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Senate

The Senate met at 1:00 p.m. and was called to order by the President pro tempore (Mr. STEVENS).

PRAYER

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

Let us pray.

Eternal Spirit, You are not only just and holy, but Your mercies endure forever. Because of Your goodness, we receive Your forgiveness and love. Forgive our past mistakes and give us new hearts that we might serve You with passion.

Today, bless our Senators physically, mentally, and spiritually. Strengthen them so that they will control their tongues, actions, minds, and hearts. Preserve them in soundness of mind that all their decisions will be made for Your glory.

We pray in 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.

RESERVATION OF LEADER TIME

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

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, today we will return to debate on several health care proposals. We had previously slated this week to consider two medical liability, medical malpractice reform bills, as well as the small business health plan bill reported by the HELP Committee. Because there was an objection to proceeding to each of these three bills, I was forced to file cloture last week on each of these bills on the motion to proceed. Thus, the first vote will be at 5:15 today on one of the medical liability bills and the second medical liability bill, if we do not get cloture on the first, to follow.

At 5:15, the vote will be on the Medical Care Access Protection Act of 2006, S. 22. If cloture is not invoked on that comprehensive bill, the Senate will then immediately vote to invoke cloture on the motion to proceed to S. 23, the Healthy Mothers and Healthy Babies Access To Care Act. That second bill is similar to the first, S. 22, but limits itself to litigation and focuses just on obstetrical and gynecological care.

If the Senate is not able to turn to either of these pieces of legislation, the next vote we will have will be tomorrow morning, Tuesday morning, on cloture on the motion to proceed to S. 1955, the Health Insurance Marketplace Modernization and Affordability Act. This is the bill reported by Chairman ENZI's committee called the small business health plans bill. The bill is intended to aid small business owners by giving them more power to negotiate for affordable insurance for their employees and their families.

We have set aside debate throughout the day today to allow Senators to speak on any of these three health care measures. I look forward to the debate on each of these issues—each very important—as we look at the overall affordability of health care, the access to health care, as well as the quality of health care for all Americans.

HEALTH CARE REFORM

Mr. FRIST. Mr. President, at this point I would like to briefly extend some comments I made at the end of last week on the issue of the medical liability bills that are before this body.

On Friday, the Senate filed cloture on the medical liability reform bill—or actually two bills—and we will vote on at least one of those bills today, this afternoon. All of this centers around the fact that our broken medical liability system is hurting every American, every patient, every physician, and the health care system. But the important thing is that it hurts every American. It is an issue that, as a physician as well as a Senator, concerns me deeply. Indeed, it needs to concern and should concern every single American who is walking or will walk into a doctor's office. That is because every American is suffering from the high costs which are totally unnecessary and, in many ways, frivolous and out of control.

A litigation lottery system is what it really is that we suffer from today. Each year, health care costs are rising three to four times faster than the average American's paycheck, and that is in part—in part—driven by this litigation lottery system, a system that is driving up costs, and when it drives up costs, it drives up the premiums that not just doctors pay, because those premiums are passed on to the patients and potential patients, but it drives up costs, diminishes access to health care today, and thus diminishes quality for every American. Access to quality issues are equally important to the costs, but they are all interrelated.

Innocent doctors and patients are being punished because of the greed of a few opportunistic trial lawyers who are exploiting the system the way it is currently configured. Thus, the legislation that we propose and that we hope we will be able to debate on the floor reforms that system—it fixes the system—with a sense of fairness and commonsense reform.

This is an issue which I have been compelled to bring back to the floor again and again, really on principle, because it is the right thing to do. In

the last Congress, in the 108th Congress, I attempted to bring medical liability reform to the Senate on three separate occasions. Each time, a minority of Senators blocked consideration and prevented an up-or-down vote on those pieces of legislation. Indeed, although we will have to see how the votes fall here in about 4 or 5 hours, they may do so again today. But I am going to remain determined to press for action on principle because it is the right thing to do. It boils down to the fact that health care dollars should be spent on patients and not on lawyers who are out abusing the system—on patients and not lawyers. It is a clear choice.

Last week, I talked a little bit about my own son Harrison who traveled with me to town meetings around the country a couple of years ago. We went to Florida, we went to Pennsylvania, and we went to Ohio and talked about a range of issues. Being a physician and a Senator, doctors would come up to me again and again and tell their stories about having to stop practicing their specialty, a neurosurgeon or an obstetrician who has to stop delivering babies, or actually moving out of Pennsylvania down to other States in the South or out of Ohio or out of Florida because they really had no choice. At the end of that trip, my son said: Dad, I know you love medicine and that is your life. My granddad was a family physician and loved it, and both my uncles are physicians. But why in the world, Dad, would you encourage me to go into a profession where everybody gets sued—not just once but again and again and again—even if they have done nothing wrong?

That is what hurts and also really scares me because it means we are going to lose a whole generation of good people, committed people who care about treating patients, who simply aren't going to go into the profession because they don't want to expose themselves or, more importantly, their own families to these frivolous lawsuits. It is happening.

I hope everybody listening to this debate over the next few hours and hopefully several days will ask their physicians, whoever they are—pick up the phone and call them or e-mail or if you are going to the doctor's office ask them: Does this medical liability stuff really mean that you are unable to treat patients in the way you otherwise would? It really is affecting cost and access and quality? Just ask them, and I guarantee the answer will be yes.

Access to care. Across the country right now, one out of two counties does not have an OB–GYN. That means mothers or expectant mothers are having to drive extra miles, as fewer and fewer people deliver babies, in order to have their babies delivered. Three-quarters of neurosurgeons will no longer operate on children, in large part because of the number of lawsuits. Increasingly, neurosurgeons are not taking trauma calls at the local hospital wherever you live in the world today because they know by taking that trauma call, their malpractice premiums, their liability premiums skyrocket because of the likelihood, even if they give good care, of being sued.

I have seen it and heard about it, talking again and again to my own medical colleagues and in traveling across Tennessee. In Tennessee, 81 out of the 95 Tennessee counties don't have a neurosurgeon. Half don't have an orthopedic surgeon, an emergency physician, or an OB–GYN. Average malpractice premiums for Tennessee doctors have increased 90 percent—90 percent—in the last 6 years.

As a result of all of this, my colleagues in Tennessee tell me, or at least nearly three-quarters of them tell me—and in a recent survey—that their medical communities already have a shortage of the high-risk specialties, the trauma specialists, the obstetricians, the neurosurgeons, and those same counties are having a hard time recruiting new physicians. Nobody is going to move into a county where those premiums are sky high and the risk of them being sued is so high.

We have to reform the system. We can do it with commonsense reforms. The reforms have been laid out in the legislation.

The nationwide picture is very similar. The AMA, the American Medical Association, says we have reached crisis proportions in 21 States, including Florida, West Virginia, Ohio, Pennsylvania, New York, and Tennessee. Families in these States are simply not getting the quality of care they need because of these out-of-control liability premiums.

Right now, if you talk to obstetricians, about one out of seven stopped delivering babies, and they point to the reason of the skyrocketing medical liability costs. We talk about the doctors and we talk about their premiums, but let's remember that as a result of those costs and premiums, you lose the access, you lose the availability. The excessive costs, the waste—it doesn't go down to the doctor-patient relationship; it doesn't mean you get better care. Ultimately, it is the patients who suffer. It is the American people who suffer—not the doctors, not just their premiums. Ultimately, it is the patient's care that suffers.

High-risk specialists. Again, I say this as a cardiac surgeon talking about my colleagues, but the neurosurgeons I mentioned are the ones who are getting hit the hardest. Emergency room staff are being depleted. That is a big concern. I will cite it again and again on the floor: If something happens to you driving home today, is there going to be a neurosurgeon there to take care of that head injury? Increasingly, it is less likely that you will have that sort of expertise there in the emergency room.

We know how to address this crisis. This is the good news. We know there are things we can do that work. Commonsense reform, based on principle, is not all that hard to do.

I was in Texas last month, about 3 or 4 weeks ago, talking to the doctors there, and they have seen the results of a reform movement that is alive and well and has had an impact. Since 2003, the rate of malpractice filings has declined by 80 percent in most major Texas counties. This year alone, the rate cuts by five major Texas insurers will save physicians nearly $49 million in premium payments. They say they save physicians $49 million and, remember, all of those premiums just get passed on to the American people and get translated into higher premiums that you pay for your monthly health care security. Between 3,000 and 4,000 doctors have moved into the State, into Texas, where just the opposite is happening in Pennsylvania and Ohio and Florida, where physicians are moving out of the State.

The Texas story is a true success story. Because of this inequity from State to State, we need a national approach.

As I mentioned, we will be voting in a few hours on the medical liability reform bills. These bills are a part of a larger vision of health care which is patient centered—patient centered—which is provider friendly, which centers on 21st century information and choice and an element of control. But this is a major piece in reaching that vision. We need our doctors and hospitals and offices to be places which they are intended to be—places of healing and not minefields for greedy, predatory lawyers who are simply exploiting a system that needs to be reformed.

Mr. President, I encourage my colleagues to vote today for cloture so that we can discuss both of these medical liability bills. My colleagues know well that the medical liability system does need reform, and as a physician and as a Senator, I know we can deliver these meaningful reforms, and I intend to do so. I hope we are given that opportunity. I encourage all of our colleagues to vote for cloture so we can address these bills.

RECOGNITION OF THE MINORITY LEADER

The PRESIDING OFFICER (Mr. SESSIONS). The Democratic leader is recognized.

IMMIGRATION

Mr. REID. Mr. President, I would simply mention to the distinguished leader before he leaves that a week ago, I came to the floor and talked about immigration and indicated that we would be willing to go forward—10 amendments on each side—and with the direction where I think we should go on conference. I hope the leader will understand that time is running out. We need to be able to do this.

We are terribly concerned, even more concerned based on the statements

from the House last week. Chairman SENSENBRENNER gave a speech last week talking about why he had, in his bill, his legislation, at the request of the White House—I am sure the White House has backed off on this; I certainly hope so—but making people who are here who are undocumented, felons. He gave some illustrations that were not very good. He talked about, Japan doesn't have many immigrants that come illegally. That is right, that is because it is an island. They would have to swim there or come in on an airplane or boat. They don't have the mass migration problems we have.

I hope the leader, with the many things he has to do, would understand that we have, after this week, only 2 weeks left in this legislative session. The leader stated we are going to try to finish this before Memorial Day. To do that, we are going to have to get on that bill. If we have all these amendments, it is going to take a lot of time.

Mr. FRIST. Mr. President, briefly, because I know the Democratic leader has another statement to make, I am absolutely committed to completing and giving adequate time to complete what is a complex bill. As the Democratic leader implied, there are a lot of issues we need to talk about in this bill. I appreciate the spirit in which he and I are approaching the bill, in terms of allowing debate and amendment and also addressing issues about conference, to make sure—I know what his intent is—that the will of the Senate is expressed strongly in that conference.

I do encourage all of our colleagues to recognize that step one is debating the bill here on the floor of the Senate, getting it off the floor with a majority vote, and I would argue for a good comprehensive bill stressing the border and border security. What I would like to do, as I discussed scheduling with the Democratic leader, is to be on the immigration bill next week and the following week. That should give adequate time.

There was one last thing, at least on our side of the aisle. In terms of numbers of amendments, we are doing our very best to focus each and every day on the amendments which would be substantive amendments, to try not to have unnecessary amendments or amendments just for political reasons but substantive amendments coming to the floor. Hopefully, coming to the floor, people will continue work. People don't see that on the floor, but literally every day we are meeting looking at those amendments. So once we get on the bill, we can have a fair process, not a lot of unnecessary time spent figuring out what the amendments would be. I am confident that we can, working together, be on a bill that will be a comprehensive bill, that will be a bill reflecting the will of the Senate, by early next week.

The PRESIDING OFFICER. The Democratic leader.

MEDICAL MALPRACTICE

Mr. REID. Mr. President, people will have other thoughts on medical malpractice legislation as they come to the floor, as they cast their vote. But for me, I want to make this a day to remember a wonderful woman by the name of Billie Robinson. I have handled medical malpractice cases. I want to talk about this one. I have talked about her before. I want to talk about her again. I could talk about other cases, but nothing has been so fixed in my mind, as I prepared for today, as Billie Robinson.

I really didn't know Billie Robinson when she had all of her faculties; I only knew her after she had this surgery. Billie Robinson came from my hometown of Searchlight. She was like some other people in Searchlight, she had basically no education. She was a hard worker. She worked very hard physically. She developed headaches that were difficult for her to describe, but she did her best and went to a series of physicians. Every physician she went to told her she drank too much and she should lay off the booze and she would be better.

She ultimately went to her fifth or sixth doctor, and the doctor decided maybe he should look and see what is inside her head and ordered some x rays and other diagnostic tests and found she had a tremendously large tumor in her head causing these blinding headaches. Her activities, her actions were not a result of alcoholism; they were the result of her head having a tumor causing her these horrible headaches. And yes, she did drink. She drank everything she could get her hands on to try to relieve that pain. A simple test early on would have determined what was wrong with Billie Robinson.

As I said, when I saw her, she had already had the surgery. She didn't speak well. She would speak with very slurred speech, but you could tell this woman was a good woman. She had a good heart. She had no alternative, in an effort to live her remaining days in some dignity, but to try to seek some type of redress for the negligence of those doctors who had seen her, and she did get some satisfaction. It was not necessary that we go to a jury because those doctors who had attempted to treat her realized they had not done their job properly. So she lived out her life in a condition that was not appropriate.

Had she had that surgery years before when the tumor was small, she would have been normal. It was not a malignant tumor. By the time they were able to operate, there had been so much damage because of the growth of the tumor that she had significant brain damage. She was able to buy herself a new mobile home and lived a quiet, peaceful life in Searchlight.

Today, I remember Billie Robinson. Had this legislation been in effect that the majority is trying to pass today, if it had been in effect then, Billie Robinson would not have been able to buy herself a new mobile home. She worked for minimum wage almost all of her life. She would not have been able to have recovered compensation for the pain and suffering, to any degree, that she went through. She basically would not have had much.

Today, I rise in protest. I rise to object to these Republican bills, these two bills that are put here as a result of the insurance industry. These measures before the Senate do not represent a serious attempt to improve health care or the civil justice system in our country. Moving to these bills is a tired political exercise, and the Senate should reject this political exercise out of hand. To think, with American consumers paying more than $3 a gallon for gas—the record is in San Diego, $3.40 today; all over Nevada, it is more than $3; the average across the country is $2.95—college tuition moving out of the reach of the middle class; to think, with the number of the Iraq war dead now pushing 2,500; to think, with immigration now being a security crisis unresolved; to think, with our country's deficit soon approaching $9 trillion; to think, with 46 million Americans lacking health care coverage, that we are moving to bills that are unnecessary and will go nowhere? What a waste of the Senate's time.

It is wrong that we are doing this. We could more profitably use this time on any of the issues about which I just spoke. We could more properly use the scarce time remaining to address any of these urgent challenges facing America's families. I haven't even mentioned energy. We could do that. And we could address the real health care crisis, not this ''make do'' health care crisis.

Both of these bills the Senate will consider today contain the same one-size-fits-all cap on damages. These bills have been rejected time and time again, and rightfully so. Both contain the same unjustified protections for hospitals, rest homes, HMOs, and, of course, insurance companies. In fact, these proposals are virtually identical to legislation we turned aside three times the last Congress. These bills are the same old song, and the votes will be the same old dance: Democrats protecting the American consumer from these huge companies.

The top of this company pyramid, of course, is the insurance company, then hospital companies, extended-care facilities, rest homes. Even though these measures would dramatically rewrite the tort laws of all 50 States and even though they would denigrate the legal rights of countless Americans, they have undergone no serious legislative review in this Congress.

Don't be fooled by the bill numbers—S. 22 and S. 23—they are simply placeholders for legislative text that was only formally introduced last Wednesday. In fact, the text of these bills was not even available until a couple of days ago.

The majority leader used a procedural technique called rule XIV that brings these bills straight to the Senate floor to avoid consideration of these bills by either the Judiciary Committee or the Health Committee. There has not been a single committee hearing, not a single witness, not a single opportunity to amend, not a single opportunity to compromise or negotiate. With this insurance industry legislation before this body, every step of the legislative process has been abandoned.

Why has the majority proceeded in this manner? Because this is not a serious exercise in legislating. It is a political stunt being performed for the sole purpose of allowing Republicans to go back to their special interest friends led by the insurance industry and say: Look what we have tried to do to help, even though they should not be fooled by these transparent theatrics because that is all it is.

The majority is short-circuiting the committee process because of the illusion of medical malpractice crisis. It is an illusion. It doesn't exist. Medical malpractice crisis? No. Health care crisis? Yes. There is a health crisis, but it has nothing to do with tort laws. It has nothing to do with the Billie Robinsons of this world. It has nothing to do with the people out there who are struggling to be able to take their kid to see the doctor, to be able to buy prescription drugs. It is a crisis when 46 million Americans have no health insurance, it is a crisis when health insurance is too costly for the average American. It is a crisis when medical errors are the sixth leading cause of death in America. But not a single provision in this legislation will provide health insurance to the uninsured, lower health care costs, or make patients safer. In reality, the whole premise of the medical malpractice crisis is unfounded.

Over the weekend, I read a book. It is an insightful book entitled ''The Medical Malpractice Myth,'' written by Tom Baker. Who is Tom Baker? Tom Baker is not a trial lawyer, he is not a lawyer who specializes in medical malpractice cases. Tom Baker's father and father-in-law are physicians. Tom Baker is a professor of law at the University of Connecticut School of Law. He is director of the Insurance Law Center at that university. He is not affiliated in any way with trial lawyers.

In this book, Professor Baker methodically debunks the most common myths in the medical malpractice debate.

Myth No. 1: ''Lawyers, not doctors, cause malpractice.''

Professor Baker presents numerous studies demonstrating that the real problem is too much malpractice, not too much litigation. Of course, most doctors are skilled professionals and don't commit malpractice, but just as there are a few rotten apples in every basket, there are a small number of unskilled, uncaring, and negligent physicians in every State. Unfortunately, they don't always come to the attention of the licensing boards, and some move from State to State to avoid disciplinary action. These rotten-apple doctors should be held accountable, and the victims of their negligence deserve to be compensated, just like Billie Robinson deserves to be compensated.

