiative does not bar qualifying for-profit businesses from obtaining necessary financing.

Finally in the area of financing programs, we have also focused on improving the SBA's procedures for overseeing lenders participating in the credit programs. By improving this oversight, we can protect against improper lending practices, produce a more consistent system for lenders, and provide taxpayers with better protection of their tax dollars.

In the area of entrepreneurial development, we set out to ensure that the SBA's programs continue to provide the products and services essential to small businesses, which in turn create a return on our investment in these programs through successful business ownership and job creation. Recognizing the tremendous accomplishments by women entrepreneurs, I introduced the Women's Small Business Improvement Act of 2003 (S. 1154) earlier this year to improve the SBA's Office of Women's Business Ownership, the Women's Business Centers Program, the National Women's Business Council, and the Interagency Committee on Women's Business Enterprise. I have incorporated those provisions into the bill before us in order to provide a universal approach to all of SBA's sponsored programs and services for women.

A cornerstone of this effort involves making the Women's Business Center Program a permanent program that will offer opportunities for new centers and renewal grants for existing centers on a competitive basis. By replacing the pilot Sustainability Program, which expires at the end of the current fiscal year, with a fair and balanced grant program, the bill will correct the funding constraints that have plagued the program in 2003. The bill will also provide for the creation of new centers and the continuation of current operating centers through renewal grants. This structure will reward successful centers with continuation funding and weed out failing centers to make room for new ones with greater potential for serving the needs of women-owned businesses.

The National Women's Business Council will also be given greater control of its mission, and I am proposing the full funding of $1 million for each Fiscal Year for this program. The Interagency Committee on Women's Business Enterprise will be reenergized by providing interim leadership and a shared focus with the National Women's Business Council, the Women's Business Centers, and the Office of Women's Business Ownership. These programs hold great potential for women-owned businesses, but they must be coordinated so that their limited resources are dedicated to a focused goal.

In addition, the SBA's entrepreneurial development partners—the Small Business Development Centers and the Service Corps of Retired Executives—continue to provide quality training and free counseling through almost 2,000 locations and are limited only by funding and their geographic locations. Therefore, in addition to minor technical changes in these programs, I propose that we increase the authorization level for these programs to support the increased demand for their services.

And we have included the Native American Small Business Development Program in the bill. This initiative will provide entrepreneurial assistance to Tribal Governments and Colleges, Small Business Development Centers in Native American communities, and small businesses located on or near Tribal Lands. Complementing the SBA's Office of Native American Affairs, this initiative will strengthen the

SBA's efforts to help Native Americans start, operate and grow small businesses.

Finally, one of the most serious problems facing small business is their inability to participate fully in Federal contracts, on either a prime or subcontract basis. In the last 10 years, contract bundling has forced more than 50 percent of small businesses out of the Federal marketplace. Steps clearly must be taken to ensure that small businesses have the opportunity to compete for the business of the nation's largest consumer—the Federal government.

President Bush recognizes the inequity that contract bundling represents. He also understands the damage it does to both small businesses and the Federal procurement process by denying the government the benefits of more robust competition, small business efficiencies, and small business innovations. He has spoken out against this practice, and I applaud his commitment to addressing this problem.

To achieve that objective, the SBA reauthorization bill addresses the practice of Federal contract bundling by limiting its use and giving small businesses access to Federal contracts and a fair opportunity to compete for them. By requiring studies to be done for all consolidations worth more than $5 million for the Department of Defense and $2 million for all other agencies, the bill also holds agencies to a higher level of accountability than exists under current law.

Those who support the practice of bundling allege that denying small businesses access to prime contracts can be offset by ensuring that such firms receive more subcontracts from the large firms that are awarded prime contracts. However, small businesses continue to experience difficulties at the subcontract level as well. This bill contains strong language that strengthens oversight and enforcement of small business subcontracting plans to ensure small business subcontractors are not neglected.

Furthermore, we have included provisions to encourage contracting opportunities for women-owned businesses—one of the fastest growing segments of the small business sector of our economy. Despite their success, women-owned small businesses have testified before the Small Business Committee about how difficult it is to do business with the Federal Government. Three years ago Congress created a Procurement Program for Women-Owned Small Business Concerns. That legislation required the promulgation of regulations to help implement new small business procurement set-asides for women-owned businesses.

The legislation, however, conditioned the regulations by first requiring a study to be conducted to justify the disparate treatment of women in various procurement instances. At the Small Business Committee's roundtable on April 9, 2003, women-owned small businesses expressed their frustration that it has taken so long to conduct the study and implement the program. This bill directs the GAO to complete that study by December 31, 2003 to ensure that the women's procurement program is finally implemented.

Finally, the bill contains improvements to the HUBZone program, which are intended, in part, to address the serious consequences that military base closings pose for our local communities. Closing a military base adversely affects the towns and communities surrounding the installation due to loss of tax revenue, defense income, base transition costs and clean-up costs.

Successful recovery from a base closing has been tied to public and private reinvestment in these communities. While Congress has taken action in the past to ease the transition for individuals and spur reinvestment, this bill supports faster redevelopment by expanding the HUBZone Program to include communities affected by base closures. It provides an incentive, through Federal government contracts, for small businesses to operate in these communities and to provide employment to these military and civilian personnel.

This year's SBA reauthorization bill paves the way to a stronger SBA able to meet the needs and concerns of the country's entrepreneurs. The future of our country is inextricably tied to the future of small business—and by enhancing the conditions that support small business, we will ensure a more prosperous future for all. I urge all my colleagues to support this important legislation on behalf of the nation's small businesses and entrepreneurs.