Myth No. 2: ''Lawsuits make health care unaffordable.''

That is a myth.

Professor Baker demonstrates that medical malpractice rates are based more on the cyclical nature of the stock market than on malpractice verdicts. When insurance companies' investments lose money, the companies raise their rates which they charge doctors to compensate for their loss.

There is no better example that exists than what St. Paul did in the Las Vegas, NV, area. In fact, they had a deal. If the Clark County Medical Association referred a doctor to them, they gave a kickback to the Clark County Medical Association. They had almost all of the medical malpractice insurance in the Las Vegas area. What happened? There was a general lapse in the economy, the stock market wasn't doing well, real estate wasn't doing well, and they were in big trouble because they do not make their money with their premiums. They invest the premiums. That is where they make the money. When they make bad investments, that is when they come in and start talking about how unaffordable medical malpractice is. As a result, caps on damages do not reduce insurance premiums in the long run.

For the most part, insurance rates have not gone down in those States which have capped damages. Nevada is a good example. After the self-imposed crisis that St. Paul created, the Governor held a special session of the legislature and they set a cap of $350,000 on pain and suffering damages. OB-GYN malpractice premiums are 37 percent higher than in States without caps, general surgery premiums are 52 percent higher, and internal medicine premiums are 44 percent higher. In fact, since 2001, claims paid by Nevada's largest insurer have dropped 16.7 percent while premiums have increased almost 33 percent.

From 2000 to 2005, the net payouts of malpractice insurers declined 3.1 percent. But over the same period in which payouts were declining, net insurance premiums were increasing by 93.2 percent. So claims decreased, but the companies more than doubled their premiums.

Even if caps on damages did affect malpractice premiums, there is no reason to believe that caps would make health care more affordable overall.

According to the Congressional Budget Office, malpractice costs amount to less than 2 percent of overall health care spending. If a reduction of 25 to 30 percent in malpractice costs were attainable, it would lower health care costs by only 0.4 percent to 0.5 percent.

Myth No. 3: ''Lawsuits deny access to care.''

That is a myth. It is only a myth.

Despite the century-old complaint that lawsuits drive doctors from their practices, the medical profession continues to grow each year, and applications to medical schools have increased—and they are increasing right now. The number of physicians in the United States has increased every year since 1996, from 738,000 in 1996 to almost 885,000 in 2004—less than 2 years ago.

In 2003, the nonpartisan General Accounting Office surveyed five States repeatedly cited by the American Medical Association as examples of communities suffering from shortages of care because doctors are fleeing. The report concluded that such claims are widely overstated, and I quote, ''Many of the reported physician actions and hospital-based service reductions were not substantiated or did not widely affect access to health care.'' Where doctor shortages exist, they are due to population shifts and the reluctance of doctors to practice in rural and low-income areas.

In any event, caps on damages do not change the availability of physicians. States without caps on damages have more doctors per capita and 14 percent more active physicians than States with caps on damages. For example, the number of OB-GYNs in the United States has increased by nearly 25 percent—from 33,000 in 1990 to 42,000 in 2004. But in Nevada, where we have caps on damages, there are 27 percent fewer OB-GYNs than in States that don't have caps.

Myth No. 4: ''Lawsuits cause doctors to practice wasteful defensive medicine.''

In his book, Dr. Professor Baker devotes a whole chapter to the goods on defensive medicine. He cites reports from the Congressional Budget Office and the former Congressional Office of Technology Assessment that question estimates of defensive medicine. The Congressional Budget Office specifically concludes that any savings from reducing defensive medicine would be small at best.

Myth No. 5: ''Most lawsuits are frivolous.''

Anyone who listened to the radio today heard a report that this isn't true. Take one look at the book ''The Faces of Neglect Behind the Closed Doors of Nursing Homes''—and you'll see case after case of neglect in these institutions, case after case, horrible pictures of things that were done to these men and women in rest homes. If this legislation passes, don't worry about holding them accountable anymore.

Not every lawsuit has merit, but the tort system has plenty of mechanisms for weeding out frivolous claims. According to Professor Baker, ''[m]ost undeserving claims disappear before trial; most trials end in a verdict for the doctor; doctors almost never pay claims out of their own pockets; and

hospitals and insurance companies refuse to pay claims unless there is good evidence of malpractice.'' And that is an understatement.

At the same time, the assertion that there exists an ''explosion'' in medical malpractice payouts in recent years is simply untrue. The average verdict size is relatively low and has remained stable for many years. A study by Americans for Insurance Reform found payouts have been virtually flat since the mid-1980s. As it is, Americans use the civil justice system as a last resort, going to court after all their efforts have failed.

For these reasons, Professor Baker concludes that the medical malpractice crisis is a product of exaggeration and distortion.

But even if there were a medical malpractice problem that needed to be cured, these bills are not the right medicine. They are riddled with major flaws. Let me talk about a few of them.

First, they would impose an unreasonably low $250,000 cap on pain and suffering. Proponents of these bills claim that the cap is $750,000, but in the typical case where there is a single negligent party, the cap remains $250,000. In cases where the wrong limb is amputated or a patient is paralyzed or a mother loses a child, $250,000, I submit, is grossly inadequate. And it is even worse under S. 23. Under this legislation, the life of a woman rendered sterile by gross negligence of an OB–GYN is worth less than that of a man mistakenly sterilized.

This is bad legislation.

Second, these bills discriminate against women in more ways than that. By capping pain and suffering while simultaneously preserving full compensation for lost wages and salary, these bills devalue the worth of homemakers and stay-at-home parents. For instance, a homemaker whose reproductive system is destroyed by negligent treatment would suffer only noneconomic losses which are arbitrarily capped by this bill.

At the same time, the bills limit punitive damages, a change which disproportionally affects women patients. Punitive damages are very rare in malpractice cases, but the cases where they do occur often involve sexual abuse of a female patient. Punitives would be virtually impossible to receive under this legislation.

Third, the bills unjustifiably protect large corporations that own nursing homes from liability when they abuse or kill their patients. The National Citizens Coalition for Nursing Home Reform released this book, I mentioned earlier, ''The Faces of Neglect; Behind the Closed Doors of Nursing Homes,'' which profiles the heartbreaking experiences of 36 Americans who have suffered from abuse and neglect while in long-term facilities. These are only a few cases of hundreds and hundreds. The book includes the story of Barbara Salerno, a Reno, NV, woman whose father died due to the neglect of a nursing home. It is a tragic case.

The numbers of seniors who could be hurt by this bill are staggering. According to the GAO, 300,000 elderly and disabled residents live in chronically deficient nursing homes where they are ''at risk of harm due to woefully deficient care.'' Nationwide, 26.2 percent of nursing homes were cited for violations related to quality of care by regulatory agencies in 2004 alone, yet this bill gives sweeping liability protections to these negligent facilities.

Fourth, these bills are an affront to federalism. Republicans love to talk about States rights, except when they want to impose a Federal solution on all 50 States. More than half of all States have already enacted malpractice reforms, but these bills would override these State legislative decisions. Specifically, this bill preempts those States which have debated a cap on damages and decided against that step on their own.

For these reasons and many others, the pending bills are objectionable. In fact, the entire concept of medical malpractice reform is misguided. The right way to bring down medical malpractice insurance premiums is to reform the insurance industry, which is badly in need of oversight.

A study commissioned by the Center for Justice and Democracy showed that insurance premiums more than doubled between 2000 and 2004 even though claims for pay-outs remained essentially flat. Given this price gouging, it is little wonder that the profits of the Nation's five largest medical malpractice insurers rose by nearly 18 percent last year, more than double the ''Fortune 500'' average.

We need to strengthen Federal oversight of insurance industry practices that contribute to these rises in malpractice premiums. Unfortunately, the insurance industry enjoys almost complete immunity from Federal antitrust laws, and using this exemption, insurance companies can collude to set rates, resulting in higher premiums than true competition would achieve. Federal enforcement officials cannot investigate any such collusion because of this exemption.

I am embarrassed to say this law came about as a result of the Nevada Senator McCarran. The McCarran-Ferguson Act. That is, I submit, the only bad thing he did.

This act was passed to give a few years of relief to the insurance industry. Now, some 70 years later, insurance companies are the only businesses—other than Major League Baseball—not subject to antitrust laws. This rationale for this exemption has long since passed. Insurance should be like any other business—subject to antitrust laws.

Senator LEAHY's bill would accomplish this. To pretend these medical malpractice bills have anything do with making health more affordable is a cruel joke. These bills override the sound judgment of State legislatures and juries and substitute the arbitrary judgement of an insurance friendly Congress.

We should not reward insurance companies making record profits. We should help doctors by reforming the insurance industry rather than undermining the legal rights of seriously injured malpractice patients. That is what these would do.

I am going to vote against cloture. It is bad legislation. I hope that once again, we will help the American consumers and defeat these two bad bills.

MEDICAL CARE ACCESS PROTECTION ACT OF 2006—MOTION TO PROCEED

The PRESIDING OFFICER. Under the previous order, the Senate will resume consideration on the motion to proceed to S. 22, which the clerk will report.

The legislative clerk read as follows:

Motion to proceed to Calendar No. 422, S. 22, a bill to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system, and for other purposes.

The PRESIDING OFFICER. Under the previous order, the time from 1:30 p.m. until 2 p.m. shall be under the control of the minority, and the time from 2 p.m. to 2:30 p.m. shall be under the control of the majority. The time will rotate in this format until the time from 5 p.m. to 5:15 p.m. which will be under the control of the majority.

The Senator from Florida.

Mr. NELSON of Florida. Mr. President, under the previous order, with the time being allocated to this side, I wish to speak on the Medicare prescription drug deadline that is fast approaching 1 week from today. Since this week is called Health Week In the Senate, it is strange we are not going to be discussing the extension of the deadline of May 15, a week from today. It is a deadline for all the senior citizens. For those who want to sign up for the Medicare prescription drug benefit, they have to do so by the deadline; otherwise, they get penalized 1 percent a month. If they sign up for the wrong plan, they are stuck for a year and they cannot change plans.

Of course, senior citizens are having a very difficult time figuring out in this multiplicity of plans what the formulary is in a plan, if it would cover their prescription drugs. If suddenly they choose a plan that does not cover their prescriptions, they are stuck for a year unless they do not sign up, and then they are going to be penalized economically up to 12 percent a year.

It is imperative we take up this legislation and extend the deadline and provide essential protections for Medicare beneficiaries during the first year of implementation of this Medicare prescription drug benefit.

We have been advocating for some period of time providing seniors with a meaningful prescription drug coverage, not one that is overly confusing and

one that fails to address the escalating costs of prescription drugs. The plan has passed. It passed several years ago, and it is being implemented. Our job now is to help the seniors who are going to choose to enroll in the program, to help them pick the plan that is right for them. The stakes are very high. We must provide them with the time and resources they need to make an informed decision.

I have spoken with Medicare beneficiaries all across my State of Florida. They are understandably confused. They are concerned about this new prescription drug benefit. They are facing a number of private plan options. Sorting through all of these options is difficult for our senior citizens.

This is not the first time the senior Senator from Florida has spoken in the Senate. I have offered this to the Senate several times. It has received majority votes, but we have not passed it into law.

An example: In my State, there are 18 companies offering 43 standalone prescription drug plans. Each of these different options differs in terms of premiums, cost sharing requirements, drugs covered, and pharmacy access. Sorting through these plans is complicated and time consuming.

Further complicating matters, the Medicare drug benefit has been marred by implementation problems. This adds to the confusion for the Senators. To give an example, in a rural community where there is only one pharmacy, seniors naturally want to get their prescriptions from that pharmacy. What happens if that pharmacy is not covered in the formulary of the plan they pick?

They need time to sort through all of this. Yet the beneficiaries, the Medicare recipients who do not select their plan, 1 week from today, will face a substantial financial penalty.

On the other hand, if we can delay the late enrollment penalties and give a Medicare recipient the chance to change plans once during the first year, we can make sure our senior citizen constituents are not forced to make a hasty decision they are going to regret later.

I have introduced S. 1841, the Medicare Informed Choice Act. This bill extends the annual open enrollment period under the Medicare prescription drug plan through all of this year of 2006. It will not impose a late enrollment penalty and allows a one-time change in plans at any point in 2006.

According to the Congressional Budget Office, if we extend the deadline for all of 2006, over 1 million more senior citizens will sign up for the program. In addition, another 7.5 million seniors will pay lower premiums because they will have fewer penalties. Why in the world would we not be doing this for our senior citizens?

A recent poll by the Kaiser Family Foundation demonstrates the need for this legislation. In that survey, 4 in 10 elderly Americans still do not know the enrollment deadline for the new Medicare drug benefit is May 15. In addition, in that survey, nearly half of all the seniors are unaware they face a financial penalty if they delay.

This bill I have filed, S. 1841, is a time-limited step to help ease the pressure of the first year of this new prescription drug benefit. It is time to stop playing politics with the health care of our seniors. It is time to start putting their needs first.

The Senators have heard their citizens back home. They are very clear in what they would like us to do. I urge all of our colleagues, every time we bring this up—a majority favor this position, but it is always beat down, saying we have to have the deadline. There is no reason we should put this imposition on our senior citizens 1 week from today when they are going to pay the penalties.

As we have already indicated earlier, I ask unanimous consent in the Senate that upon disposition of Calendar No. 417, S. 1955, the Enzi small business health care bill, the Committee on Finance be discharged from further consideration of the bill I have just talked about, S. 1841, and that the Senate proceed then to its immediate consideration. That is my unanimous consent request.

The PRESIDING OFFICER. In my capacity as a Senator from Alabama, I object. The matter has not been cleared by committee or the Republican leadership.

Mr. NELSON of Florida. I understand that is the position of the majority.

We will continue to fight this out over the course of this week. This is ''doing right'' by our seniors. As the Good Book says: Come and let us reason together.

I am offering an extension for the entire year. We ought to have some coming together, to reason together, on some kind of extension, even if it is not for the remaining 6 months of the year in which we can help out our senior citizens.

I will continue to press this in the course of this week's debate. I will continue throughout, as I have just indicated, to bring up this matter. I will continue to ask unanimous consent from the Senate that this matter be brought to the Senate because of the emergency nature of meeting the deadline a week from today, May 15, to help out our senior citizens.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Mr. President, with great fanfare, the majority leader has announced this is Health Week in the Senate. This is a week he has set to address the Nation's urgent health issues. But there is something very big missing from this agenda. The American people are demanding action on embryonic stem cell research.

In poll after poll, the overwhelming majority of Americans favor lifting the President's arbitrary and harsh restrictions on embryonic stem cell research. The American people want the Senate to vote on H.R. 810, a bill passed almost a year ago, 350 days ago to be exact, by the House of Representatives. It was offered by a Republican, Congressman Mike Castle from Delaware, and a Democrat, Congresswoman DEGETTE from Colorado. It was bipartisan. It passed the House. Yet it has been sitting here for nearly a year and we cannot bring it up.

How in the world can we have Health Week in the Senate and not bring up H.R. 810 and allow consideration of the public's No. 1 health research priority? Instead we are scheduled to debate three bills that have no chance of passage in the Senate. The majority leader knows it, I know it, and the rest of the Senate knows it.

It is a gimmick that we are talking about health care. However, we will have bills that somehow excite the political base, get certain segments moving in this political year.

The American people want the Senate to address the issue of embryonic stem cell research. I tried to explain to my nephew, Kelly, who was injured 26 years ago in a tragic accident on an aircraft carrier. He has been a quadriplegic ever since. He finds it incomprehensible and totally unacceptable that we in the Senate cannot bring up this bill and pass it. I tried to explain to him that it is politics. He says this is ridiculous, it shouldn't be Democrat or Republican.

This is the most promising revolutionary avenue of biomedical research, and it is being blocked because of politics? Try explaining that to someone with juvenile diabetes, ALS, Parkinson's, spinal cord injuries.

I appreciate the fact that some Republican Senators have been outspoken. I see Senator HATCH in the Senate, Senator SPECTER, and Senator SMITH urging the majority leader to bring up the bill. Senator FRIST himself gave an eloquent and courageous speech last summer when he endorsed H.R. 810.

Why don't we have it in the Senate? This is Health Week. Bring it up.

Leader FRIST said last summer:

> Therefore I believe the President's policy should be modified. We should expand Federal funding and current guidelines governing stem cell research carefully and thoughtfully, staying within ethical bounds.

That is what the majority leader said last summer. I could not agree more. In December, they asked unanimous consent to pass the cord blood bill. I spoke on it at that time. We wanted the two to go together. We let the cord blood bill pass—fine, I am all for that—with a promise that we would somehow get a vote on H.R. 810 sometime in this session.

This session is almost half over. We have Health Week. Stem cell research is not on the agenda. That is a shame. Why don't we bring up H.R. 810 and debate it? We could have a time limit. The votes are here to pass it. We know

that. We know the votes are here to pass it. Why don't we bring it up?

On the President's arbitrary date of August 9, 2001, he said there were 78 stem cell lines. We now know there are only 22. Of those 22, all are contaminated with mouse cells. They will never be used for any kind of human interventions.

The President's policy of August 9, 2001, is a dead end. It offers false hope to millions of people across America and around the world who are suffering from diseases that could be cured or treated throughout embryonic stem cell research.

Scientists have made great advances in deriving the stem cell lines since August of 2001. They have been grown without mouse cells. Shouldn't our top scientists be studying those lines instead of being limited to the 22 that will never be used in humans?

In closing, we do not expect our astronomers to study the heavens with Galileo's telescope. We do not expect geologists to study the Earth with a tape measure. It is time we move to the next level of research to help people who are suffering from ALS, Parkinson's disease, and juvenile diabetes. We should bring up embryonic stem cell research and pass it in the Senate during Health Week.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Ms. MURKOWSKI). The Senator from Utah.

Mr. HATCH. Madam President, I share the frustration of the distinguished Senator from Iowa about stem cell research, but I do believe the majority leader is committed to bringing it up, and I expect him to do that, I hope, within the near future.

But today I rise to speak in support of S. 22, the Medical Care Access and Protection Act of 2006, and S. 23, the Healthy Mothers and Healthy Babies Access to Care Act. I am a proud cosponsor of both bills.

These bills address the medical liability and litigation crisis in our country, a crisis that is preventing patients from receiving high-quality health care or, in some cases, any care at all because doctors are being driven out of practice. This crisis is limiting or denying access to vital medical care and needlessly increasing the cost of care for every American.

This issue is much more difficult to assess than just studying physicians who leave practice. The more important issue is how physicians are changing their mode of practice and financial structure in response to increasing costs from medical malpractice insurance premiums.

As many know, this crisis began when obstetrician/gynecologists started getting out of the obstetric care business. Unfortunately, it has now progressed to almost all medical specialties, limiting high-risk/low-return activities, such as emergency room coverage, to limit exposure. Just last week, the RAND Corporation reported that over 70 percent of emergency rooms in this country do not have adequate physician staffing. And who ends up suffering the most as a result? Well, the patient does.

In a city such as Salt Lake, where there are academic medical centers, this results in patient cases shifting from lower cost community hospitals to the higher cost settings.

The chief operating officer of our University of Utah Hospital was in my office recently to discuss the impact of this problem on the financial stability of the hospital. He told us it is becoming increasingly difficult for his hospital to provide care to the poor and uninsured.

On the financial side, we are seeing physicians' practices modifying their financial structure and, in some cases, taking advantage of the fact that there is growing demand and diminishing supply in the physician world. Primary care physicians are creating upfront fees for services which also allow for reduced practice size. The bottom line is, lacking a different strategy for reimbursement and/or practice costs—a good part of which is driven by malpractice insurance—we are driving private physicians away from traditional settings. Instead, we are creating a trend that adversely affects physician access and supply and increases costs in other sectors of the health care environment.

The Utah Hospital Association president tells me that a major hospital system in Utah saw its malpractice premiums increase 300 percent in the last 10 years, while at the same time being continually recognized nationally for its outstanding clinical practice.

The time to act is now. This crisis is jeopardizing access to health care for many Americans. The medical liability crisis also is inhibiting efforts to improve patient safety and stifling medical innovation. Excessive litigation is adding billions of dollars in increased costs and reducing access to high-quality health care.

I am really deeply concerned that we are needlessly compromising patient safety and quality health care. We know that about 4 percent of hospitalizations involve an adverse event and 1 percent of hospitalizations involve an injury that would be considered negligent in court.

These numbers have been consistent in large studies conducted in my home State of Utah, New York, California, and Colorado, just to mention 4 States. However, the equally troubling statistic is that few cases with actual negligent injuries result in claims and less than one-fifth—that is 17 percent—of claims filed actually involve a negligent injury.

This situation has been likened to a traffic cop who regularly gives out more tickets to drivers who go through green lights than to those who run through red lights. Clearly, nobody would defend that method of ensuring traffic safety. And we should not accept such an inefficient and inequitable method of ensuring patient safety. These numbers are a searing indictment of the current medical liability system.

I believe we can do better for the American people. The two bills before us are important steps in that path.

The problem is particularly acute for women who need obstetrical and gynecological care because OB/GYN is among the top three specialties with the highest professional liability insurance premiums. This has led to many leaving their practices, thus resulting in a shortage of doctors in many States, including my home State of Utah.

Studies by both the Utah Medical Association and the Utah Chapter of the American College of Obstetricians and Gynecologists, often called ACOG, underscore the problem in my State. Over half—50.5 percent—of Utah family practitioners have already given up obstetrical services or never even begun the practice of obstetrics at all.

Of the remaining 49.5 percent who still deliver babies, 32.7 percent say they plan to stop providing obstetric services within the next decade. Most plan to stop within the next 5 years.

An ACOG survey revealed that over half—53.16 percent—of OB/GYNs in Utah have changed their practice. They are retiring, relocating, or dropping obstetrics because of the medical liability reform crisis. This change in practice leaves 1,458 pregnant Utahns without OB/GYN care.

The medical liability crisis, while affecting all medical specialties and practices, hits OB/GYN practices especially hard. Astonishingly, three-quarters—76.5 percent—of obstetrician/gynecologists report being sued at least once in their career. Indeed, over one-fourth of OB/GYN doctors will be sued for care given during their residency. These numbers have discouraged Americans finishing medical school from choosing this vital specialty. I know this is the case in my home State of Utah.

Currently, one-third of OB/GYN residency slots are filled by foreign medical graduates, compared to only 14 percent one decade ago. That is one-third to 14 percent. OB/GYN doctors are particularly vulnerable to unjustified lawsuits because of the tendency to blame the doctor for brain-injured infants, although research has proven that physician error is responsible for less than 4 percent of all neurologically impaired babies.

Ensuring the availability of high-quality prenatal and delivery care for pregnant women and their babies—the most vulnerable members of our society—is imperative. We need to pass this legislation.

An August 2003 GAO report concluded that States that have enacted tort reform laws with caps on noneconomic damages have slower growth rates in medical malpractice premiums and claims payments. From 2001 to 2002, the average premiums for medical malpractice insurance increased about 10

percent in States with caps on noneconomic damages. In comparison, States with more limited reforms experienced an increase of 29 percent in medical malpractice premiums. Overall, the situation has gotten worse. In 2004, malpractice insurance costs increased 55 percent; in 2005, 34 percent; and in 2006, 18 percent. That is 107 percent in just 3 years. Now, under anybody's measure, that is an unfair cost for physicians to bear for a system that does not achieve the goal of either rewarding the most injured patients or improving the safety and quality of health care.

Medical liability litigation directly and dramatically increases health care costs for all Americans. In addition, skyrocketing medical litigation costs indirectly increase health care costs by changing the way doctors practice medicine.

Defensive medicine is defined as medical care that is primarily or solely motivated by fear of malpractice claims and not by the patient's medical condition. According to a survey of 1,800 doctors published in the journal, Medical Economics, more than three-quarters of doctors believed they must practice defensive medicine. A study of defensive medicine conducted by the current director of the Centers for Medicare and Medicaid Services, Dr. Mark McClellan, before he took office used national health expenditure data and showed that medical liability reform had the potential to reduce defensive medicine expenditures by $69 billion to $124 billion in 2001, an amount that is between 3.2 and 5.8 times the amount of malpractice premiums. That amount would be significantly greater today

The financial toll of defensive medicine is great and especially significant for reform purposes as it does not produce any positive health benefits. Not only does defensive medicine increase health care costs, it also puts Americans at avoidable risk.

Now, there is good defensive medicine and there is bad defensive medicine. But the vast majority of defensive medicine is extra defenses in order to have the history of the patient show the doctor did everything in his power. Frankly, that leads to more and increased costs every time the doctor has to do extraordinary analyses just to make sure his history has everything he possibly can think of in it, even though that is very seldom necessary.

Nearly every test and every treatment has possible side effects. Thus, every unnecessary test, procedure, and treatment potentially puts a patient in harm's way. Seventy-six percent of physicians are concerned that malpractice litigation has hurt their ability to provide quality care to patients.

What can we do to address this crisis? The answer is plenty. And there are excellent examples of what works.

HHS has reported how reasonable reforms in some States have reduced health care costs and improved access to and quality of care. More specifically, in States with limits of $250,000 to $350,000 on noneconomic damages, premiums have increased at an average of just 18 percent compared to 45 percent in States without such limits.

California enacted the Medical Injury Compensation Reform Act, also known as MICRA, more than a quarter century ago. MICRA slowed the rate of increase in medical liability premiums dramatically without affecting negatively the quality of health care received by the State's residents. As a result, doctors are not leaving California.

Furthermore, between 1976 and 2000, premiums increased by 167 percent in California while they increased three times as much—505 percent—in the rest of the country. Consequently, Californians were saved billions of dollars in health care costs and Federal taxpayers were saved billions of dollars in the Medicare and Medicaid Programs.

Before coming to Congress, I litigated several medical liability cases as a defense lawyer. I have seen heart-wrenching cases in which mistakes were made. But, more often, I have seen heart-wrenching cases in which mistakes were not made and doctors were forced to expend valuable time and resources defending themselves against frivolous lawsuits. And the vast majority of these suits are frivolous.

An Institute of Medicine report, ''To Err Is Human,'' concluded that ''the majority of medical errors do not result from individual recklessness or the actions of a particular group—this is not a 'bad apple' problem. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them.''

We need reform to improve the health care systems and processes that allow errors to occur and to identify better when malpractice has not occurred.

The reform that I envision would address litigation abuses in order to provide swift and appropriate compensation for malpractice victims, redress for serious problems, and ensure that medical liability costs do not prevent patients from accessing the care they need.

So we need to move ahead with legislation to improve patient safety and reduce medical errors.

Without tort reform, juries are awarding astounding and unreasonable sums for pain and suffering. A sizable portion of those awards goes to the attorney rather than the patient. The result is that doctors cannot get insurance and patients cannot get the care they need.

All Americans deserve the access to care, the cost savings, and the legal protections that States like California and Texas provide their residents. Today's bills will allow us to begin to address this crisis in our health care system, give our citizens, especially women and their babies, access to OB/GYN doctors, and enable physicians to provide high-quality, cost-effective medical care.

So I strongly support this legislation and urge my colleagues to support cloture on the motion to proceed.

I yield the floor.

The PRESIDING OFFICER (Mr. ENZI). The Senator from Alaska.

Ms. MURKOWSKI. Mr. President, I appreciated the opportunity to listen to the statement of my colleague from Utah and hearing of the effects that medical malpractice liability costs are having in his particular State. I think all of us in this body could stand on the Senate floor and discuss what is happening in our respective States and in our respective regions as we look at how medical malpractice issues are affecting access to care and access to quality physicians.

Truly, across the Nation, emergency departments are losing staff. Critical services are being cut and even trauma units being closed. One in seven obstetricians has stopped delivering babies. Countless surgeons are no longer performing high-risk procedures. You have to stop and ask the question: What has happened? What has caused this breakdown in our Nation's medical liability system?

Skyrocketing medical liability rates are forcing so many of our doctors across the country to stop practicing medicine. It is the millions of patients around the country who suffer when this happens.

In the State of Alaska, where our patients, my constituents, live throughout some 586,000 square miles, the situation is chilling. It is a crisis. We have 25 to 30 percent fewer physicians than our population needs. In fact, Alaska has one of the smallest numbers of physicians per capita in the United States. We need a minimum of 500 more doctors just to be at the national average of physicians per capita.

An American Medical News article recently declared Alaska's precarious situation by stating that ''Alaska has long ranked among the worst states in terms of physician supply.'' Just recently, we learned about new deployments with one of our medical units in the Anchorage area coming out of Elmendorf. We have had a recent deployment of Alaskan military physicians and health care providers, and this month we are losing over 60 health care providers. So the few civilian physicians we have in the area are being asked to absorb some 5,400 military and military families into their already strained practices.

In certain of the physician specialties, the shortages there are at even worse levels.

For example, we all know Alaska is a huge State, a State larger than Texas, California, and Montana combined. Envision that area. We have lost half of our internists. Over one-half of the internist population is now gone from the State of Alaska. And, in Alaska, a State where we have the highest rate

of traumatic brain injury in the Nation, we have three neurosurgeons for the entire State. Where do you go? You have to go outside, you go to Seattle. But you have to leave the State for that medical care.

In Nome, a town in western Alaska where my mother was born, there are no anesthesiologists. Nome is the regional hub in the Northwest. There are no anesthesiologists. So if you are a woman who is delivering a baby and the condition requires that a C-section be performed, you can't have the C-section done in Nome because there is no anesthesiologist. You have to get on a jet and fly an hour and a half to Anchorage. These are the situations we deal with in Alaska on a daily basis.

Many of these physicians were forced out of practice because they could no longer afford their medical liability premiums. Our physician shortage crisis was a key reason that medical liability reform was so important to Alaska. It was last May, as the legislature concluded its business, as they are doing this week, that the Alaska State Legislature passed a medical liability reform bill. Like the bills currently before the Senate, the Alaska bill fully compensates a patient for all quantifiable damages, such as lost wages and all medical and future medical costs. And like the legislation we have before us, the Alaska law places reasonable limitations on unquantifiable, noneconomic damages.

The American Academy of Actuaries has stated that placing limitations on unquantifiable, noneconomic damages is ''imperative in stabilizing the physician professional liability insurance marketplace.''

Our hope with the new legislation is that the Alaska law will provide equitable and predictable settlements in medical injury cases resulting in a more stable, professional liability insurance marketplace and, most importantly, it will help us with the recruitment of physicians to fill the chronic shortage.

I am happy to report that our medical liability reform does appear to be working. Ketchikan General Hospital, for the first time in years, has been able to recruit two new physicians. We have an internist and a general surgeon. For the first time also in years, I am told, their medical liability premiums have not increased.

Additionally, the Mat-Suu Valley has been able to recruit a cardiologist and Anchorage has finally been able to recruit a reconstructive surgeon. Both of these physicians fled their states that were in ''liability crisis'' and moved to Alaska where reform has been enacted. This is good news.

However, this is an issue that has national implications. That is why we in Washington must act now. The bills before the Senate, S. 22 and S. 23, are based on a fair and commonsense approach that passed in the State of Texas. As a result of the Texas law, physicians are returning to that State, particularly in the underserved specialties and counties. Insurance premiums to protect against frivolous lawsuits have declined dramatically, with the State's largest carrier reporting declines of up to 22 percent and other carriers reducing premiums by an average of 13 percent. The number of lawsuits filed against doctors has been cut almost in half.

Too many lives around the Nation are threatened or lost because good, quality physicians are forced out of their practice. A majority of the American public supports medical liability reform and ending lawsuit abuse. It is time that the Senate passed effective medical liability reform. I am pleased we are at that juncture today.

I see the chairman of the HELP Committee. He has done a great job on so many of these issues.

I yield the floor.

The PRESIDING OFFICER (Mr. SESSIONS). The Senator from Wyoming.

Mr. ENZI. Mr. President, I thank the Senator from Alaska for her kind comments. I want to make a few comments about medical liability, and then I want to talk about a bill for which we will be voting tomorrow morning on the motion to proceed. There is not much debate time on that so I will try to work in about 5 minutes on it and hope that that will convince everybody it needs to be debated. That is all we are going to be voting on, whether we ought to debate it at all.

First, I want to read a little bit from a book entitled ''Fixing Our Broken Health Care System.'' It was written by Senator Charles Scott, a State Senator from Wyoming. He has been the chairman of the Labor, Health, and Social Services Committee for many years. He was chairman of that committee when I served. He writes in his book:

> We in Wyoming are having the problem in one of our communities right now. In 2003 the doctors in Newcastle quit delivering babies. The community is small and the doctors each were delivering between 20 and 25 babies a year. At that rate their malpractice insurance costs had risen to over $1,000 per delivery.

He does the math to show what the difference would be between obstetrics and family health, and divided it by the 20 babies.

> Roughly half of their deliveries are paid for through the state Medicaid program which pays $866.25 per delivery for a normal . . . delivery; the payment increases to $1,401.87 if normal prenatal and post-partum care is provided.

The cost for them is $1,317, and the most they can get is $1,401.87. Usually you get $866. You can see where they are losing money before they pay rent, before they pay the nurses, before they pay themselves a dime. They couldn't raise their private rates because in that community most young couples starting a family couldn't afford a higher rate, and too many were not covered by insurance.

> The economics were clear—the doctors were losing money with each delivery. They dropped the obstetric part of their practice, and now a woman in Newcastle has to be driven 73 miles to Gillette, Wyoming, or 80 miles to Rapid City, South Dakota, to have her baby delivered by a medical doctor.

You have to remember that we get a little bit of snow out in Wyoming sometimes, which can make that journey a little bit hazardous because there is a lot of cost to traveling 73 or 80 miles to have your baby, and probably cuts into the prenatal care.

I want to devote the remaining couple of minutes I have to talking about the bill we will vote on tomorrow morning with hardly any debate. It shouldn't hardly take any debate because the motion that we will be debating is whether we are going to debate a bill that will provide health care for small businesses across this Nation, that is supported by over 200 small business associations that recognize that there are about 22 million employers and employees out there who are uninsured because they can't afford it. This bill is designed to give them access to insurance. They have none right now. They recognize what they need to be able to do is ban together across State lines with their association to have enough clout to negotiate with their insurance carrier so they can get a lower rate.

But what we are talking about now is cloture on a motion to proceed. That allows for about 3 days' worth of debate, normally, before you get the vote. Then when you have the vote, you devote another 30 hours to deciding whether you are going to debate the bill or not. I am hoping the other side will see the need not to have this vote. I know they are hearing from their small businessmen. Everybody knows that small business is the backbone of the U.S. economy. If they have looked at the polls, they have found that 89 percent of the people in the United States, even after hearing the disadvantage of the old AHP form of this legislation, which is not this legislation, even after hearing those disadvantages, 89 percent said this legislation was needed to save small businesses.

We shouldn't be taking a needless vote. I am hoping it will be vitiated in the morning, and we will go ahead with the debate so people can see where the bill is going to go. I have never seen so much money spent in opposition to a bill before there was even permission to debate it. And neither have all the people who called me from Wyoming, other places in the United States, and in the District. You may have heard ads that said: Stop ENZI.

It isn't stop ENZI. It is keep small business from being able to get reasonable insurance. That shouldn't happen before a debate. That kind of thing sometimes happens when a bill is coming out of conference committee, after it has been amended on the floor of the Senate, after it has been amended on the floor of the House, after the two sides have gotten together and said: Is

there a solution on which we can agree?

If they agree on something that is radical, then this kind of action is usually done, not when we are talking about whether we ought to debate it, whether we ought to amend it, where it ought to go, where it can go, and what can be done. This bill needs to be voted on after a debate, not stopped from having a debate.

The NFIB collected 500,000 petitions asking for us to debate this bill. It isn't the same bill that we have been talking about before, the bill that the House has passed eight times in the past. This is a different bill. I got the insurance companies and the insurance commissioners to sit down with the associations and talk about a fair way of maintaining State control and maintaining consumer oversight at the State level. I have to say there are a lot of rumors out there. That is partly what PBS did. They reported a bunch of assertions without verification.