(At the request of Mr. DASCHLE, the following statement was ordered to be printed in the RECORD.)

• Mr. KERRY. Mr. President, today, as Ranking Democrat on the Committee on Small Business and Entrepreneurship, I join the Committee's Chair, Senator OLYMPIA SNOWE in introducing a three-year reauthorization bill for the Small Business Administration's programs. These programs help small businesses, often called the engine of the American economy, with access to capital, business advice and training and Federal procurement opportunities. But before I speak more specifically about the provisions of the bill, I would like to thank Chair SNOWE for working hand-in-hand with me on this, my third, reauthorization of the Small Business Administration. Having worked closely on two previous reauthorizations, and as a member of the Small Business and Entrepreneurship Committee for over 18 years, I can tell you that the SBA reauthorization process takes diligence and a strong attention to detail. I want to commend Senator SNOWE for taking the initiative to draft legislation that makes such important and necessary changes to the SBA during this reauthorization process and for showing great leadership in her first seven months as Chair of the Committee on Small Business and Entrepreneurship.

Our bill will strengthen the SBA and dramatically improve the agency's ability to deliver services to small businesses in every state. It is based on a sound Committee record. In addition to holding two hearings and three roundtables to specifically address SBA's programs and related reauthorization issues, our Committee met and spoke with numerous constituents, program directors and small business advocates. It is through this correspondence, research and input that our Committee has been able to prepare a comprehensive piece of legislation that will likely serve the Small Business Administration and the entire small-business community well past even the next reauthorization period.

Over the past three years, as Chairman and Ranking Member of this Committee, I have seen this administration reduce government funding and transfer that money to the wealthy with tax cut after tax cut, resulting in a significant loss of revenue for essential programs aimed at fostering small businesses and the economic activity they bring about. While many of us like to note that small businesses are the engine of economic growth and should be bolstered by our government, this administration has given small businesses more words than action.

The need for small business programs—for access to capital, for training and counseling, for assistance in gaining access to the Federal marketplace—runs counter cyclical to the economy. When the economy is slumping, as it now is, small businesses and entrepreneurs need the SBA even more. Our Committee has heard from the small-business community that demand for training and assistance and access to capital is up, yet this administration has proposed freezing funding for virtually all SBA programs for six years. Their proposal includes no adjustment for inflation or demand, despite SBA's own numbers that show demand is up for its programs.

It is carrying out our legislative and oversight responsibilities that Chair SNOWE and I raised a number of concerns regarding the SBA's reauthorization proposal and the overall management and direction of many of the agency's programs through hearings, and roundtables and in letters and phone calls to the administration. And after hearing from the community and working with small business experts in the field, Senator SNOWE and I came to the conclusion that many of the proposals put forth by the Small Business Administration would not help the agency's programs but ultimately hinder them.

This administration and small businesses across this Nation will find, however, that our prescription for small businesses in a flailing economy

is quite different. Our reauthorization legislation embraces the programs that have worked for years, redirects those that have struggled and sets the SBA and up for continued success.

Although banks have plenty of cash to lend, small businesses are still having a problem getting access to credit. For the past few years as the economy has fizzled, the Federal Reserve has reported that banks have cut back on lending to small businesses, making it harder and more expensive to get loans. And who has been there to pick up the slack? The Small Business Administration and its lending partners.

Lending is up in SBA's largest lending program for working capital. Lending is up in SBA's microloan program, which serves those with the least access to capital through the private sector. And SBA's venture capital programs account for a significant role—more than 50 percent—in this country's investment in our fastest-growing small businesses. Last year these loans pumped about $20 billion into the economy, leveraged millions more from the private sector, fed the local tax base as the Federal government cut back, and created at least 400,000 jobs.

As the Committee reviewed SBA's programs for reauthorization, these facts figured largely into establishing the program levels. I thank our Chair, Senator SNOWE, for working with me to set the levels for SBA's lending and venture capital programs at increasing levels for the next three years. I am particularly pleased with the increased funding levels for the microloan programs.

I disagree with the administration's proposals over the past few years to cut back its investment in microloans and training assistance to micro-entrepreneurs. And I disagree with the Adminstration's contention that these borrowers are being served through the 7(a) loan program. The small borrower in the microloan program is different than the small borrower being served through the 7(a) loan program. Both are important, but they are different, and one is not a substitute for the other.

And who are these borrowers being served through the microloan program? Thirty percent are African American. Eleven percent are Hispanic. Thirty-seven percent are women. And anywhere from 30 to 40 percent go to small businesses in rural areas. Banks turn these borrowers away, and yet the administration proposed cutting the microloan program by 36 percent in its most recent budget. SBA needs to fully fund these programs and put more resources into the office that manages the program. Four people is not enough to manage 1,400 loans and 180 grants.

Aside from setting the levels for each small business financial assistance program, we made important program changes and started new initiatives. In the 7(a) loan program, SBA's largest loan program, which provides working capital to small businesses with long terms of up to 25 years, we made permanent the reduction in the fees borrowers and lenders pay. We are testing a proposal that allows the most proficient 7(a) lenders in good standing to lend in every state. Lenders have complained that applying for lending autonomy in each of the 70 district office and branches is administratively burdensome, both for them and for the Agency staff, and that some district offices have taken advantage of the power to approve or disapprove lenders when they apply for this special lending status.

I want to make clear while I want to avoid unnecessary paperwork and eliminate reported abuses, I do not want the lenders to take this as authority to quit working with the district directors. It is important to have a local connection and for the SBA and the lenders to work together to maximize service to the small businesses. For this purpose I have included a provision which directs the SBA to consider the recommendations and comments of any district directors and regional administrators when reviewing a lender for national lending authority.

To increase the value of 7(a) loans sold in the secondary market, the Committee has included a provision to allow SBA to pool and sell the guaranteed portion of loans with varied rates. Currently SBA has the authority to only sell those loans with identical rates. This should create efficiencies in market and bring down borrowing costs for the small business borrower. At Senator SNOWE's request, in order to reach more under-served small businesses, we have enhanced the Low-Doc program, allowing lenders to use the simplified application form for loans up to $250,000 from $100,000, making it the same as the SBA Express program. We have also expanded the incentives for lenders to provide financing to export small businesses, and proposed letting 7(a) borrowers use a simplified size standard when determining if an applicant is a small business.

To improve the 504 loan program, which makes long-term loans of up to 20 years to small, growing businesses to buy equipment and buildings, we have also raised the debenture size to keep pace with the rising cost of commercial real estate and equipment. We have brought the job requirement standard up from $35,000 to $50,000 after ten or twelve years. We have directed SBA to simplify the application and documentation process of applying for and closing 504 loans, long a goal of this Committee and made a priority based on the testimony of one of our witnesses during the reauthorization process. We have created two alternatives for 504 lenders to use when establishing a loan loss reserve to cover potential losses.

I am particularly pleased that we have included S. 822, the Child Care Lending Pilot Act in the reauthorization bill. It allows small, non-profit childcare businesses access to 504 loans. I thank Senator SNOWE and my colleagues for agreeing to try this for three years, similar to what we have done with the microloan program. And I thank the trade association of 504 lenders, the National Association of Certified Development Companies, and other 504 lenders for their endorsement of an input on the pilot.

The more research I've done, the more I've come to realize how vitally important it is that we give non-profit day care providers the same opportunities as for-profits to expand their businesses. Non-profit day care centers are often the only child care suppliers available in needy areas, from the most urban to the most rural. Giving these businesses access to 504 loans for three years will allow us to gauge whether this valuable loan program is the best way to aid these valuable providers of care to our Nation's children. I have taken note of states like Oregon, where 79 percent of day care providers are non-profit, Michigan, where that number jumps to 86 percent, Iowa with 77 percent, my own State of Massachusetts with 90 percent, Ohio with 62 percent, and the list goes on and on. I've learned that in State after State families are waiting for affordable day care; from more than one thousand families on the waiting list in Nevada and Maine to more than thirty thousand on the list in Texas. These parents are waiting for quality day care they can afford, and making available affordable loans to all licensed child care providers may increase access to care and cut down those waiting lists.

I understand the concerns of those who are concerned about the precedent of SBA lending to non-profits. And I agree it should not be expanded to all industries. However, this is a very unique industry that in many States is delivered mostly through non-profits, and the only way to penetrate the market is to reach both for-profit and non-profit. Further, non-profits are usually the providers that care for the neediest kids. I have added provisions to ensure the underwriting standards are just as tough, if not more so, as those applied to for-profit centers. The loans must be personally guaranteed, the collateral must be owned outright by the child care provider, and it must be able to make its loan payments and cover normal operating expenses from the revenue generated from its clients. With these protections, the loans to non-profits should perform just as well as those made to for-profits, and if there is a problem, the loans should be collateralized sufficiently to cover the losses.

The bill defines a small, non-profit child care business to mean an entity organized as a 501(c)(3), but not just any organization. It must be a licensed child care provider; it must meet the size standard for a small business; and it must provide care to infants, toddlers and pre-kindergarten and older children after school. At Senator SNOWE's request, the pilot is limited to

7 percent allowed for pilots under SBA's 7(a) guaranteed business loan program. I feel that the agreed upon cap should allow for sufficient lending under the pilot to adequately test whether lending to non-profit childcare providers is effective in increasing access to affordable childcare, and whether it protects the general 504 program, which is vital to the financing of small businesses in this country.

The bill also includes a comprehensive study by the GAO to track and monitor the impact of this program both on the industry and the program. Last, I want to remind my colleagues that the 504 program is funded entirely through fees and does not require appropriations.

Also included in this bill is S. 318, the Small Business Drought Relief Act. This simply reinforces in legislation something which SBA should already be doing. You see, the SBA doesn't treat all drought victims the same. The Agency only helps those small businesses whose income is tied to farming and agriculture. However, farmers and ranchers are not the only small business owners whose livelihoods are at risk when drought hits their communities. The impact can be just as devastating to the owners of rafting businesses, marinas, and bait and tackle shops. Sadly, at present these small businesses cannot get help through the SBA's disaster loan program because of something taxpayers hate about government—bureaucracy.

The SBA denies these businesses access to disaster loans because its lawyers say drought is not a sudden event and therefore it is not a disaster by definition. However, contrary to the Agency's position that drought is not a disaster, as of July 16, 2002, the day this legislation was introduced last year, the SBA had in effect drought disaster declarations in 36 states. That number had grown to 48 the beginning of this year, demonstrating that problem had gotten worse and even more small businesses were in need.