We are trying to get that corrected now. But I have never seen a bill that generated so much opposition before it was even debated. I hope we will cut that out and go ahead and vitiate the cloture motion so that we don't have to take the 30 minutes it is going to take to do that vote, and get right to the debate and start offering amendments and debate what can be done.

That is the process we ought to use. That is the process that we normally use. But I suspect there is a lot of money that can be lost if those small businessmen can actually negotiate against the insurance companies. I will get into that more when it is the appropriate time, not when we are talking about whether we ought to proceed on the bill at all.

I see that I have used my time. I yield the floor.

The PRESIDING OFFICER (Mr. ALLEN). The Senator from North Dakota is recognized.

Mr. DORGAN. Mr. President, today marks the start of what the majority leader has called Health Week in the Senate. We start today with two cloture votes because legislation has been brought to the Senate that deals with what is called medical malpractice, or ''medmal,'' reform. The bills we are being asked to consider have not been before a Senate committee, have not been a part of a committee hearing. They have just been brought to the floor of the Senate so we can have two cloture votes, both of which will fail. This is about someone wanting to cross a check off their list of what they feel they must do in the Senate. It hardly serves the opportunity to address serious issues. There is a way, for example, to address the issue of medical malpractice reform. But it is not this way.

I must say, as I said the other day, there are challenges in this area, but I think the way to address the challenge of medical malpractice is not to decide that victims of medical malpractice should not be given the opportunity to seek redress. That doesn't make any sense to me.

Mr. President, there are many things we can and should talk about this week, if this is, in fact, Health Week. When the cloture votes are held later in the afternoon—and both will fail—then my understanding is that we will go to the legislation offered by the Senator from Wyoming. It is further my understanding that the leader will what is called ''fill the tree''; that is, we will be on that legislation, but we will not be able to offer any amendments.

Let me talk about a couple of things. I came to the floor to talk about, during Health Week, the need to deal with something called stem cell research. I know that is a controversial issue. But it is one I think the American people deserve to have the Congress address and deal with. Almost 1 year ago—May 24, 2005, to be exact—the U.S. House of Representatives passed their Stem Cell Research Enhancement Act with broad bipartisan support. It will expand the number of embryonic stem cell lines eligible for Federal funding.

Back in July of 2005, the majority leader in the Senate made a speech and he outlined his support for expanding the number of stem cell lines available for research. He pledged to bring the issue to the floor of the Senate at some point during this Congress. If this is the week we are going to be dealing with health care in the Senate, I encourage the majority leader to set aside time for an open and fair debate on stem cell research.

Embryonic stem cell research holds great promise for addressing some of the devastating diseases that we face—diabetes, Alzheimer's, Parkinson's, heart disease, cancer. To shut off or limit medical research is an unbelievable mistake for this country. I, like many others, have lost loved ones to disease. When I lost a daughter to heart disease, I decided that I would never try to placate one group or another by stopping promising research to try to address diseases that people all across this planet face.

Embryonic stem cell research is so unbelievably promising. This is not just about some ethereal debate, it is about real people. We have about 400,000 embryos frozen at in vitro fertilization clinics, and 8,000 to 11,000 of them are thrown away every year. Yes, 8,000 to 11,000 fertilized embryos that are frozen at the IVF clinics are just discarded, put in a trash can called ''medical waste.'' Would they not better be used to advance medical research? One million babies have been born in this world by in vitro fertilization. It started in England, called the ''test tube baby.'' One million babies have been born.

When we had a hearing in the Commerce Committee about stem cell research, one of the witnesses was asked the question—in fact, I asked the question. He opposed in vitro fertilization. He said it should not happen.

I said: Do you think those 1 million people who were born that way should not have been born?

He didn't think they should have been born; it was wrong. There are 1 million people living among us that are here as a result of in vitro fertilization. At the clinics where IVF takes place, the egg and sperm are united in a test tube and fertilized in a petri dish for the purpose of implanting in a woman's uterus and growing a baby. They produce far more embryos than they need. As a result, you have in storage about 400,000 embryos—400,000—of which 8,000 to 11,000 each year are simply discarded.

President Bush and others have decided that they shall not be used for stem cell research. I am not talking about the stem cell research in which a cell is cloned. That is called somatic cell nuclear transfer. I will talk about that in a moment. I am talking about embryos that are going to be thrown in a waste can and discarded. This Administration and too many in this Congress believe these discarded embryos cannot and should not ever be used for embryonic stem cell research.

Let me put a face to this issue and hold up this picture. This is a young woman I met with recently. This is a picture of Camille Johnson. She is in the middle. She plays the clarinet in the middle school band. I have met Camille and her mother several times. She is a volunteer with the Juvenile Diabetes Research Foundation. She gave me something that I keep in my office. This is to describe what this young girl goes through with diabetes—and I will describe why I am talking about diabetes.

This young lady has had some very close calls and serious hospitalizations with her diabetes. It is very aggressive. She is poked with a needle every day at 7 o'clock, 11 o'clock, 5 o'clock, and 8 o'clock—1,460 pokes with a needle to test her blood every single year. She receives 1,095 shots every year. She has to watch her diet every day. If she does not keep her diabetes under control, the complications are amputation, blindness, kidney failure, heart failure, and death.

Why do I describe that? Because there is remarkable research going on to use stem cells to treat diabetes. The work that has been done in the transplant of islets to the pancreas is unbelievably important work. Yet we are told that much of this work cannot continue with Federal funding. Stem cell research has shown such great promise. For example, in spinal cord injuries, stem cell research has allowed disabled rats with damaged spinal cords to walk again. It has relieved diabetes and Parkinson's disease symptoms in mice. It has developed heart cells, eye cells, and nerve cells. I was told of a researcher who described, I believe, two dozen mice in which researchers induced severe heart attacks. They injected stem cells back into the heart muscles of those mice, and a couple of weeks later nearly all of the

mice not only didn't show severely damaged hearts, which they had after a heart attack, but they showed no damage to their hearts at all. So there has been unbelievable progress with stem cell research.

Yet we are told by some that research should not go forward. Let me describe for a moment some of the other areas, in addition to embryonic stem cell research, that are so controversial: The issue of taking one skin cell from one's ear lobe, for example, and putting it into an evacuated egg. The skin cell is stimulated to create a blastocyst, or cluster of cells, 100 to 200 cells. Those cells can eventually be injected back into your own heart muscle. There has been no fertilized egg. It is simply your own skin cell that has been stimulated to reproduce. Yes, it creates an embryo, but there is no fertilized egg. It creates an embryo that will never become a human being.

We are told by some that is murder; you have destroyed an embryo. No, this is about life, about saving lives. Those who want to shut down these promising areas of research, in my judgment, are just dead wrong.

The last campaign I ran for office, the first two television commercials that were run by my opponent—the first was about gay marriage, that I voted against amending the U.S. Constitution to prohibit gay marriage. I can hardly think that George Washington, Thomas Jefferson, Ben Franklin, Mason and Madison, as they looked at what they had created as a Constitution, would think: What have we missed here? We need to put something in about gay marriage. I don't think that belongs in the Constitution.

The first commercial was of two men kissing, with the message you would expect from the extremists. The second commercial was about a campfire leader sitting around a campfire at night with little kids sitting around gathered in front of him. ''Tell us a scary story,'' the little kid said. Then the campfire leader said, ''Well, there is a man named Byron''—referring to me, I guess—''and he has a plan to implant embryos into mommies' uteruses, wombs, and harvest them later for body parts.''

That is an unbelievably ignorant television commercial, but that commercial was born of an attempt to distort my position on the issue of stem cell research.

I am not interested in harvesting body parts. I am not interested in the discussion about murdering embryos. I am interested in a discussion about saving lives and about continuing the kind of promising research that exists that might unlock the mysteries of Alzheimer's disease, might provide a cure for Parkinson's, for diabetes, or heart disease.

I am not suggesting there are not some ethical considerations that need to be made with respect to how we do it, and I don't suggest we should discard those issues. But I am suggesting that a country that shuts down that research has made a horrible mistake. My point in coming to the floor was, if this is Health Week, then let's talk about health issues, about the Indian Health Care Improvement Act that has been stranded. Let's talk about that and bring it to the floor and vote on it.

No group of Americans has more difficult health issues to face than Native Americans. Let's talk about that on the floor of the Senate.

Let's vote on the proposition the majority put in the prescription drug bill that prohibits the Federal Government from negotiating for lower drug prices with the pharmaceutical industry. Let's have that on the floor and vote on that. There are half a dozen of those issues. But I speak today about stem cell research. If we are going to be serious about health care and have a health care week, then we ought to talk about this issue.

The House of Representatives has already passed a bill. The majority leader said we would have a bill on the floor of the Senate, and it appears at this point that we will head toward the end of this session, despite the fact there is bipartisan support for legislation that will deal with stem cell research in the appropriate way.

I understand this is a serious issue. I don't dismiss the concern of others, nor do I accept, however, that this is somehow a discussion about murder. This is a discussion about saving lives. It is a discussion about finding cures to devastating diseases. This country ought to be in the lead when it comes to research that can provide cures for diseases. Stem cells provide much of that opportunity.

This young girl, Camille Johnson, deserves to have the opportunity to have the very best treatment available. Some of that will come from stem cell research. And perhaps we will find a cure for diabetes. Perhaps Camille Johnson will not live her life as a diabetic. Maybe through stem cell research we will find this cure and one day she won't have to take shot after shot to provide her body with sufficient insulin for her to live. Let's hope that is the case.

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

The PRESIDING OFFICER (Mr. ALLARD). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, I rise this afternoon to voice my concern about the current debate we have begun on the floor of this body. This is the fourth time that we in this Chamber have devoted floor time for legislation to restrict the rights of those injured by medical malpractice. Once again, this bill is being considered without any committee consideration whatsoever, without any hearings examining this question, and without any attempt to enter into meaningful negotiations with the minority over our very legitimate concerns about this legislation. So to begin with, we are going to take a week of the Senate's time to debate a piece of legislation which has not been considered by committee, has had no hearings and no effort to try to reach any kind of a compromise position on critical legislation dealing with medical malpractice.

I have always believed that the best public policy comes out of consensus, when we work together as Democrats and Republicans, not when one side tries to dictate to the other exactly what we are going to have to accept or reject. By bringing together a broad coalition of people, we can and have on many occasions enacted laws and made sure they work as they ought to. Yet, too often these days, we are seeing tactics meant to divide rather than to reach any kind of consensus at all—tactics, in my view, which have no place in our system of governance and which will undoubtedly lead to bad public policy, if any public policy at all.

I come to this medical liability debate with no prejudgments about the merits of the claims of those who support this legislation. I have never shied away from legal reform when warranted, and most of my colleagues know this. In the past, I have supported reform to class action litigation, securities litigation, asbestos litigation, Y2K litigation, and the list goes on. In each and every one of those instances, I worked with Republicans and other Democrats to fashion compromise consensus legislation. We did it on class action, we did it on asbestos, we did it on securities litigation, and I was pleased to do it with my colleague from Utah, Bob Bennett, on Y2K legislation. Yet on this occasion dealing with medical malpractice, no effort is being made at all to reach any consensus. No hearings, no committee work, just take it or leave it with legislation that is seriously flawed.

I have also opposed legal reforms when I believed it was unwarranted, such as reforms that effectively inoculate gun manufacturers and sellers from essentially any and all liability, and I say that as a Senator representing a State with the largest number of gun manufacturers in the United States, and one of the largest gun manufacturers in the world. They are wonderful people. I respect them immensely. But the idea that we would take an entire industry and excuse it even from the worst kind of negligence made no sense to me whatsoever.

A recent proposal to shield vaccine manufacturers from responsibilities for the safety and effectiveness of their products was something I opposed as well, since it made no sense to me whatsoever.

The two bills we are going to consider this week—one to cap noneconomic damages for all medical malpractice cases and one to cap damages in cases involving women and children—fall into the latter category. These are unwarranted proposals, they are unfair, and they are terribly unwise.

I could quote facts to let my colleagues know how troubled I am about these proposals. The point is very simple. The pillars upon which the supporters of this legislation rest their arguments are deeply flawed. As we heard our colleague from New York, Senator Pat Moynihan, say on numerous occasions: Everyone in this Chamber is entitled to their opinions, but they are not entitled to their own set of facts.

The facts here are very clear. The fact is the magnitude of this crisis regarding medical malpractice has been drastically overstated. The number of physicians in the United States increased from 814,000 to 885,000 between the years 2000 and 2004, and the number of OB/GYNs increased from 40,000 to 42,000 in the same period, while the birth rate was in decline in many States.

What we normally hear is we are losing physicians, people are leaving the profession, OB/GYNs are packing up and moving on to other professions. The fact is there are more OB/GYNs today than there were in the year 2000.

We should be looking to rein in health care costs, but the supporters of this proposal are looking in the wrong place, in my view. The fact is, liability premiums account for less than 1 percent of health care costs. Let me repeat that. Liability premiums account for less than 1 percent of health care costs, and yet, when we hear this debate this week, we will hear numbers that bear no relationship to the facts.

The fact is that the number of claims and the value of jury awards have not spiked, as some suggest. Between the years 2001 and 2004, the number of claims filed actually decreased by almost 14 percent, and the amount that defendants and their insurers are paying for medical malpractice claims, including jury awards and settlements, has not increased in relationship to medical inflation.

The fact is that those States which have adopted caps have seen greater increases in premiums than States without caps. Let me repeat that. In those States which adopted caps, they have seen a greater increase in premiums than States without caps. Seven of the 10 States with the highest premiums already have caps. In 2003, premiums actually increased by 17.1 percent for OB/GYNs in States with caps, compared to a 16.6-percent increase in States without caps on these awards. In 2004, the average premium for physicians in States with caps was $46,733. The average premium in States without caps was $42,563. So, if anything, the evidence suggests the caps on patient damages actually correspond to higher insurance premiums for doctors.

Again, these numbers are high. Premiums that are $46,000 or $42,000 are extremely large. But if we are going to address the problem, then we ought to address the cause of why these premiums are so high.

I could continue to quote a number of these facts to underscore my point, but I think the point is very simple. Again, the facts which the supporters of this bill rest their arguments on are flawed. Again, they are entitled to their opinions but not their facts.

The number of practicing physicians is on the rise. The number of medical malpractice claims is actually falling. The amount of awards to victims actually lags behind inflation. Malpractice premiums in States with caps are higher than in States without caps. Those are the facts. And based on this evidence, we are being asked to limit the rights of injured patients. The facts fail utterly to dictate such a conclusion, in this Senator's opinion.

But if neither the number of claims nor the amount of malpractice awards can explain rising premiums, then what is the explanation? What is going on? According to several analysts, the increase in premiums does, in fact, correlate with fluctuations in the stock market and interest rates.

One recent study showed premiums closely tracked insurers' economic cycles. During good economic times, insurers slashed premiums to attract as much business as possible. This is because every new policy brings in an additional so-called float, money to invest in a booming market. However, when the market turns, the investment returns are weak, as has happened in the last few years, and insurers raise their rates or, in some cases, leave the market altogether. When this happens, of course, the result is often a crisis in the availability and affordability of insurance. This is what we have seen over the past several years. In fact, with markets showing some improvement, the evidence suggests today that premium increases are slowing dramatically.

The idea of placing caps on noneconomic damages is also unfair. One of the bills we are considering today seeks to limit the legal rights of a very specific segment of our society, and that is women and newborns.

It is important to remember that this bill is going to affect those who have actually been injured by malpractice. This is not just anyone who has a bad outcome, but malpractice. An individual has been accused of malpractice. A jury has already decided that they are eligible to collect noneconomic damages, that malpractice has occurred. Somebody has messed up terribly and caused a woman or a child to suffer. That conclusion has been reached. Now we are saying we are going to put a cap on that damage and limit it only to economic damages. We are essentially telling women and infants that their injuries and the suffering they experience as a result are not worth as much as the injuries and suffering of other people in this country.

We are going to single out women and children for special consideration, and that is to say: You have been damaged because of malpractice, and here we are going to make it almost impossible for you to collect any damage beyond economic damages.

Furthermore, these bills do not take into account the extent of injuries and the costs thereof. As a result, they will hurt the most seriously injured, those who might receive a noneconomic damage of more than $250,000 were it not for this arbitrary cap.

Finally, this legislation is terribly unwise, in my view. Reasonable litigation provides accountability. When health care providers make mistakes, they should be held accountable. Placing a cap on noneconomic damages simply removes the incentive for the health care system to improve quality and patient safety, and it does so with no guarantee that there will be any reduction in doctors' medical malpractice premiums. In fact, time and time again, insurance companies have refused to commit to lowering premiums, even if a cap is enacted.

Last year, for instance, a spokesman for the American Insurance Association said:

> We have not promised price reductions with tort reform. Six months after Texas enacted a cap like the one we are debating here today, one insurer in that State tried to raise premiums by 19 percent, arguing that noneconomic damages are a small percentage of total losses paid. Capping noneconomic damages would show lost savings of 1 percent or less.

I just have a few more comments to make on this issue. I realize I am extending my time. I see my colleague from Kentucky and my colleague from Tennessee are here. Let me just wrap up, Mr. President, and take a minute, if I can.

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

Mr. DODD. There are other things we need to be doing. Information technology in health care would be a major step forward. I have supported almost every major tort reform piece of legislation here in the last 10 years. I have done it on securities litigation reform. I did it on class action. I was willing to do it on asbestos and on Y2K legislation. In all of those cases, we worked out compromises to make sure that what we were doing would make sense.

This bill makes no sense whatsoever. The facts show that there is no justification for moving in the direction we would be with this piece of legislation. I urge my colleagues to reject this proposal and come back with a piece of legislation that really would make a difference.

If we really want to reduce these kinds of costs, there are steps that can

be taken to allow us to do it. But with this bill, the number of doctors is increasing, the number of OB/GYNs is increasing. States with caps are watching premium costs go up, and States without caps are watching premium costs go down—the exact reverse of what we are claiming we would accomplish with this legislation. The details of my statement make that clear.

Again, you are entitled to your opinion but not facts. The fact is, we are going in the wrong direction with this bill. I urge my colleagues to step back, allow for some hearings to go forward, allow for people to sit down and look into things as we did with class action, as we did with Y2K and asbestos litigation. With those bills, we put together and produced good legislation. This bill is nothing like that and does not deserve to be on the floor without that kind of work.