As I have said time and again, the SBA has the authority to help all small businesses hurt by drought in declared disaster areas, but the Agency won't do it. For years the Agency has been applying the law unfairly, helping some and not others, and it is out of compliance with the law. The Small Business Drought Relief Act of 2003 would force SBA to comply with existing law, restoring fairness to an unfair system, and get help to small business drought victims that need it. I thank Senator BOND for working with me on this when he was the Ranking Member of the Committee on Small Business & Entrepreneurship, and I thank Senator SNOWE and her staff for all their help and support. While we might have had a lot of rain recently in the Northeast, there are areas like Lake Mead in Arizona where it is so dry that the water level is down and small businesses are losing business and making expensive changes to extend docks to reach the water.

In this bill are also provisions to shore up SBA's venture capital programs—the Small Business Investment Company Debenture and Participating Securities programs, and the New Markets Venture Capital Program. We have balanced investment incentives with soundness issues and allowed small businesses to receive more SBIC financing than currently permissible if they also have a 504 or 7(a) loan. We have improved the arrangement for distributing payments from successful SBICs so that SBA and the investors are treated more fairly and the taxpayers has more protection for realizing repayment on the investments. We have put in place conforming amendments to make the New Markets Venture Capital program work with the New Markets Tax Credit, as Congress intended. We have clarified that new markets venture capital companies have two years to raise their matching capital, as Congress intended. The Committee has been troubled by the Agency's interpretation of the NMVC statute which they viewed as permitting SBA to choose how much time it can give conditionally approved NMVCs to raise the private-sector matching money. The chosen time frames were unreasonable and not what Congress intended.

We have also included many measures to strengthen SBA's oversight of lenders, responding to findings by the General Accounting Office and the Office of Inspector General. And we have reauthorized and clarified the law for surety bond guarantees to help small businesses get government contracts.

While no one would deny the importance access to capital plays in the success of small businesses, as SBA Administration Hector Barreto and past SBA Administrators have acknowledged time and again, debt is not always the answer. In the SBA's FY 2004 budget request, there is reference to information from the Ewing Marion Kauffman Foundation and Dun & Bradstreet that indicates ''80 percent of new businesses discontinue operation within five years because of lack of 'knowledge' of key business skills.'' Despite the recognized importance of such assistance, the SBA's funding request for FY 2004 and its legislative proposal to implement that request would freeze funding levels for virtually all Agency programs, without even accounting for inflation, for a six-year period. If enacted, that would severely hamstring this nation's small businesses and their ability to effectively compete and prosper in the national economy.

Cuts to or inadequate funding of the SBA's entrepreneurial development programs are often attributed to vague and unfounded claims of duplication. Such claims mistake a common mission of training and counseling for duplication, ignoring the reality that small businesses vary greatly, are often at very different stages of development, and have many different needs. Just as it would be ineffective to only have one type of loan or venture capital financing structure for the 25 million small businesses in this country, it would be futile to water down specialized management and training programs to impose a one-size-fits-all approach.

I want to commend Chair SNOWE for giving women entrepreneurs such a prominent place in the reauthoziation process. Rarely do women entrepreneurs get the recognition and attention they deserve for their contributions to our economy: 18 million Americans would be without jobs today if it weren't for these entrepreneurs who had the courage and the vision to strike out of their own. During my tenure as a member, Chair, and lead Democrat of the Senate Committee on Small Business and Entrepreneurship, I have worked to increase and improve the opportunities for enterprising entrepreneurial women in a variety of ways, leading to greater earning power, financial independence and asset accumulation—and I am glad that Senator SNOWE is joining me in this endeavor.

As Chair SNOWE expressed when she introduced the Women's Small Business Programs Improvement Act—and when Senator SNOWE and I passed the Women's Business Center's Preservation Act—protecting the extremely effective and well-established Women's Business Center network was a high priority in this reauthorization. For that reason, we make permanent the Women's Business Center Sustainability Pilot Program by creating three-year ''renewal'' grants for those centers with sustainability grants and four-year ''initial'' grants for new centers; increase the program's authorization levels; and direct the Office of Women's Business Ownership, OWBO, to make all Women's Business Center grants at $150K and to consult with the associations of Women's Business Centers when making improvements to the program. Other changes to the Women's Business Center Program include streamlining the data collection and the grant application and selection criteria, protecting the privacy of Women's Business Council, WBC, clients, and providing for a smooth transition from sustainability to the newly established WBC program. Our legislation will not only secure the future of the Women's Business Center Program, but it will connect all SBA-related women's initiatives with a unified mission, similar guidance and training. These changes were coupled with minor, yet significant, changes to the National Women's Business Council, NWBC, and the Interagency Committee on Women's Business Enterprise. Senator SNOWE and I included provisions to give the NWBC cosponsorship authority, to allow more flexibility in the way the Council uses funds, and to direct the Council to serve as a clearinghouse for historical data. Each of these things will enable the Council to become a better resource for the Administration, Congress and the entire small-business

community. To bolster the representation of women business owners in the federal government, our bill re-establishes the Interagency Committee on Women's Business Enterprise, directs the Deputy Administrator of the SBA to serve as acting chairperson of the Interagency Committee until a chairperson is appointed, establishes a Policy Advisory Group to assist the Committee's chairperson in developing policies and programs under this Act and creates three subcommittees similar to those created under the National Women Business Council.

This bill also supports and protects the Small Business Development Center network, which has served 9 million small-business owners since its inception more than 20 years ago. It should also be noted that in 2001, SBDCs helped small businesses create or retain over 80,000 jobs, generate $3.9 billion in sales and obtain $2.7 billion in financing. For every dollar spent on an SBDC, $2.09 in tax revenue was returned to the Federal Government. Numbers aside, the nationwide network of SBDCs provide important counseling services to small-business owners that are unable to afford private consulting, many of whom are women and minority clients. The SBDC program has grown to serve 1.25 million small-business owners and entrepreneurs each year, and there are nearly 1,000 centers serving every State in Nation.

While this bill rejects the potentially detrimental changes proposed by the SBA to the SBDC network, it does address concerns expressed by the centers and small businesses. Included in our bill are increased authorization levels to keep up with increased demand and a provision to protect the privacy of the program's clients and a provision to help SBDCs that have been adversely affected by poor economic conditions or government downsizing.

Also, included in the entrepreneurial development section of our bill is a provision to increase to $7 million annually the authorization level for the Service Corps of Retired Executives, SCORE, which has nearly 11,000 volunteers, and a technical change to allow SCORE to keep its modest staff of fourteen employees.

I want to thank Senator SNOWE for working with me to include, as introduced, the Native American Small Business Development Act, which I reintroduced earlier this year together with Senator JOHNSON and Senator SMITH to address the SBA's growing lack of commitment to the Native American community. According to a report released by the U.S. Census Bureau, the ''three year average poverty rate for American Indians and Alaska Natives [from 1998–2000] was 25.9 percent; higher than for any other race groups.'' With an unemployment rate well above the national average and household income at just three-quarters of the national average, Native American communities need a commitment from the Federal government that we will help them, particularly during these difficult economic times. To reaffirm this commitment, the Johnson-Kerry-Smith bill provides Native Americans the resources they need to take advantage of the opportunities of entrepreneurship.

The Native American Small Business Development Act, as included in our reauthorization bill, will ensure that the SBA's programs to assist Native American communities cannot be dissolved by making the SBA's Office of Native American Affairs, ONAA, and its Assistant Administrator permanent. Our legislation would also create a statutory grant program, known as the Native American Development grant program, to assist Native Americans. It would also establish two pilot programs to try new means of assisting Native American communities and require Native American communities to be consulted regarding the future of SBA programs designed to assist them. In short, this legislation will ensure that our Native American communities receive the adequate assistance they need to help start and grow small businesses.

To address the growing business development needs of veterans, Senator SNOWE and I reauthorized the Advisory Committee on Veterans Affairs, expanded veterans outreach grants from just service-disable veterans, to veterans, reservists and service-disable veterans. Further, we increase the funding for the Office of Veterans Business Development to enable that office to better deal with the demand by veterans for outreach and development services.

We continue to receive reports of the detrimental effects of the Administration's policy of reduced staffing and resources for essential programs aimed at allowing small businesses to thrive. Week after week, the Federal Times reports on the decline in contracts being allocated to small businesses, small businesses losing ground in the federal marketplace, and most recently, on the awarding of more big contracts with less oversight from Federal agencies. With agencies awarding larger, more complex and more costly contracts with less staff performing oversight, this nation's small businesses and its tax payers are the ones shouldering the burden when small business goals continue to be unmet. In addition to helping small businesses obtain access to procurement opportunities, these goals are meant to help the government benefit from the cost-savings and innovations small business contractors can often provide.

Significant improvements to the ongoing problem of contract bundling, also called contract consolidation, are included in this bill. The first provision creates a two-tiered approach to preventing unnecessary contract consolidation. Civilian agencies will be required to meet specific standards if they attempt to consolidate contracts above $2 million and additional requirements for those contracts above $5 million. The Department of Defense is required to meet two types of similar requirements for contracts above $5 million and $7 million. The bill also eliminates the use of the term ''contract bundling'' and expands the definition of ''contract consolidation,'' closing a loophole that has been widely used and has detrimentally affected small businesses.

The second provision increases in the number of Procurement Center Representatives (PCRs) stationed throughout the country. These representatives advocate on behalf of small businesses in cases directly affecting contracting, such as the bundling or consolidation of contracts. In the bill, we have increased the number of PCRs to ensure that every state and every major procurement center is allocated at least one PCR. Meanwhile, we have also ensured that these PCRs are not burdened with responsibilities that were previously the duties of Breakout PCRs and Commercial Marketing Representatives. These two improvements will dramatically increase the efficacy and efficiency of all three positions and allow proper review of the approximately 40 percent of Federal contracts, nearly $90 billion, that are currently not being reviewed by PCRs. This should increase small business's access to Federal contract opportunities.

The bill would also create a reporting requirement for the BusinessLINC program, which has been showing promise in creating real teaming opportunities for small businesses in the private sector. Although the Administration recommended elimination of the program, the reports this Committee received regarding the overwhelming success of the existing nine programs made it clear that the SBA did not have sufficient information about BusinessLINC to make an informed decision on its effectiveness. The Committee's bill would ensure that the SBA offers the proper level of oversight and would foster the continued success of the program. I would like to thank Senator SNOWE for working with me to find a compromise to preserve this successful program.

At each of this Committee's three Roundtables on Reauthorization and the hearing on contract bundling, the small business community reiterated the need for accountability for small business contracting at the agency level. I applaud Senator SNOWE on her efforts to ensure that Federal agencies be held accountable for fully utilizing small businesses and to allow a greater amount of Congressional oversight of the implementation of agency procurement strategies. Provisions within this bill will ensure that the heads of Federal agencies identify a specific portion of their budget request that will be awarded to small businesses in their strategic plan and their annual budget

submission to Congress; will hold senior executives and senior program managers accountable in their annual performance evaluations for small business utilization in Federal contract awards.