Mr. President, I yield the floor.

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

Who seeks recognition?

Mr. ALEXANDER. Mr. President, I ask unanimous consent to speak as in morning business for 2 minutes.

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

(The remarks of Mr. ALEXANDER and Mr. AKAKA are printed in today's RECORD under ''Morning Business.'')

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. SANTORUM. Mr. President, I am here today to stand in strong support of S. 22 and S. 23. I do so as a Senator from Pennsylvania representing a State that has been racked by the consequences of having a tort liability system that is simply out of balance, out of whack. That imbalance is causing real tragedies to occur on a daily basis in the Commonwealth. People are not getting access to the kind of care they deserve because, as I will lay out in great detail, physicians are leaving the State and hospitals are closing down because of the cost of awards, in particular in areas that serve high-risk patients in some of our communities where there are underserved populations, whether they are inner city or very rural. Patients are not getting access, whether it is to neurosurgery or high-risk obstetrics or orthopedic care and other types of high-risk specialties, and physicians are leaving areas in our State, both rural and urban, because of this liability crisis.

I had hoped that the Commonwealth itself and our State legislature would have responded to this problem. They have tried on a couple of occasions, and the Governor has vetoed legislation to make that happen, and so we are here today to try to solve this problem on a national level.

I believe that while Pennsylvania is severely impacted, probably as much as any State in the country, this is a problem which has national impact. It impacts the Medicare and Medicaid system which this Congress and which the Federal Government pay for. So I do believe it is appropriate for us to consider it.

I wish to make sure that folks understand what we are trying to accomplish. I have had people come to me on more than one occasion and ask questions about why we are trying to limit people's right to sue. No. 1, we are not limiting anybody's right to sue. People can sue a physician or a hospital or a drug company or anybody else in the health care arena. They can sue as many times as they want and as often as they want and for as much as they want. The only thing we are attempting to do as far as a limitation in this bill is to limit the award in one category of damages.

There is, of course, more than one category of damages allowed in most liability suits.

Certainly there are economic damages allowed for income loss, so that if you lost income as a result of the injury you incurred, you have lost the ability to earn future income or some portion of future income, that is fully recoverable. If you have medical bills in the past or going forward—for example, let's say you were left without the use of an arm or maybe you ended up in a wheelchair as a result of medical malfeasance on the part of a provider—there is no limit on the amount of medical recovery you could have. Nothing in the bills we are looking at limit recovery in those areas whatsoever. There are also punitive damages that are available. Punitive damages are damages against someone who does something malicious or willful to harm you in the conduct of providing care, and there is no limit whatsoever on any punitive damages in this legislation.

All we attempt to do is take one category of damages, which is loosely known as pain and suffering, and try to put a cap on that; we try to quantify that. It is very hard to quantify it in the first place, but we are just trying to say that we want to put a cap on that. Why? Why would you want to put a cap on that? Because in some cases, you look at the harm that has been done to somebody and you say: Wow, I can't even think about how much pain or how much suffering or how that person's life has changed, and I would like to help. Well, the reason we need to put some sort of limitation on it is in order to strike a balance between the desire of our fellow citizens, through a jury or judge, to compensate someone for the injury they had in exchange for the costs associated to our society and to the medical system, which results in other people not getting care.

We can go to a recent conference I attended in Philadelphia where it was relayed to me that we have had I think it is nine maternity wards in the city of Philadelphia close down over the past few years—nine—one most recently in northeast Philadelphia and the last one in the most densely populated area of Philadelphia, an urban population, where the OB ward closed down. So if you live in northeast Philly, which is again the largest area population-wise in the city of Philadelphia, there are no hospitals to deliver babies. You have to come into the Center City area or the neighboring county to get obstetrical care. You have consequences. You have consequences of high-risk pregnancies where people do not get to the delivery room on time and mothers and children are harmed.

One of the reasons I have introduced S. 23, the bill we are going to have a cloture vote on later today in order to proceed, is, in fact, to say that this is of crisis proportion in my State, and even if we can't do a broader bill, let's try to do a narrower bill that deals with the issue of mothers and children to make sure there is care for those particularly vulnerable in our population.

I had an ER doctor in suburban Philadelphia tell me that just over the last couple of years, they have been able to document I think seven people who have shown up in emergency rooms in suburban Philadelphia with head traumas who were not treated because there were no neurosurgeons available on call. There just was no one to come. As a result, seven people are now dead who, had there been someone on call and available, without question would have lived. You ask the question: Who do the family members of those deceased people sue? The answer is they can't sue anybody. They get no recovery. They get nothing. Why? Because we have a system that rewards a very few—maybe justifiably. I am not arguing that their award isn't justifiable. I would probably argue for an enormous amount of money, depending on what the injury is. The question is, How do we balance that person's right to be compensated with another person's right in the future to get health care?

That is what this attempts to do: balance the rights of those who are injured with the rights of those who will be injured if we don't limit those first rights. We see that happening every day in Pennsylvania, and that is one of the reasons I feel so passionate about bringing this legislation to the floor and trying to attempt to do something here on the floor of the U.S. Senate.

What we do in trying to limit rights is actually different from what we have done in the past here. We try to limit the ability to recover—not the right to sue but the ability to recover—in some small way. It most cases, it will be a small way.

What this does is it provides certainty in the insurance market. Right now, you have a category of damages called pain and suffering. I think if you asked 100 people how much suffering—if you took a case and said: How much should this person be awarded for this much suffering, would you get 100 different answers. It is hard to insure against those 100 different answers about what a judge or a jury is going to do. So by putting a limit here, you are

then able to quantify for insurance purposes and allow insurance companies to offer reasonable insurance packages for physicians and hospitals, and you put physicians in—this is also important—you put physicians in a position where they are not simply practicing defensive medicine, which drives up the cost of health care precipitously.

The cap we are talking about here is a $250,000 cap on a physician, a $250,000 cap additionally on the health care provider, on the institution where the care is provided. If there is more than one institution, it is a total cap of $500,000, so two or more institutions could combine, for a total of $500,000. So it is a $750,000 total cap, which is three times what we voted on here last session of Congress.

So this is a much higher cap. I have said in the past, both on the floor and around my State, that I thought the $250,000 cap was a bit low, and I feel more comfortable with this cap, and it allows flexibility for the States to do something different. This just takes care of situations where there aren't any caps in place by the State.

So I think we have a situation where we have a bill that puts in a reasonable limitation on damages. Even though I certainly can make the argument that there may be cases where this would be a difficult limit, it is a balance between limiting somebody's recovery and making sure that by doing so, you have access to care for other people who will be harmed if we don't limit that recovery.

I want to talk about the situation specifically in Pennsylvania. This is a tragic situation that we have seen evolve over the past several years where the liability costs have just gone through the roof. We have a situation where, if you look between 1999 and 2005, the 20 most populous States saw a 15-percent to 35-percent increase in the number of Medicare physicians. In Pennsylvania we saw a 10-percent decline in the number of physicians available to treat Medicare patients.

The number of doctors in training who stayed in Pennsylvania? In Pennsylvania we are very blessed with a lot of great medical schools. We train a lot of physicians and train a lot of health care workers generally in Philadelphia and Pittsburgh and in between. Twelve years ago, in 1994, we had a rate of about 50 percent of all the physicians we trained in Pennsylvania stayed in Pennsylvania. Two years ago it was 7.8 percent. We went from 13th in the country, during this time, of the percentage of physicians under the age of 35—we were 13th in the country in the percentage of physicians under the age of 35. Today we are 45th in the country in the percentage of physicians under the age of 35. We have older and older doctors; fewer and fewer are staying. This is a crisis. It is horrible now. It is only going to get worse if we do not do something about it.

Why? If you look at it, the payouts have skyrocketed from $180 million in 1991 to $450 million 2 years ago. The average liability payout per physician—the average is $6,000 nationwide. It is $16,000 in Pennsylvania, almost three times as much. This is a serious problem in our State.

We are looking to Washington, DC, to help. They are saying just in a couple of years we could have a shortfall of nearly 10,000 physicians in the Commonwealth of Pennsylvania. So this is a pressing problem, one I hope we can get to.

Just allow us to bring up the bill, allow us to debate. Here we are, the greatest deliberative body in the world. We have a huge problem in my State, and I suggest we have others stand up and talk about the problem in their States. If you don't like the solution we have put forward, then let's have a debate. Let's have some amendments. Let's talk about how we can change the bill around to move it forward. But not allowing us to bring it up is not a reasonable alternative.

We have heard from folks in our State. This is a petition. We have gotten a whole bunch. I just wanted to reproduce one of the hundreds of petitions we have received, particularly focused on what is going on with our obstetrical care. These are citizens, in this case, from West Reading, PA, who said:

> Every day OBGYNs are closing doors because of America's medical liability crisis. Is yours next? We the undersigned are in favor of keeping women's health care availability and strongly urge Congress to enact meaningful legislative relief.

That is what we are trying to accomplish today. It is amazing, the effect of this on—I always say physicians, but it is health care professionals, not just physicians. ''One-third of residents''—

This is from the Department of Health Policy and Management in the Harvard School of Public Health. They did some surveys and talked to physicians out in our State. It says:

> One-third of residents in their final or next to last year of residency planned to leave Pennsylvania because of the lack of availability of affordable malpractice coverage. . . . Those who are about to leave Pennsylvania named malpractice cost as the primary reason three times more often than any other factor.

I met with a woman graduating from the University of Pennsylvania in thoracic surgery. She had a decision to make: to come to Washington DC, or stay in Philadelphia. She is from Philadelphia; her family is there. She wants to stay. The cost of malpractice insurance in Washington is $4,000 for her specialty. In Philadelphia, $40,000, 10 times the amount, plus the complexity of not being able to practice the medicine she wants to practice.

> Seventy-one percent of residency program directors reported a decrease in retention of residents in the state since the onset of the professional liability crisis. For some programs the decreases were very large.
>
> An environment of mounting liability costs in Pennsylvania appears to have dissuaded substantial numbers of residents in high risk specialties from locating their clinical practices in the state.

This is a serious problem. I am going to talk about it some more. We probably are not going to be successful today, but I will be back on the floor, not just today but in the future to continue to talk about this critical crisis that we have in our commonwealth. It is not just about making sure that we have reasonable malpractice rates. It is about access to care. It is about people who are going to be hurt and are going to die because we have not put this medical liability system in balance. We need to do so and it would be a great start if the Senate would allow us to proceed to that debate today.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, I commend the Senator from Pennsylvania for his observations, not only about the state of medical care access in Pennsylvania, but across the Nation. I would like to make some observations about the situation in Kentucky and across the Nation as well.

I am obviously here to support the Medical Care Access Protection Act. On several occasions in recent years this body has attempted to debate commonsense reforms to our medical liability system—a system that we all know is increasing health care costs and limiting patients' access to care.

Unfortunately, the minority party's obsession with obstructionism has prevented this body from even considering medical liability reform. But the problem of patients not getting the care they need is simply not going to go away on its own. The Senate needs to act, and act now.

Passing the Medical Care Access Protection Act would leave doctors free to go where the patients are, not just where the lawyers aren't. Let me turn briefly to the Commonwealth of Kentucky.

Like 20 other States across our Nation, we, in Kentucky, are facing a medical liability crisis. In past years, I have shared stories of doctors who left Kentucky, of hospitals that have closed their maternity wards, and of women who have been denied access to care because their doctors could no longer afford the medical liability premiums.

I wish I could tell my colleagues that I was out of such stories; that the problem had fixed itself. Unfortunately, that is not the case. The minority has not allowed this body to act, and the problem has not gone away. So today I would like to share a story that ran earlier this year in my hometown newspaper, the Louisville Courier-Journal, back on January 29.

> Rashelle Perryman's first two babies were born at Crittenden County Hospital in Marion, KY, about 10 minutes from her home. But her third child, due in June, is to be born in Madisonville, 40 miles away in Hopkins County, because rising malpractice insurance rates caused doctors at the Crittenden County Hospital to stop delivering babies last year.
>
> That forced the hospital to drop obstetrical services and Ms. Perryman to find a new doctor.

''I don't like it at all,'' she said about having to give birth in another county. She's a nurse at Crittenden County Hospital and its former obstetrics supervisor.

So she knows a good bit about the subject matter.

With Perryman's first two deliveries, ''I knew everybody here in the hospital, and I was comfortable,'' she said. ''And now I am going somewhere where I don't know anybody, or how anything's done.''

Ms. Perryman will have to travel a long 40 miles to deliver her child. Just to put her plight in perspective, 40 miles is about the same distance from the Capitol to downtown Baltimore. I know we will all hope for a safe delivery for Ms. Perryman, but what if there are complications along the way? Wouldn't it be better for both Ms. Perryman and her baby if they could still go to their local hospital, rather than driving 40 miles down the road?

Would any Member of the Senate want his wife, or his or her daughter, to have to drive as far as Baltimore in a similar circumstance?

Unfortunately, this is not an isolated problem within this one Kentucky community. Our Lady of Bellefonte in Ashland, KY, and Knox County Hospital in eastern Kentucky have also stopped delivering babies. They are not delivering babies anymore. Patients in west Kentucky who need the services of an emergency neurosurgeon frequently must be transferred to St. Louis or Nashville because there are not enough neurosurgeons to staff the hospitals in Paducah around the clock.

From 2000 to 2004, the number of practicing OB/GYNs in the country fell from 504 to 473. Among those OB/GYNs who have remained in the State, fewer and fewer of them are still willing to deliver babies. Even among those who are staying in the State, fewer of them are willing to deliver babies.

The American College of Obstetrics and Gynecology report that 18 percent of Kentucky OB/GYNs have stopped delivering babies entirely. Nearly one-third of OB/GYNs, 31 percent, have limited the number of ''high-risk'' expectant mothers they will see for liability reasons.

So even among those who are still willing to deliver babies, they are sort of preselecting the mothers based upon the riskiness of the procedure and parceling out those who are more risky to someone else or some other community or whoever will accept the liability potential.

The Kentucky Medical Association reviewed State and hospital records and found that only 426 doctors in Kentucky delivered babies last year. That is down 79 doctors from 1 year before.

Let me say that again. We have in Kentucky gone down to 426 doctors who delivered babies last year, down 79 from the year before.

As I have noted in the past, 66 of Kentucky's 120 counties have no OB/GYNs at all. The red counties on the map, all across my State, from east to far west—the red counties have no OB/GYNs at all; 66 out of 120 counties. Over half of our counties have no OB/GYNs at all.

What does this mean to the patients? I think it is rather obvious. It means that patients such as Ms. Perryman, on one of the most challenging but important days of her life, will need to travel far from home to deliver her baby.

This problem extends far beyond Kentucky's borders. In his State of the Union Address this year, President Bush noted that 1,500 American counties have no OB/GYN. So these 66 counties in Kentucky are not unique; 1,500 counties across America don't have a single OB/GYN.

As the map next to me shows, the American Medical Association reports that 21 States are now facing a full-blown medical liability crisis.

The red States have a full-blown medical liability crisis—21 of them. A few years ago, there were just 12. You will notice Texas, Mr. President? Texas is an interesting State to note. It is getting itself out of the crisis stage, heading in the direction of being a State not in crisis, as a direct result of legislation similar to what we are suggesting be enacted on the Federal level.

So we know the Texas reforms work because we see Texas now moving from a State in crisis to a State that is effectively reforming and basically halting the crisis.

An example of a State with a serious problem still is Arizona. Some of my colleagues might recall the story of one Arizonan, Melinda Sallard, from a few years ago. In 2002, the administrators at Copper Queen Community Hospital College in Brisbee, AZ, were forced to close their maternity ward because their doctors' insurance premiums had risen by 500 percent; 500 percent. A few months later, Melinda awoke at 2 o'clock in the morning with sharp labor pains. Since her local hospital stopped delivering babies because of the medical liability crisis, Melinda and her husband were faced with a 45-mile drive to Sierra Vista in order to reach the nearest hospital with a maternity ward.

As many of us who are parents know, babies don't always wait for the hospital, particularly when that hospital is almost an hour away.

Melinda gave birth to her daughter in a car on a desert highway leading to Sierra Vista.

When the child was born, she wasn't breathing. Her levelheaded mother cleared the child's mouth and performed CPR. After resuscitating the infant, Melinda wrapped her in a sweater, and the new family completed the journey to Sierra Vista.

Thankfully, both mother and daughter survived. However, it is clearly unacceptable that expectant mothers should be forced to drive past a perfectly good hospital and continue on 45 miles through the desert to deliver a child.

We have here a picture of the mother and daughter, and in that particular instance, because of a particularly alert mother, we were able to avert a crisis.

There are commonsense reforms the Senate can adopt that will lower medical liability premiums and allow doctors to continue their lifesaving work. In past years, the Senate has considered legislation modeled after the successful MICRA reforms out in California that have contained medical liability premiums for more than 25 years. I have supported those efforts, but we are taking a different approach this year and we are modeling this legislation offered by Senators SANTORUM, ENSIGN, and GREGG on the Texas reforms to which I referred a few moments ago. The Texas reforms are a little more generous, and they also are clearly working to get the right result.

It is important to remember that under any of this legislation, patients would be allowed to recover 100 percent of their economic damages. This can include hospital bills, lost wages, therapy, and rehabilitation costs, and a wide variety of additional expenses a victim might incur.

In an attempt to reach a compromise on the contentious issue of non-economic damages, the Medical Care Access Act includes, as I said, Texas's tiered cap on non-economic damages that could allow a patient to recover as much as three-quarters of a million dollars. That is three times the amount of non-economic damages that was available under legislation we previously considered here in this Senate.

Our colleagues across the aisle have indicated they would not consider legislation that would limit non-economic damages at $250,000. This bill does not have that limitation. Hopefully, a limitation on non-economic damages alone of three-quarters of a million dollars will be more acceptable.

This legislation also includes important reforms, such as ''fair share liability,'' limits on lawyers' fees, and collateral source reforms that have been a part of previous proposals here in the Senate.