In addition to increasing opportunities for prime contracts, this bill addresses another serious problem: small businesses have been severely hamstrung by dishonest practices by some businesses that have prime contracts with the Federal Government and receive preference over other prime contractors due to their superior subcontracting plans. Senator SNOWE and I have worked closely to address the concerns of small businesses regarding delays in payment, false reporting and the use of ''bait and switch'' tactics by prime contractors.

This bill holds prime contractors responsible for the validity of subcontracting data, requiring the CEO to certify to the accuracy of the subcontracting report under penalty of law. It also expands the penalties for falsifying data included in subcontracting reports to match the $500,000 penalty for businesses that falsify their status as a small and disadvantaged business. If one intentionally falsifies data as a part of a subcontracting report to a Federal agency, he is defrauding the United States government and will be punished to the full extent of the law. I commend Senator SNOWE for her diligence in creating these strict penalties and her efforts to create a bipartisan response to protect small businesses.

I want to thank Chairwoman SNOWE and her able staff for all of their hard work over the past several months. I also want to express my gratitude to all members of the Committee and urge them and my other Senate colleagues to support the Small Business Administration 50th Anniversary Reauthorization Act of 2003.●

By Mr. REID (for himself and Mr. ENSIGN):

S. 1376. A bill to include the Department of Energy and the Nuclear Regulatory Commission as employers for the purposes of whistleblower protection; to the Committee on Energy and Natural Resources.

Mr. REID. Mr. President, I rise today to introduce legislation providing greater protection for workers dealing with nuclear materials and nuclear power. I am pleased to introduce this legislation today with my colleague from Nevada, Senator ENSIGN.

Several weeks ago, I chaired a hearing of the Energy and Water Development Subcommittee on problems facing the Yucca Mountain project. I was extremely disappointed that two of the witnesses—both current employees of the Department of Energy and one of its contractors—failed to testify at the hearing.

It was clear to me that these people failed to appear before the committee because they were concerned that their appearance could have negative repercussions on their jobs. That is completely unacceptable.

So today, Senator ENSIGN and I are introducing legislation to expand the whistleblower protections. The bill we are introducing does two things.

First, the bill would expand whistleblower protection to all Department of Energy and Nuclear Regulatory Commission employees and their contractors' and subcontractors' employees.

Second, the bill would provide a process for whistleblowers to utilize Federal courts if their cases are not addressed quickly by the Department of Labor.

Our Democracy depends on the ability of citizens and their elected representatives to make informed decisions. That means we need to know the truth about the issues.

These changes are simple fixes that help ensure that Federal employees and other people working for the Federal Government never have to fear they will lose their jobs for simply telling the truth.

I hope the Senate will act quickly on this important legislation.

By Mr. DORGAN:

S. 1378. A bill to transfer to the Secretary of the Interior authority to revise the Missouri River Master Water Control Manual; to the Committee on Environment and Public Works.

Mr. DORGAN. Mr. President, thirteen years ago the Corps of Engineers was given 6 months to revise the Missouri River Master Manual. The Master Manual provides a framework for managing the flows on the Missouri River.

But here we are, thirteen years later, and nothing has happened. So today I am introducing legislation to take management away from the Corps of Engineers and give it to the Bureau of Reclamation.

In my judgment, the Corps has failed miserably in its efforts to revise the Master Manual. In the interim, the Corps has managed the River in a way that benefits the downstream States at the expense of the upstream States, despite the fact that the upstream States generate ten times more economic activity from recreational use than the downstream states generate from barge traffic.

And this mismanagement has cost North Dakota a lot. Enough is enough. It's time to take this responsibility away from the Corps and give it to the Bureau of Reclamation. The Bureau manages other rivers, like the Colorado River, so let's give them a chance to manage the Missouri and to revise the Master Manual. Perhaps this will give the upstream States a chance to be treated fairly for a change.

I have written a letter to the head of the Corps of Engineers, General Robert Flowers, expressing my concern about this issue and I ask unanimous consent that this letter be printed in the RECORD.

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

U.S. SENATE,
Washington, DC, July 1, 2003.

LTG ROBERT B. FLOWERS,
Chief of Engineers, U.S. Army Corps of Engineers, Washington, DC.

DEAR GENERAL FLOWERS: More than a decade ago, the Corps of Engineers was tasked with revising the Missouri River Master Manual, which governs the management of the Missouri River. As you well know, I have been very frustrated with the long history of missed deadlines and continual delays. It certainly appears that the Corps has no intention of moving forward with a new Master Manual any time in the near future. In addition, as I have learned more about the unfairness of the current management plan, I am concerned that the Corps is either unwilling or unable to implement equitable management of the River.

Lake Sakakawea in North Dakota has suffered lake level decreases of over 16 feet. This has had a devastating effect on the recreational uses of the lake. It is unacceptable for the Corps to continue to shortchange the upstream states by sending water downstream for a barge industry that generates less than a tenth of the economic activity as the upstream recreational interests. Fort Peck in Montana has seen lake level declines of 21.2 feet and Lake Oahe in South Dakota has suffered lake level reductions of more than 22 feet.

And the downstream lakes? These lakes have seen virtually no change in their lake levels. Harry S. Truman Lake in Missouri has lost less than half a foot of elevation. Lake Rathbun in Iowa is down just 2.4 feet.