This problem is not going to go away on its own. The Senate has an opportunity to act. I hope we will, in fact, vote cloture and get to this legislation. If there are amendments to be offered, fine. Let us have votes and move in the direction of addressing this serious national health care problem.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, this legislation, S. 22, 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 the bipartisan deliberations of a Senate committee. It was designed to score political points, not to achieve the bipartisan consensus which is needed to enact major legislation. In fact, the legislative language was not even available for review until late last

week. For these reasons, 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 much of the 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 insurance companies and large health care corporations. This amendment would enrich them at the expense of the most seriously injured patients; men, women and children whose entire lives have been devastated by medical neglect and abuse.

S. 22 would drastically limit the financial responsibility of the health care industry to compensate injured patients for the harm they have suffered. This legislation is extremely broad in its scope. It defines a ''health care liability claim'' as any claim ''based upon the provision of, use of, or payment for—or the failure to provide, use, or pay for—health care services.''

It is attempting to use the sympathetic family doctor as a Trojan horse concealing an enormous array of special legal privileges for every corporation which provides a health care service, or insures the payment of a medical bill. For example, this proposal would shield HMOs and health insurers that refuse to provide needed care. Less accountability will never lead to better health care.

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 an arbitrary cap on how much they can receive for non-economic loss, that is for the very real pain and suffering these victims experience every day. This cap only serves 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 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.

The sponsors of this bill claim that they have increased the cap from $250,000 to $750,000. But that claim is very misleading. The $250,000 limit would still apply to the overwhelming majority of malpractice victims, no matter how severe their injuries. The $750,000 limit would apply only to the small number of cases in which three different defendants—one doctor and two health care institutions—were all responsible for the victim's injury. It would not even apply in cases where three doctors all committed malpractice. In reality, nothing has changed from prior Republican bills. Nearly all victims would still be prohibited from receiving more than $250,000 for their injuries.

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 homemakers and caregivers for their families sustain no lost wages when they are injured, so they only receive minimal economic damages. Should a woman working in the home receive less compensation for the same injury than a woman working outside the home? Is that just?

A seriously injured child may be confined to his or her home for years of painful recuperation, but that child has no lost wages. Should he get less compensation than an adult with a similar injury? Is that fair?

Noneconomic damages—compensation for lost quality of life—is 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.

First , it would abolish joint and several liability for all damages. This means the most seriously injured people may never receive all of the compensation that the court has awarded to them. They may not even receive full payment for their lost wages and medical bills. Under this provision, health care providers whose misconduct contributed to the patient's injuries will in many cases be able to escape responsibility for paying full compensation to that patient.

Second, the bias in the legislation could not be clearer. It would preempt State laws that allow fair treatment 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(c) shows how result-oriented the legislation really is. It is not about fairness or balance. It is about protecting defendants.

Third, 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.

Fourth, 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 entirely 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, the bill 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.

Fifth, it imposes unprecedented limits on the amount of the contingent fee which a client and his or her attorney can agree to—limiting it to 15 percent of most of the recoveries. 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 injured 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, 0.66 percent, of the Nation's health care expenditures each year. For example, in 2004, health care costs totaled $1.88 trillion, while the total cost of all medical malpractice insurance premiums was $11.4 billion. Malpractice premiums are not the cause of the high rate of medical inflation. This bill will not make health care more affordable.

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.

Between 2000 and 2003, there were dramatic increases in the cost of medical malpractice insurance in States that already had damage caps and other restrictive tort reforms on the statute books, as well as in States that did not. No substantial increase in the number or size of malpractice judgments suddenly occurred which would have justified the enormous increase in premiums that many doctors were being forced to pay. Now rates have stabilized, again both in States with and States without damage caps.

Comprehensive national studies show that 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. Slightly more than half of the States have a cap on medical malpractice damages. Many of them have had those statutes for a substantial number of years. The other half of 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 2005 for doctors practicing in States without caps on malpractice damages $45,719—was actually lower than the average premium for doctors practicing in States with caps, $51,405. 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 2005 for doctors practicing internal medicine was more—18.7 percent more—for doctors in States with caps on malpractice damages—$16,212—than in States without caps on damages—$13,658. Internists actually pay more for malpractice insurance in States that have caps.

The average liability premium in 2005 for general surgeons was more—19.4 percent more—for doctors in States with caps—$57,662—than States without caps—$48,267. Surgeons are paying more for malpractice insurance in the States that have caps.

The average liability premium for OB/GYN physicians in 2005 in States with caps—$80,341—was also more than for doctors in States without caps—$75,233. OB/GYNs in States with caps paid slightly more—7 percent more—than in States without caps.

Clearly, a State's tort laws do not determine that State's medical malpractice insurance rates.

This evidence demonstrates that capping malpractice damages does not benefit the doctors it purports to help. It only helps the insurance companies earn even bigger profits. As Business Week Magazine concluded after reviewing the data at the height of the malpractice rate crisis ''the statistical case for caps is flimsy.''

In 2003, Weiss Ratings, Inc., a nationally recognized financial analyst, conducted an in-depth examination of the impact of capping damages in medical malpractice cases. Their conclusions sharply contradict the assumptions on which this legislation is based. Weiss found that capping damages does reduce the amount of money that malpractice insurance companies pay out to injured patients. However, those savings are not passed on to doctors in lower premiums.

The Weiss Report, stated:

> 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 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 cap proponents.

Since malpractice premiums are not significantly affected 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 283 physicians per 100,000 residents in States that do not have medical malpractice caps and 249 physicians per 100,000 residents in States with caps. 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 problem, will benefit.

Insurance industry practices were responsible for the sudden dramatic premium increases which occurred in some States between 2000 and 2003. 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 were substantial increases in a number of insurance lines, not just medical malpractice, during that period. 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 several years ago was the reason for the sharp increase in medical malpractice insurance premiums during that period. What we witnessed then was 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.

Data from the National Association of Insurance Commissioners shows that in 2005, the profits for the five largest for-profit medical malpractice insurers were more than double those of the Fortune 500 average 17.7 percent v. 8.7 percent.

Doctors, especially those in high risk specialties, whose malpractice premiums have increased dramatically do deserve premium relief. That relief will only come as the result of tougher regulation of 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 now.

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 malpractice premiums.

There are specific changes in the law which should be made to address the abusive manner in which medical malpractice insurers operate. The first and most important would be to subject the insurance industry to the Nation's antitrust laws. It is the only major industry in America where corporations are free to conspire to fix prices, withhold and restrict coverage, and engage in a myriad of other anticompetitive actions. A medical malpractice ''crisis'' does not just happen. It is the result of insurance industry schemes to raise premiums and to increase profits by forcing antipatient changes in the tort law. I have introduced, with Senator LEAHY, legislation which will at long last require the insurance industry to abide by the same rules of fair competition as other businesses.

Unlike the harsh and ineffective proposals in S. 22, this is a real solution which will help physicians without further harming seriously injured patients. Unfortunately, the Republican leadership continues to protect their allies in the insurance industry and refuses to consider real solutions to the malpractice premium crisis.

I want to conclude with a quotation from the analysis of medical malpractice premiums by Weiss Ratings, Inc. Weiss Ratings 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 rating. Here is their recommendation 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.

Before yielding the floor, I want to briefly address the second malpractice bill, S. 23, that the Republican leadership has brought before the Senate. The only difference between them is that the first bill would take basic rights away from all patients, while the second bill takes those rights away only from women and newborn babies who are the victims of negligent obstetric and gynecological care. That difference does not make the latter bill more acceptable. On the contrary, it adds a new element of unfairness.

The proponents argue that they are somehow doing these women and their babies a favor by depriving them of the right to fair compensation when they are seriously injured. It is an Alice in Wonderland argument which they are making. Under their proposal, a woman whose gynecologist negligently failed to diagnose her cervical cancer until it had spread and become incurable would be denied the same legal right as a man whose doctor negligently failed to diagnose his prostate cancer until it was too late. Is that fair? By what convoluted logic would that woman be better off? Both the woman and the man were condemned to suffer a painful and premature death as a result of their doctors' malpractice, but her compensation would be severely limited while his is not. She would be denied the right to introduce the same evidence of medical negligence which he could. She would be denied the same freedom to select the lawyer of her choice which he had. She would be denied the right to have her case tried under the same judicial rules which he could. That hardly sounds like equal protection of the law to me. Yet, that is what the advocates of this legislation are proposing.

Of course, this bill does not only take rights away from women. It takes them away from newborn babies who sustain devastating prenatal injuries as well. These children face a lifetime with severe mental and physical impairments all because of an obstetrician's malpractice, or misconduct by a health care provider or insurer. This legislation would limit the compensation those children can receive for lost quality of life to $250,000 in nearly all cases—just $250,000 for an entire lifetime. What could be more unjust?

There are babies who suffered serious brain injuries at birth and will never be able to lead normal lives. There are women who lost organs, reproductive capacity, and in some cases even years of life. These are life-altering conditions. It would be terribly wrong to take their rights away. The Republicans talk about deterring frivolous cases, but caps by their nature apply only to the most serious cases which have been proven in court. These badly injured patients are the last ones we should be depriving of fair compensation.

The entire premise of this bill is both false and offensive. Our Republican colleagues claim that women and their babies must sacrifice their fundamental legal rights in order to preserve access to OB/GYN care, that they must leave their rights at the door. The very idea is outrageous. For those locales—mostly in sparsely populated areas—where the availability of OB/GYN specialists is a problem, there are far less drastic ways to solve it.

This bill is based on the false premise that the availability of OB/GYN physicians depends on the enactment of Draconian tort reforms. If that were accurate, States that have already enacted damage caps would have a higher number of OB/GYNS providing care. However, there is in fact no correlation. States without caps actually have 29.1 OB/GYNS per 100,000 women, while States with caps have 25.5 OB/GYNS per 100,000 women. States without caps actually have more OB/GYNS serving their female population.

This is not a more acceptable bill because it applies only to women and newborn babies injured by obstetrical and gynecological malpractice. That makes it even more arbitrary, even more outrageous. Not one victim should be denied the basic rights that this bill would take away.

I urge my colleagues to oppose both of these very unfair bills.

The PRESIDING OFFICER (Mr. CORNYN). The Senator's time has expired.

The Senator from New Hampshire.

Mr. GREGG. Mr. President, I want to speak directly to the issue of the bill that applies to the need of women to be able to access doctors when they are delivering children and generally to get care from OB/GYNs. The Senator from Massachusetts has characterized this bill. Let me characterize it, as I think the facts are on the side of this bill.

The purpose of this bill is to allow women, especially women who are trying to have children, to have adequate health care. There is a crisis in this country today. Large numbers of women either cannot find an OB/GYN to assist them or if they can find an OB/GYN, they only have one choice. If they do not get along with that doctor, if they find they are not comfortable with that doctor, they have no other choice but that doctor.

This bill sets up a very clear decision: You can be for the trial lawyers or you can be for women. You can be for the trial lawyers or you can be for doctors who want to deliver babies as their profession. You can be for the trial lawyers or you can be for children, especially children in prenatal situations. That is the choice in this bill.

The facts are almost uncontrovertible because they are so clear. The number of doctors practicing and delivering babies is dropping radically. This is especially true—especially true—in rural areas. You cannot—let's put it this way: A trial lawyer cannot deliver a baby. They are talented people. In fact, in the years 2003 and 2004, they contributed over $185 million in political contributions, and as a result, they were able to garnish $18 billion in fees dealing with malpractice activity. So they are talented people. I do not deny that. But a trial lawyer cannot deliver a baby.

But we are getting to a point where if you are a young woman or a woman who desires to have a child, you are probably going to have to drive by the courthouse to find your doctor because they are being subjected to so many lawsuits, if they happen to be in the business of delivering babies.

New Hampshire is a classic example of this situation. There is only one doctor north of the White Mountains, which is a fairly large amount of area and a great place to live, and people who live there choose to live there because it is a great place to live. There is only one doctor above the White

Mountains—that is called northern New Hampshire—who delivers babies. If that doctor is not around or if that doctor is on a break or maybe if you do not like that doctor, you literally are going to have to drive an hour, 2 hours, maybe even longer, in order to see a doctor if you are a woman who wants to get care in delivering your child. And believe me, that can be a dangerous experience, driving in a snowstorm. Hopefully, you can get somebody to drive you if you are about to deliver. But in any event, driving through a snowstorm in northern New Hampshire is a difficult situation. But that is what people are subjected to in that part of the State because the doctors who used to practice up there, who used to deliver babies, cannot afford to deliver babies any longer in that part of the State. Why? Because the population is not large enough to pay their premiums, which have escalated, skyrocketed, doubled—doubled upon doubled—over the last 20 years in the area of delivering children. So they have opted out of the practice. In fact, one doctor simply closed her practice and moved to another State because of the fact that the cost of insurance premiums was so high.

Another whole practice in Rochester, NH, with five OB/GYNs, simply picked up their practice and moved across the State line to Maine because of the cost of delivering babies.

One of the leading doctors in the State, Dr. Cynthia Cooper, who is head of the New Hampshire Board of Medicine and an OB/GYN, has given up delivering babies, as I understand it.

Dr. Patricia Miller from Derry, NH, a town of 38,000 people, has also given up delivering babies, after 15 years.

I had a doctor in Laconia, which is in the Lakes region—a beautiful part of the State—who essentially told me he has to deliver babies through November simply to pay the cost of the premium for his insurance. He does it because he feels it is his obligation, his obligation as a doctor, because that region would not have his talent and his care. But believe me, it is hardly an incentivizing event to pursue that type of practice.

What drives these premiums? Well, if you listen to the Senator from Massachusetts, it is the evil insurance companies. Insurance companies do not drive these premiums. What a fallacious argument that is. They set the premium in order to be able to afford to pay the costs, which costs are generated by the excessive amount of lawsuits that are being brought and the extraordinary recoveries which, on occasion, are simply out of whack.

When trial lawyers in this country are obtaining $18 billion in fees over a 2-year period that could have been money—if the Senator from Massachusetts wants to help out the health care system—that could have been money which could have gone into health care delivery, think of how many OB/GYNs would be practicing out there.

Well, one State decided to do something about that, the State of the Presiding Officer: Texas. In an act of considerable clairvoyance, I would say, they decided to take the California model, which has worked pretty well, and improve on it. As a result, they have put in place a tiered system of recovery, which is what the bill does. It essentially follows the Texas model, which was a follow-on to the California model.

In both Texas and California, recovery has been reasonable for those people injured. But equally important, doctors have started to practice medicine again, instead of just basically defending themselves from lawsuits. It has become affordable to become a doctor and practice in the State of Texas, so much so that the facts speak for themselves. Mr. President, 3,000 new doctors have moved into Texas since this law was passed, with 81 new obstetric doctors. That is a huge increase in medical opportunity and care, especially for women, women of childbearing years, and for children because Texas had the good sense to take this approach. The same has occurred in California.

So progress has been made. We have uncontrovertible facts which show that you can resolve this issue, that you can allow women to have the opportunity, especially women of childbearing age, to see doctors and have choices in doctors and be able to be cared for by doctors who wish to deliver babies and can afford to deliver babies.

This is a huge step forward for those two States. It is time the Federal Government, the National Government, address the issue, also. That is why we have brought forward this very targeted bill.

The bigger bill, which I also support, is an excellent idea. There are other specialties that need attention: neurosurgeons, emergency room docs, doctors, especially, practicing in underserved areas. If you are a doctor in an emergency room or if you are a doctor practicing in an underserved area, you are not making a lot of money. You are fortunate if you are making anything. I do not know what the hourly rate works out to, but those doctors work massive hours. Considering the huge amount of expense they put into their education and their professional development, their return is not all that high if they have decided to pursue caring for people in underserved areas, rural or urban areas, or emergency rooms. Yet they get hit with these premiums, which essentially make it very difficult for doctors to choose that course of practice, which is so important.

So a broader bill does make sense. But it gets attacked, and it has been attacked rather aggressively from the other side, with the footnotes that have been handed to the other side by the trial lawyer groups, as they try to set up the straw dog of the insurance companies or the straw dog of some sort of recovery system that is unfair to the seriously injured. So the bigger argument becomes more complex and more difficult to understand and can be more obfuscated and has been effectively by our friends on the other side and by the trial bar.

But it is very hard to obfuscate, it is very hard to get past the simple fact that there is only one OB/GYN practicing in northern New Hampshire. It is very hard to get by the simple fact that if you are a woman in rural Kansas or rural New York or rural Illinois or urban areas within those States or rural Texas, you are going to have a lot of problems finding a doctor when you decide to have children because the doctors have been driven out of the business of the practice by these excessive and unrelenting lawsuits.

So this bill is very simple. Rather than getting into the rather convoluted, smoke-filled discussion of the entire medical reform issue, it just goes at one great, important need in our country; that is, if a woman wants to have a child, she should have high-quality medical care so that child is brought into the world in the best possible condition and the woman's health is protected during the childbearing period. This bill will do that, and I hope everyone will support it.

At this point, I reserve the remainder of our time.

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. THUNE. 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. THUNE. Mr. President, today the Senate will vote on a couple of cloture motions dealing with medical malpractice reform. We will have a debate later this week on small business health plans. This is a week in which we have an opportunity to address what is probably one of the most important, if not the most important, domestic policy issues that we will deal with in the foreseeable future; that is, access to health care for more Americans, more affordable health care for more Americans.

These issues are not new to the Congress. In fact, as a Member of the House of Representatives, I had the opportunity to vote numerous times on medical malpractice reform, on small business health plans to allow more people to have access to health care by joining larger groups, thereby driving down the cost of insurance and providing coverage to some of the 45 million people who currently are not covered.

Estimates are that as small business health plans pass, we will have 11 million more Americans with health insurance, making a big dent in the ranks of the uninsured. In the time since I first came to Congress in 1996, in the last

decade, there have been 13 different votes in the Congress: There have been five votes on medical malpractice reform; there have been eight votes on small business health plans. In those cases, the House of Representatives has acted. There have been majority votes coming out of the House. That legislation would then come to the Senate where it would be obstructed, filibustered, and ultimately would die.