This is truly a case of double jeopardy for the upstream states. The water from their lakes gets drained off for a nearly non-existent barge industry at a time when the downstream states are not asked to make any contributions from their own lakes. The table below shows the inequity of this situation.

DOWNSTREAM LAKES

Lake	Change in elevation (feet)
Harry S Truman Lake (MO)	−0.4
Stockton Lake (MO)	−4.8
Pomme De Terre (MO)	−1.9
Lake Rathbun (IA)	−2.4

UPSTREAM LAKES

Lake	Change in elevation (feet)
Fort Peck (MT)	−21.2
Lake Sakakawea (ND)	−16.2
Lake Oahe (SD)	−22.1

The Corps has developed a deplorable track record of managing the Missouri River to the detriment of the upstream states and the millions of people who live in that region. This is just the latest in the Corps' string of poor decisions.

It is clear the Corps is simply incapable to managing the Missouri River in a fair and equitable fashion.

For this reason, I plan to introduce legislation when the Congress returns from its July work period, that would transfer authority for the revision of the Master Manual and the responsibility for the management of the dams along the Missouri River, to the Bureau of Reclamation. The Corps has failed in its mission to manage the River in an effective way and has neglected to revise the Master Manual despite 13 years of work on the project. My patience has run out, and I believe it is time to make a dramatic change in the stewardship of and the responsibility

for the River so that the upstream states can have some hope of fairness and equity.

Sincerely,

BYRON L. DORGAN,
U.S. Senator.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1378

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. MISSOURI RIVER MASTER WATER CONTROL MANUAL.

(a) FINDINGS.—Congress finds that—

(1) the original study for the revision of the operating plan under the Missouri River Master Water Control Manual was begun in November 1989 and was scheduled to be completed 6 months later;

(2) the Corps of Engineers has missed that deadline by more than 13 years and has consistently missed every other deadline set in the interim;

(3) the Corps of Engineers is unable or unwilling to move the process forward to revise the Manual, despite legal requirements, direction from Congress, scientific evidence, and various lawsuits from affected parties;

(4) in report number RCED–92–4 in January 1992, the Comptroller General of the United States concluded that there is no statutory or regulatory basis for any contention by the Corps of Engineers that the Corps is bound to give higher priority to navigation interests than to recreation interests affected by the operation of dams on the Missouri River;

(5) the Missouri River yields more than 10 times the economic benefit for recreation and tourism in upstream States than it does for shipping interests in the downstream States; and

(6) it appears that the Corps of Engineers is unable to provide the leadership necessary to finalize revisions to the Manual.

(b) DEFINITIONS.—In this section:

(1) SECRETARY OF THE ARMY.—The term ''Secretary of the Army'' means the Secretary of the Army, acting through the Chief of Engineers.

(2) SECRETARY OF THE INTERIOR.—The term ''Secretary of the Interior'' means the Secretary of the Interior, acting through the Commissioner of Reclamation.

(3) MANUAL.—The term ''Manual'' means the Missouri River Master Water Control Manual.

(c) TRANSFER OF AUTHORITY.—There is transferred from the Secretary of the Army to the Secretary of the Interior all authority of the Secretary of the Army to—

(1) revise the Manual; and

(2) operate the dams the operation of which is governed by the Manual.

(d) COMPLETION OF CURRENT REVISION.—The Secretary of the Interior shall, to the maximum extent practicable, complete the revision of the Manual begun by the Secretary of the Army before the date of enactment of this Act not later than the date set for completion by the Secretary of the Army.

(e) MANAGEMENT OF WATER RESOURCE PROJECTS.—After the Secretary of the Interior revises the Manual, the Secretary of the Interior shall manage water resource projects formerly operated by the Corps of Engineers in accordance with the revised Manual.

AMENDMENTS SUBMITTED & PROPOSED

SA 1135. Mr. LAUTENBERG submitted an amendment intended to be proposed by him to the bill S. 925, to authorize appropriations for the Department of State and international broadcasting activities for fiscal year 2004 and for the Peace Corps for fiscal years 2004 through 2007, and for other purposes; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 1135. Mr. LAUTENBERG submitted an amendment intended to be proposed by him to the bill S. 925, to authorize appropriations for the Department of State and international broadcasting activities for fiscal year 2004 and for the Peace Corps for fiscal years 2004 through 2007, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in the bill, add the following:

SEC. ___. JUSTICE FOR UNITED STATES MARINES ACT.

(a) SHORT TITLE.—This section may be cited as the ''Justice for United States Marines Act''.

(b) AMENDMENT.—Section 1404C(a)(3) of the Victims of Crime Act of 1984 (42 U.S.C. 10603c(a)(3)) is amended by striking ''December 21, 1988, with respect to which an investigation or'' and inserting ''October 23, 1983, with respect to which an investigation or civil or criminal''.

NOTICES OF HEARINGS/MEETINGS

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DOMENICI. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Committee on Energy and Natural Resources.

The hearing will be held on Tuesday, July 15, at 2:30 p.m., in room SD–366 of the Dirksen Senate Office Building.

The purpose of this hearing is to receive testimony regarding the Compact of Free Association with the Federated States of Micronesia and the Republic of the Marshall Islands.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send two copies of their testimony to the Committee on Energy and Natural Resources, U.S. Senate, Washington, DC 20510–6150.

For further information, please contact Meghan Beal at 202.224.7556 or Meghan__Beal@energy.senate.gov.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DOMENICI. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Committee on Energy and Natural Resources.