I submit to my colleagues that these are both measures for which there is majority support in the Congress. If you look at the House, they have passed it repeatedly. If you look at the Senate, if we had a vote today and we had to get 51 votes or a simple majority in the Senate, we would be able to pass medical malpractice reform. We would also be able to pass small business health plans. The other side has repeatedly denied us an opportunity to have an up-or-down vote on these particular issues. That is wrong. It is wrong for a lot of reasons, but it is wrong, most importantly, because it is hurting the welfare of Americans who desperately need access to health care and need the cost of health care brought down.

Today when we vote on medical malpractice reform, we will be addressing an issue that affects the well-being of all Americans because in one way or another, when physicians have to deal with escalating premiums for liability insurance, those costs ultimately get passed on to all of us. If you don't believe that, look at the statistics.

In 2002, the Health and Human Services issued an update on the medical liability crisis. It found that the direct cost of medical liability coverage and the indirect cost of defensive medicine increased the amount the Federal Government must pay for Federal health programs such as Medicare and Medicaid by $22.5 billion a year.

Additionally, a January 2006 Pricewaterhouse Coopers study entitled ''The Factors Fueling Rising Health Care Costs,'' concluded that medical liability and defensive medicine accounted for 10 percent of the increase in the rising cost of health insurance premiums.

The median liability jury award in medical liability cases almost tripled between 1997 and 2004. In 2003, the GAO found:

> Losses on medical malpractice claims—which make up the largest part of insurers' costs—appear to be the primary driver of rate increases in the long run.

With these statistics and findings of not only the GAO but numerous independent studies, it is easy to see that it is time for Congress to address the medical liability crisis. S. 22 and S. 23 provide needed and sensible medical liability reform. Based on the Texas stacked cap model for noneconomic damages, these pieces of legislation allow up to $750,000 for noneconomic damages and unlimited awards for economic damages. Additionally, plaintiffs may recover punitive damages twice the amount of economic damages, or $250,000, whichever is greater.

S. 22 and S. 23 also maximize patient recovery by limiting the fees attorneys may recover on a contingency basis. My State of South Dakota currently has a cap of $500,000 for noneconomic damages. S. 22 and S. 23 respect States rights and do not preempt noneconomic damage caps in place, not only in South Dakota but in 25 other States as well. It is time the obstruction in the Senate come to an end and that we put patients before lawyers and allow a straight up-or-down vote on S. 22 and S. 23. Obstructing a vote on medical liability reform jeopardizes every American's access to quality health care and raises the cost for individual taxpayers as well as for State and Federal Governments. This is especially true in rural States such as South Dakota where there is only one licensed physician for every 450 residents.

I believe it is high time the Senate show the American people that Congress understands their concerns about access to and the cost of health care. Pass S. 22 and S. 23 and do what I believe a majority in the Senate and the House of Representatives support; that is, to address the rising cost of health care by putting reasonable limits in place, many of which have been adopted and are successfully working in States throughout the country. It is time to end the obstruction and allow these measures to be voted on. I hope my colleagues will vote that way when the cloture votes come up.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mrs. HUTCHISON. Mr. President, a lot has been said about the Texas model, which is the bill that we are considering today. I wanted to talk a little bit about what the Texas situation was before 2003 when significant medical malpractice reform was enacted.

According to the Texas Department of Health, 24 counties in Texas had no primary care physicians, 138 counties had no pediatricians, and 158 counties had no obstetricians. Texas ranked 48th of the 50 States in physician manpower. Why were we having such trouble? Because the cost of doing business in Texas before 2003 was unsustainable due to increased litigious activity. Insurance rates were driving our doctors out of Texas, or they were going out of business and not even practicing medicine anymore.

In 1991, Texas averaged 13 claims per 100 physicians. Yet by 2000, Texas averaged over 30 claims per 100 physicians. Of these claims, there was a disproportionate growth in noneconomic damages, damages such as pain and suffering, loss of consortium. This growth was in contrast to awards of economic damages such as lost wages and medical care costs. In 1991, noneconomic damages averaged only 35 percent of total verdicts. By 1995, they were 65 percent of total verdicts.

From 1999 to 2003, the Texas Medical Liability Trust, which covered about one-third of the State's doctors, increased rates by 147 percent. In the Rio Grande Valley, physicians in general surgery and OB/GYNs ranked sixth and seventh, respectively, in the Nation for highest premium rates in 2002. Naturally, all of these costs were passed on to consumers. The impact on litigation in the Texas health care system was undeniable and unsustainable.

In 2003, Texas made bold changes to the tort system in an attempt to restore access to health care, and we have seen a dramatic change. Texas has gained more than 3,000 physicians since passing liability reform. After a net loss of nine orthopedic surgeons in our State from 2000 to 2003, the State has experienced a net gain of 93 orthopedic surgeons since 2003. After a net loss of 14 OB/GYNs from 2001 to 2003, Texas has had a net gain of 91 since 2003.

We have also added 273 anesthesiologists, 24 neurosurgeons, 24 pediatric cardiologists, 14 pediatric oncologists, and 10 pediatric surgeons since passing liability reform.

Claims in most Texas counties have been cut in half. Prior to the reforms, statewide claims averaged close to 400 per month. After the reforms, claims have averaged 200 per month in our State.

Prior to reform, Texas had five liability carriers. Since reform, Texas has added 3 new rate-regulated carriers and 13 new unregulated insurers. The five largest insurers announced rate cuts last year, with an average premium reduction of 11.7 percent.

Anecdotally, I have talked to doctors who are coming back into practice, doctors who have said they have seen as much as 40 percent cuts in premiums for medical liability.

Medical liability reform works. Lawsuits are down, insurers have returned to the State, rates are down, and physician numbers are up. This means better health care for the citizens of our State.

The bills before us that we will be voting on today are modeled on the Texas plan. Damages for pain and suffering are allowed, but not at such exorbitant rates that doctors are taken out of our health care system. Since 2003, Texas has seen an increase in the quality of health care for our citizens because more physicians are coming back to the State.

I urge my colleagues to support the bill. Year after year, we have tried to reform medical malpractice in this country, and the Senate has been the stumbling block. Let's do something good for health care and access to health care for our citizens, and let's start debating malpractice reform.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont is recognized.

Mr. LEAHY. Mr. President, what is the parliamentary situation?

The PRESIDING OFFICER. The minority controls the time until 5 p.m.

Mr. LEAHY. Mr. President, I find it unfortunate that we do not hear any discussion by proponents of this legislation about what is best for patients injured or killed by medical errors. The debate in favor of malpractice award caps has been cast in terms of patient accessibility to health care, but what about patient safety? Capping noneconomic damages may benefit insurance companies, but it does nothing for victims and nothing to address the serious problem of preventable medical errors.

Despite all of the rhetoric and all the myths and misinformation about the so-called crisis facing our medical professionals, what about the fact that studies have estimated that medical errors kill up to nearly 100,000 people each year? How does capping what a victim can recover help address this tragic fact? Rather than having all the talk be about alleged physician shortages and phantom reductions in insurance rates, we should be looking at how to improve the quality of care patients receive and how to improve patient safety. This legislation does nothing to provide any incentive for health care providers to improve the safety of their services, drug companies to rigorously test their products, or nursing homes to provide responsible and compassionate care to our elderly citizens.

Aside from the fact that caps on noneconomic damages will not address exorbitant insurance rates, such caps harm both women and children. The Wall Street Journal published an article in 2004 detailing the effects of California's non-economic damages cap. The article discussed how the California law has created two classes of malpractice victims: those who earn large amounts of money and get good representation, and those who do not and cannot find advocates willing to take on their cases. The effect is that many women who do not work, but raise children, cannot get representation because they cannot point to an annual salary that will be lost, and thus lawyers are reluctant to invest the hundreds of thousands of dollars necessary to litigate a meritorious claim. The same is true for children, whose recovery under this legislation would depend on often difficult estimates of the cost of future care. A California attorney quoted in The Wall Street Journal article summed up the California law's effect by concluding: ''We are saying to doctors and hospitals it's OK to kill somebody who comes from a poor family because ultimately they aren't going to have the same effect on our medical-malpractice insurance as somebody who comes from a rich family.'' The similar one-size-fits-all approach in this legislation is the wrong way to go.

I also question the timing of partisan legislation that will do nothing to address patient safety. As insurance rates, like gas prices, continue to soar to the benefit of corporate profits, as the number of uninsured continue to rise during this presidency, the Republican-controlled Senate seeks to take up partisan legislation that will help a few very powerful insurance companies become even more powerful. Rather than take up legislation to apply competitive antitrust principles to the business of insurance, the majority leader insists that we limit our actions to legislative proposals that will deprive citizens injured by medical errors a full measure of justice. Instead of taking up legislation to push the frontiers of life-saving medicine through stem cell research, we are going to debate whether we should make it easier for insurance companies to continue their predatory behavior at the expense of both doctors and patients. Instead of calling this a malpractice bill, we should call it a gift to the insurance companies bill.

In recent weeks, hundreds of thousands of Americans have taken to the streets in peaceful demonstrations to urge sensible and humane immigration reform and the public clearly wants Congress to address these issues and to strengthen our borders, and instead we are discussing how to dismantle our internal borders and tread on State sovereignty by nullifying State tort law. A war rages in Iraq in which our Nation's best and bravest are making the ultimate sacrifice to advance democracy, and meanwhile we are talking about how to curtail Americans' access to justice. Forty-five million people do not have health insurance in this country, and yet we are considering legislation that will make it harder for children who suffer lifelong injuries from medical errors to get the long term care they need. The gap between the richest Americans and everyone else continues to widen, but instead of taking up legislation to raise the minimum wage, the majority leader wants to shield lucrative insurance companies from having to pay fair awards to medical malpractice victims. Where in the majority leader's schedule are the American people's real priorities?

There are ways to improve health care. These bills do not do that. There are alternatives that address the high costs of medical malpractice insurance and patient safety, but they differ from the narrow approach we debate today. There are solutions to both the current high rate of medical errors, as well as high insurance costs, that will not further victimize patients or intrude into the sovereignty of State legislatures and citizens, but they are not brought before the Senate for consideration and action.

If we want to address high insurance costs, let us address the unhelpful practices within the insurance industry and find a real solution that does not penalize victims of medical errors. If we want to bring down the number of medical errors, merely cutting costs and increasing profits for insurance companies is not the way to go. Capping malpractice awards does nothing to treat the root cause of malpractice lawsuits. Let us put patients before insurance companies in this debate and find real solutions to the preventable medical errors that are occurring every day.

Some of us have proposed legislation to tackle the problem of rising insurance costs without taking away American citizens' access to justice. If we want to improve patient care and lower the number of medical malpractice claims, we need to find ways to prevent medical errors at the rate they occur now. That is common sense. Senator OBAMA has proposed the Hospital Quality Report Card Act of 2006 to provide accountability within those hospitals compensated through Medicare by requiring highly detailed reporting of safety procedures, patient accessibility, the incidence of errors and infections, and many other areas important to both patient safety the effectiveness of treatment. Senator OBAMA's bill would provide the information to help consumers make an informed decision about where to obtain treatment. It would provide the information necessary for hospitals to improve the safety and effectiveness of their services. It would allow insurers and purchasers of insurance to reduce the likelihood of claims by sending their insured customers and employees to the best hospitals available, and would allow doctors and policy makers to target areas in need of improvement. Senator OBAMA's bill puts the priorities of patient safety and health care improvement first. I commend the Senator from Illinois for this bill and I urge other Senators to join me in supporting it.

If we want to reign in the costs of insurance for health care providers, we must address the conditions within the insurance industry. I have proposed a bill along with Senator KENNEDY to exempt medical malpractice insurers from the counterproductive McCarran-Ferguson Act. This bill would give regulators the tools necessary to prevent anti-competitive business practices that hurt doctors and patients. If medical malpractice insurers are artificially driving up the costs of insurance, we should stop it. Health care in our country is too important to allow profits at the expense of patients. We are not going to stop soaring insurance premiums by cutting off the access of victims to justice. We are going to stop them by stopping the anti-competitive behavior of the insurance companies. Again, health care in our country is too important to allow profit at the expense of patients, especially when in the last 6 years we have seen the highest increase in the number of uninsured Americans in my lifetime.

I urge other Senators to join me in rejecting legislation that will do nothing more than benefit profitable insurance companies under the guise of improving patient accessibility. Let us work together in a bipartisan fashion to come up with real solutions to the

problem of preventable medical errors. Let us find ways to end the abusive practices in assisted living facilities and nursing homes. Let us find ways to lower insurance costs without hurting victims. Those in need of care must be able to trust their doctors and health care providers without doubt. Elderly Americans deserve the best care that can be provided. Our doctors and other health care providers deserve to be treated fairly in the marketplace when purchasing malpractice insurance, and not be affected by artificial monopolies and price-fixing cartels. If we work together, we can make progress and make a difference.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. NELSON of Nebraska. Mr. President, first, I thank Senator ENZI from Wyoming and his staff and my staff for the effort they have put into S. 1955. I was pleased to work with them in trying to help our Nation's small businesses and our Nation's uninsured.

Mr. President, 45 million people don't have health insurance in our country today. We have heard that statistic so many times that it is starting to feel numb to us, but we can't let that happen. Forty-five million people translates to about one of every six Americans. I would like to put a face to that figure and start bringing some feeling back to the state of health insurance coverage in the United States.

If the 45 million uninsured Americans held hands and formed a chain between New York City and Los Angeles, they would not only stretch the entire distance, they would be able to go back and forth from coast to coast 14 times.

We can no longer wait to help this ever-growing number of people gain health insurance. It is time to start increasing the number of insured people in our country, and this bill does just that.

It is projected that S. 1955 will make health insurance affordable for 1 million working Americans, and that is a sizable start to the process of providing health insurance to the one in six without it.

By allowing business and trade associations to band their members together and offer group health insurance coverage on a national or statewide basis, we will be making an important stride in making health insurance affordable for Americans.

Nearly every week since becoming a Senator, I have heard from small business owners in my State that can no longer afford health care for themselves or their employees.

Health care premiums are experiencing double-digit growth annually. Small businesses can't keep up with the costs. Since 2000, group premiums for family coverage have grown nearly 60 percent. So if we don't do something to help small businesses cope with the cost of health insurance, soon we will have an entire workforce without health insurance coverage.

This bill, the Health Insurance Marketplace Modernization and Affordability Act of 2005, is designed to lower health insurance costs by stimulating market reforms and promoting competition, while allowing trade associations the ability to offer group insurance plans for employees.

It is important to note that we keep oversight at the State level with the State insurance commissioners. For the past 10 years, the Senate has debated AHP legislation, and for 10 years nothing has happened to help our small businesses provide those health benefits. And small business health plans can work. It is time we looked at something that can and will work.

I believe in this legislation because it is the first health benefits legislation to get both sides—the business folks and the insurance folks—working together.

Senator ENZI and I know that concerns have been raised about this bill, and each time we have been approached by a group with a concern, we have listened and we have tried to work together to strengthen this bill and its hopes for making health insurance affordable for America's small businesses.

The traditional AHP bill gave a rating and mandate advantage to association plans that resulted in adverse selection and an unlevel playing field. The Enzi-Nelson bill eliminates the rating and mandate advantage that Federal AHPs would have had under previously proposed legislation, which went nowhere. As a former insurance commissioner myself, it was crucial to me that this bill adhere to strict insurance principles. I think the bill before us will do just that.

As I see it, we have three options. The first is to do nothing to help the 45 million uninsured Americans. Since I genuinely believe we all want to improve health care, I will move on to the next option.

The second option is to keep trying to pass AHP legislation year after year, but I am afraid this approach will result in about the same dismal outcome as the do-nothing option that no one wants.

The third option, which I think is the best solution, is to act on small business health plans and pass this legislation.

In Nebraska, there are at least 30,000 small businesses with fewer than 50 employees who would be directly impacted by this legislation. Currently, 20,000 of these businesses don't offer health benefits.

I read a report last month by respected actuaries who looked at our bill. They believe it will help small businesses reduce health insurance costs by $1,000 per employee and shrink the number of uninsured working families by 8 percent. That is 1 million Americans who will now be able to afford health insurance because of the bill.

Recent survey results conducted by a bipartisan research firm shows that S. 1955 enjoys the support of 89 percent of Americans. It is a rare day in the United States anymore when 9 out of 10 people are united behind a cause.

So I hope this unity carries over to the Senate floor and that colleagues will join with Senator ENZI, myself, and others and pass S. 1955. It is in the best interest of Americans who want health insurance.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, I rise today to speak about the medical liability reform bills before us today: one is a comprehensive reform bill that I introduced, and the other specifically deals with OB/GYNs, which Senator SANTORUM introduced.

There are a couple of very important points to make on this legislation. First of all, Senator NELSON, a friend of mine, just spoke about the number of uninsured Americans. Over the next couple of days, we are going to vote on legislation to establish Small Business Health Plans. This is good legislation that is intended to help reduce the number of uninsured.

But another problem related to the number of uninsured Americans is the high cost of health care. The cost of health care is making it too expensive for people to afford health insurance. One of the primary drivers of health care costs is increasing medical liability premiums for health care providers.

Doctors are being forced out of their practices because they cannot afford to practice anymore. We saw the trauma center in southern Nevada close for a 10-day period. It serves 10,000 square miles. People died because of the closure. We have also seen maternity wards close across the country. Neurosurgeons and other specialists are no longer taking calls unless the calls are for cases that are not very risky. Specialists can't afford to take high-risk cases because they risk losing everything they have based on seeing one case.

I have a good friend in southern Nevada who practices obstetrics. In his practice, he specializes in high-risk pregnancies. Because of the medical liability problems that we have seen in the past several years, his insurance company limits the number of high-risk pregnancies with which he can assist.

If you are a woman and you are pregnant with a high-risk pregnancy, it would seem to me that you would want the best of the best to take care of you. That only makes sense. But because of the medical liability crisis we are facing in this country, the best of the best are limited in the number of cases they can see.

If you are a doctor in America today—this is becoming a truism—you will be sued. If you practice long enough, you will be sued in America today. We need to deal with the number of frivolous lawsuits that are clogging our legal system.