The hearing will be held on Thursday, July 17, at 10 a.m., in room SD–366 of the Dirksen Senate Office Building.

This is the second in a series of hearings devoted to the improved understanding of the governance of the Department of Energy laboratories and approaches to optimize the capability of those laboratories to respond to national needs.

The purpose of this second hearing is to contrast the management of science and technology resources by the Department of Energy with management of such resources in other agencies and in the private sector towards the goal of suggesting approaches for optimizing the DOE's management and use of its science and technology resources.

Because of the limited time available for the hearings, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send two copies of their testimony to the Committee on Energy and Natural Resources, U.S. Senate, Washington, DC 20510–6150.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. ENZI. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Tuesday, July 8, 2003, at 2:15 p.m., in closed session, to receive a classified briefing on the situation in Africa, with a focus on Liberia.

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

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. ENZI. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on Tuesday, July 8, 2003, at 9:30 a.m., on the nomination of Nicole Nason, DOT, and Pamela Harbour, FTC, and immediately following a hearing on ''Radio Ownership'' in SR–253.

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

COMMITTEE ON FINANCE

Mr. ENZI. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session on Tuesday, July 8, 2003, at 10 a.m., to hear testimony on An Examination of U.S. Tax Policy and Its Effect on the Domestic and International Competitiveness of U.S.-Based Operation.

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

COMMITTEE ON THE JUDICIARY

Mr. ENZI. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a hearing on ''Executive Nominations'' on Tuesday, July 8, 2003, at 2:30 p.m., in the Dirksen Senate Office Building Room 226.

Agenda

Panel I: Senators.

Panel II: Michael J. Garcia to be Assistant Secretary, U.S. Department of Homeland Security; and Jack Landman Goldsmith III to be Assistant Attorney General, Office of Legal Counsel, U.S. Department of Justice.

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

SUBCOMMITTEE ON CLEAN AIR, CLIMATE CHANGE, AND NUCLEAR SAFETY

Mr. ENZI. Mr. President, I ask unanimous consent that the Subcommittee on Clean Air, Climate Change, and Nuclear Safety be authorized to meet on Tuesday, July 8, at 9:30 a.m., to examine agricultural sequestration of carbon.

The hearing will take place in SD 406 (Hearing Room).

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

SUBCOMMITTEE ON NATIONAL PARKS

Mr. ENZI. Mr. President, I ask unanimous consent that the Subcommittee on National Parks of the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Tuesday, July 8, 2003, at 10 a.m.

The purpose of the hearing is to conduct oversight of the maintenance backlog, land acquisition backlog, and deficit in personnel within the National Park System, including the impact of new park unit designations on resolving each of these concerns.

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

PRINTING OF THURMOND TRIBUTES

Mr. BROWNBACK. Mr. President, I ask unanimous consent that tributes to Senator Strom Thurmond be printed as a Senate document.

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

ORDERS FOR WEDNESDAY, JULY 9, 2003

Mr. BROWNBACK. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 9:30 a.m., Wednesday, July 9. I further ask that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then resume debate on the motion to proceed to the consideration of S. 11, the Patients First Act, provided that the time until 11:30 a.m. be equally divided between the two leaders or their designees, and provided further that the time from 11:10 a.m. to 11:20 a.m. be under the control of the Democratic leader or his designee and the remaining time until 11:30 a.m. be under the control of the Republican leader or his designee.

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

PROGRAM

Mr. BROWNBACK. For the information of all Senators, tomorrow the Senate will resume debate on the motion to proceed to the consideration of S. 11, the Patients First Act. Under the previous order, at 11:30 a.m. the Senate will vote on the motion to invoke cloture on the motion to proceed. Immediately following that vote, the Senate will proceed to executive session and vote on the nomination of Victor Wolski to be a judge on the U.S. Federal Claims Court. Therefore, the first vote of tomorrow's session will occur at 11:30 a.m. and that vote will be the first of two back-to-back votes.

Following the two votes at 11:30 a.m., the Senate will begin consideration of S. 925, the State Department reauthorization bill. Amendments are expected to be offered to the bill, but it is the majority leader's hope that we can complete action on this measure in short order. Therefore, Members should expect rollcall votes throughout the afternoon tomorrow.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. BROWNBACK. If there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 7:57 p.m., adjourned until Wednesday, July 9, 2003, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate July 8, 2003:

DEPARTMENT OF JUSTICE

DANIEL J. BRYANT, OF VIRGINIA, TO BE AN ASSISTANT ATTORNEY GENERAL, VICE VIET D. DINH, RESIGNED.

IN THE ARMY

THE FOLLOWING ARMY NATIONAL GUARD OF THE UNITED STATES OFFICER FOR APPOINTMENT IN THE RESERVE OF THE ARMY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be brigadier general

COL. CHARLES S. RODEHEAVER, 0000

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be vice admiral

REAR ADM. RODNEY P. REMPT, 0000

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be major

PATRICE L. PYE, 0000

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE AND FOR REGULAR APPOINTMENT (IDENTIFIED BY AN ASTERISK (*)) UNDER TITLE 10, U.S.C., SECTIONS 624 AND 531:

To be major

*REBEKAH F. FRIDAY, 0000

CONFIRMATION

Executive nomination confirmed by the Senate July 8, 2003:

THE JUDICIARY

DAVID G. CAMPBELL, OF ARIZONA, TO BE UNITED STATES DISTRICT JUDGE FOR THE DISTRICT OF ARIZONA.