Every American needs to ask themselves this fundamental question: If you were in an automobile accident or if you needed care in an emergency room, and the specialist you wanted to see wasn't available, wasn't there, was no longer practicing, or wouldn't take the call, would you accept the reason that this happened is because this body, the Senate, wouldn't even take up a bill and debate medical liability reform, which could bring down health care costs, as it has in several States across America? If you were a mother who had a high-risk pregnancy or any type of pregnancy, and you couldn't get obstetrical care, how would you feel if the reason you couldn't get care was because your doctor left practice or left the State because medical liability insurance premiums were too high?

We have a serious problem. According to the American Medical Association, 21 States are in crisis today, 6 States are not, and the rest of the States are headed toward crisis. The six States that are not in crisis have all passed meaningful medical liability reform. The bill before us today is modeled after one of those States: the State of Texas. The State of Texas has a $250,000 cap for a judgment against a health care provider. In addition, the patient can be awarded up to $250,000 for a judgment against one health care institution. If two or more institutions are involved, the patient can receive up to $500,000, with each institution not liable for more than $250,000. Thus, injured patients can be awarded noneconomic damages for pain and suffering totaling $750,000. The legislation has no limits on economic damages for necessary health care expenses that you may incur over your lifetime. You can sue for unlimited economic damages. But, the caps on noneconomic damages are key to whether the legislation is effective.

Let's compare a couple of States, Texas and Pennsylvania. Texas has enacted meaningful medical liability insurance reform; Pennsylvania has not. These are just two examples. In Texas, doctors are moving back to the State. As a matter of fact, nine hundred doctors specializing in emergency care and high-risk procedures have moved to Texas since 2003, when Texas law was enacted. Texas infants and children now have better access to specialists. Ninety-four pediatric specialists alone have moved into the State. In contrast, Pennsylvania doctors are leaving the State. I believe there are more medical schools in Pennsylvania than practically anywhere else in the country, yet doctors are leaving the State—not because they don't love Pennsylvania, but because they cannot afford to practice in Pennsylvania. In Texas, the premiums for medical liability insurance policies are going down. In Pennsylvania, they continue to skyrocket. Because of medical liability reform in Texas, 30 new medical liability insurers have come into the State to write policies for doctors. In Pennsylvania, medical liability insurers are leaving the State.

The difference here is that doctors in Texas can shop among 30 different medical liability insurers. And, market forces bring insurance prices down. Because of all of this, it is becoming less expensive to practice medicine in Texas and more expensive to practice in Pennsylvania.

The bill I offered, which is before us today, is modeled after the Texas legislation. The bill establishes caps on noneconomic damages. The bill also limits attorneys' fees. This provision will ensure that patients receive a larger percentage of their damage awards. I believe that the person who is injured with a true medical malpractice case should get the award instead of having the award go to higher and higher attorneys' fees.

My legislation also includes an expert witness provision to ensure that relevant medical experts serve as trial witnesses. This provision is extremely important. Today, if you have a medical liability case before a jury, they bring in so-called professional witnesses to testify who are used to further abuse the system. There is a whole industry of these so-called professional witnesses who travel around the country and testify. The problem is that a lot of these so-called professional witnesses are not experts in the field in which they are testifying. This bill says that if you are, for instance, testifying in a neurology case, then you should be a specialist in neurology. I know this is common sense, but that is not the way our courts work today. This bill would require a specialist or an expert to truly be an expert in the field in which they are testifying.

This bill has been contentious for several years. The trial lawyers and their cohorts spent $182 million over the last few elections. And they have gotten back out, just in medical liability awards, $18 billion. That is a 10,000-percent return on their investment in politics.

We cannot allow the trial lawyers to control this debate. We cannot allow the trial lawyers to say: We are not even going to allow for debate of this bill on the floor of the Senate. That is what is happening. This bill isn't even going to be allowed to have an up-or-down vote. Some people say: Let's have insurance reform. Let's bring it all on. Let's have those amendments and let's debate it. But the other side of the aisle is not even allowing us to debate this bill on the floor of the Senate.

This crisis is not going away; it is getting worse in America. We must act as a responsible body. It is unfortunate that the greatest deliberative body supposedly in the history of the world can't even deliberate on this bill. It is time to bring real medical liability reform to the floor of the Senate and debate it. Let's let the American people see what the medical liability reform debate is all about. Let's go forward so that we can save our doctors, nurses, nurse midwives, and other health care providers, so that when patients need care, they get that care.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. SANTORUM. Mr. President, I want to continue on with some of the comments I was making earlier about the critical situation in Pennsylvania with respect to this liability crisis and a couple of examples of how out of control the system has become. I was at St. Luke's Hospital up in the Lehigh Valley, and I was saddened by the changes that have happened with some of the losses of physicians that have occurred in there. It is one of the growing areas of our State, and this is an area that has been hit with very high rates of malpractice and obviously, as I will discuss here, losing physicians.

I want to talk about a couple of things. One is a case that St. Luke's was involved in that tells you how absurd, and particularly in this case, the jury awards are in Philadelphia, which has been the big problem area in Pennsylvania—some of the jury awards that have come out of Philadelphia.

We had a case in September and October of the year 2000 which involved a baby girl born 3 months premature to a 17-year-old mother whose medical records indicated a crack cocaine addiction. The mother began experiencing complications, including a partial placental abruption and premature labor. The mother was admitted to another hospital for these complications and then transferred to St. Luke's. The mother was placed on strict bed rest and given medication to stop the onset of labor and to prevent progression of the placental abruption. Despite warnings from her doctor about the risks to her baby of premature birth and possible neurological damage, possibly death, the mother, against medical advice, left the hospital. She turned up 3 days later with complete placental abruption and premature delivery could not be avoided at that point. Emergency surgery was performed. The baby was delivered weighing 4.1 pounds. The baby had a common condition with premature babies which is an opening in the heart that usually closes shortly after birth. The baby was treated for 29 days in the neonatal intensive care unit at St. Luke's, was given medication to attempt to close the opening in the heart. The baby had an adverse reaction to the medication. Surgery was required to close the opening. The surgeon was unsuccessful. There were no documented complications in the surgery, no allegations that St. Luke's did anything wrong or improper in her care.

The baby was transferred to another hospital for further surgery. During treatment at the second hospital, the baby had complications, was transferred back to ICU at St. Luke's. Again, no documented complications during the second stay at St. Luke's up

until the child's release. The mother during this time gave up parental rights. The baby was adopted down the road by parents who elected not to seek legal action. But—and this is somewhat unknown—somehow or another, an attorney in Philadelphia was appointed the guardian ad litem to the child because of the child's nexus to a second hospital located in Philadelphia County. So the lawyer sued on behalf of the baby without the consent or knowledge of either the actual parent or the adopted parent.

The verdict in the case was $100 million against the hospital—a $100 million verdict in this case. So you wonder: Well, gee, why are we trying to put caps on awards? A $100 million verdict in this case. That verdict would have shut down this hospital, which is a major medical center in the Lehigh Valley. Subsequent to the verdict, they negotiated a settlement for substantially less money. But the bottom line is, you have a situation where things get out of control because bad things happen to people. People are injured. In this case this little baby, because of a whole lot of factors I have detailed, is going to have a tough life. But is it the fault of St. Luke's Hospital? Is it the fault of the physicians who were attending? The answer from all indications is no. But you have someone who feels bad that this child is going to need some help, so you give verdicts of $100 million.

The consequence at St. Luke's was that since 2000, 32 private physicians have left St. Luke's as a direct result of the malpractice insurance crisis. Twelve OB–GYNs, 5 neurosurgeons, 2 pulmonary specialists, 3 orthopods, 3 general surgeons, 2 internists, and 1 pain management specialist. There has been a 44-percent decline in the number of private practice OB–GYN physicians on their medical staff.

One of the reasons I have introduced S. 23 is because it is not just a problem at St. Luke's, it is a problem in Philadelphia, a problem in Pittsburgh. We are down to I think three maternity wards in the city of Pittsburgh. This is a problem across our State. Unfortunately, the heavy hand of politics is played not just here in Washington but also in our State Capitol.

There was a study done that showed that the trial attorneys in America in the 2003–2004 election cycle contributed $182 million to political campaigns—$182 million. That sounds like a lot of money. It is a lot of money. But it is actually a pretty good investment on the part of the trial attorneys. Because for that $182 million, they were able to collect $18 billion in fees—$18 billion in fees. That is a 10,000-percent rate of return. Not a bad investment. So they are investing in the political climate here. They are investing to make sure there is no balance in the system. They are investing because they want to keep things out of whack. They want to keep those 40- and 50-percent awards, the percentages of contingency fees to these big awards, so they can keep the gravy train coming.

That is something our health care system cannot afford. We cannot afford to allow this kind of litigation to be practiced in the health care arena. It is destroying our ability to keep physicians in Pennsylvania. It is destroying our ability to have responsible medicine practiced—not defensive medicine but appropriate medicine and responsible medicine that treats patients the way they should be treated, not the way they need to be treated to avoid possible litigation.

That is not responsible medicine. That is not the medicine physicians want to practice. But, increasingly, in my State, that is the medicine they are practicing, and unless we do something tonight, in a few minutes, they are going to have to continue to practice that way.

Mr. VOINOVICH. Mr. President, I rise to speak today about the dilemma this Nation is facing regarding access to quality, affordable health care. Next to the economy, it is the greatest domestic challenge facing our Nation. In fact, the rising cost of health care is a major part of what is hurting our competitiveness in the global marketplace.

One of the biggest factors driving health care costs through the roof is medical lawsuit abuse. I have been concerned about this issue for quite some time—in fact, since my days as Governor of Ohio. I wish we had the outpouring of support for medical liability reform back then 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.

While things are getting marginally better in some communities in Ohio thanks to the California MICRA-like reform initiatives that were passed in Ohio in 2002 and 2003, doctors are still leaving their practice, and in too many towns, patients are not able to receive the care they need. In fact, too many physicians in northeast Ohio are still feeling the strain of skyrocketing premiums. For example, thoracic surgeons in Ohio are paying as much as $181,000 annually, and OB/GYNs in the area are paying $200,000 annually for liability coverage.

The past 5 years have been especially tough on physicians.

Back in 2002, The Medical Liability Monitor ranked Ohio among the top five States for premium increases, and no one felt the impact of this increase more than the Schwieterman family in Ohio's rural west-central Mercer County. I have mentioned brothers, Doctors Jim and Tom Schwieterman, along with their father, retired Dr. Don Schwieterman, before here on the floor, but their story is worth repeating.

Together, these 3 doctors have delivered about 5,700 babies over the years. This family has a 113-year history of bringing babies into the world—their great-grandfather started their current medical practice in 1896. Most importantly, they have never been sued for a delivery.

Yet, as of September 27, 2004, this family gave up delivering babies because of escalating malpractice insurance costs. Their insurance rates rose from $25,000 annually to over $80,000 in just 4 years—a threefold increase. Dr. Jim Schwieterman has stated that he would continue to deliver babies if he could just break even; unfortunately, he can't.

This situation becomes even more devastating when you learn that Dr. Jim Schwieterman was one of only a handful of obstetricians providing obstetrical care in Mercer County. Now, pregnant mothers must travel, in many cases, outside of the county to get obstetrical care.

Women in Morrow County, OH, are faced with a similar situation. As of January 2003, the only remaining physician in the county still delivering babies, Dr. Bachedler, was forced to stop after his liability costs more than doubled in one year.

Sadly, obstetricians are not the only physicians in my State who are being forced out of practicing medicine. Dr. Romeo Diaz, an oncologist from my hometown of Cleveland, saw his liability premiums rise $60,000 annually. Despite his patients attempt to help him raise the money he needed to remain in practice, Dr. Diaz closed his doors in 2003.

The decision to limit or close their practice does not come easily to these physicians. Some time ago, a good friend of mine brought to my attention a letter from an OB/GYN in Dublin, OH, who had decided to retire from his practice. He wrote the following to his patients:

> On June 17, 2003, I received my professional liability insurance rate quote for the upcoming year, and it is 64 percent higher than last year's rate. I have seen my premiums almost triple during the past two years, despite never having had a single penny paid out on my behalf in twenty-seven years as a physician. Even worse, during this time the insurance company has reduced the amount of coverage that I can purchase from $5 million to only $1 million, while jury verdicts have skyrocketed, often exceeding $3–4 million. If I were to purchase this policy, I would be putting all of my family's personal assets at risk every time that I delivered a baby or performed surgery. I refuse to do that. I have therefore decided to retire from private practice on July 31, 2003, the final day of my current liability insurance policy. This is not a decision that I take lightly, but unfortunately it has become necessary. For many of you, I have been part of your life for years. I have delivered your babies, and helped you through some of life's most difficult challenges. It has truly been an honor.

Like these doctors, in 2004, a survey by the Ohio State Medical Association, OSMA, indicated that 34 percent of Ohio physicians expect to close their

practices within the next 2 years without a reversal in medical liability rates. And whether they are ultimately forced to close their doors, a majority of physicians in Ohio agree that rising medical liability rates have directly impacted the way they practice medicine. Fifty-six percent of them believe they have increased the number of tests they have ordered for patients in order to protect themselves from potential lawsuits.

In fact, a March 3, 2003, report by the Department of Health and Human Services calculated the practice of defensive medicine costs the United States a total of between $70 and 126 billion a year and estimates that the cost for the Federal Government alone is between $35 and $56 billion. This is costing you and me real money.

Nevertheless, I am very hopeful when I now hear from physicians back home that thanks to the latest packages of tort reform measure that passed the Ohio State Legislature, medical liability rates are finally beginning to stabilize.

In fact, a January 2006 Ohio Department of Insurance report found that overall rate increases pursued by the five largest insurers were significantly less in 2005 than in previous years—6.7 percent in 2005, compared to 20 percent in 2004 and approximately 30 percent in 2003. For 2006, one insurer has even lowered its rates by 5 percent.

Good, balanced legislation can make all the difference. Just like we are beginning to see in Ohio, medical liability reform efforts in States like Texas are providing real results. We have been hearing a great deal about the good news coming out of Texas this week on the Senate floor, and it is for good reason. In 2003, the Texas Legislature enacted comprehensive sweeping medical liability reforms, with reasonable limits on noneconomic damages. Texas voters also understood the importance of this reform and approved proposition 12 amending the State constitution to specifically allow the legislature to enact the reasonable caps.

In just 3 short years, the results have been tremendous. It is hard to believe, but Texas physicians are once again able to competitively shop for medical liability coverage according to the Texas insurance commissioner.

While this is great news, in many places across the Nation, the situation is not the same, and the need for Federal medical liability reform is still very real.

Since the 107th Congress, I have been coming to the floor to speak in support of numerous medical liability bills: The HEALTH Act, the Patients First Act, The Healthy Mothers and Babies Access to Care Act, and the Pregnancy and Trauma Care Access Protection Act, and others. Unfortunately, none of these pieces of legislation garnered the 60 votes needed here in the Senate to achieve cloture.

Frustrated by this, several years ago, I spent countless hours along with the American Medical Association, AMA, going door to door to meet with my colleagues to examine other possible approaches for reform. I met with a number of my colleagues to explore those approaches and generate the kind of support needed to get to 60 votes.

The biggest complaint I heard from my colleagues is that the cap on noneconomic damages in these earlier bills was too low. For this reason, I am especially hopeful about the legislation before us today and proud to be a cosponsor of both the Medical Care Access Protection Act and the Healthy Mothers and Healthy Babies Access to Care Act.

These bills provide the Senate with a new approach to reforming our medical liability system. Like past bills, this legislation provides for unlimited payments on economic damages, but it would also mimic the State of Texas' approach to capping noneconomic damages. This legislation would limit noneconomic damage awards to $250,000 for each claimant, a healthcare provider, or each of two health care institutions. In total, this legislation creates a $750,000 cap on noneconomic damages.

I also heard concerns from my colleagues that past versions of medical liability reform bills would preempt State laws when some States already have laws that are working.

The bill before us preserves States' rights by keeping medical liability statutes in place and by allowing future State laws to supersede Federal limits on damages.

Further, the bill protects patients by placing reasonable limits on attorney fees, provides a review of expert witnesses to provide greater creditability to cases, and maximizes patients' recovery for damages by limiting the amount of payment attorneys are able to claim from awards.

I have been so passionate about the need for liability reform over my public service career because the issue is very personal to me. When I was young, I suffered from osteomyelitis, a disease in the bone marrow. During my 6-month hospital stay, I had two physicians who approached my parents with treatment options for me. One physician wanted to go with the ''gold standard'' treatment at the time, which would more than likely have saved my life but also had the potential to leave me without use of my right leg. The second physician, Dr. Holoway, offered my parents a more experimental option, one that was less invasive and posed less of a risk to my leg. I am thankful my parents chose the more experimental treatment, which left me with full mobility.

I wonder whether a physician in Dr. Holoway's shoes today would have taken the same approach with all the potential legal implications. I fear in today's environment that doctor would not.

For this reason, I urge my colleagues to support both the Medical Care Access Protection Act and the Healthy Mothers and Healthy Babies Access to Care Act. I am confident these bills strike a delicate balance between the rights of aggrieved parties to bring lawsuits and receive rapid and fair compensation and the rights of society to be protected against frivolous lawsuits and outrageous rewards for noneconomic damages—damages that are disproportionate to compensating the injured and made at the expense of society as a whole.

Mr. SPECTER. Mr. President, I seek recognition to support moving to legislation which would address the serious problems faced today by doctors, hospitals and other medical professionals who provide medical services, including obstetrical and gynecological services, while providing fair treatment to people who are injured in the course of medical treatment.

While most of the attention has been directed to OB/GYN malpractice verdicts, the issues are much broader, involving medical errors, insurance company premiums and insurer investments.

I support caps on noneconomic damages so long as they do not apply to situations such as the paperwork mix-up leading to an erroneous double mastectomy of a woman or the death of a 17-year-old woman on a North Carolina transplant case where there was a faulty blood type match or comparable cases in the OB/GYN services area.

An appropriate standard for cases not covered could be analogous provisions in Pennsylvania law which limit actions against governmental entities or in the limited tort context which exclude from the caps death, serious impairment of bodily function, and permanent disfigurement or dismemberment.

Beyond the issue of caps, I believe there could be savings on the cost of OB/GYN malpractice insurance and other malpractice insurance by eliminating frivolous cases by requiring plaintiffs to file with the court a certification by a doctor in the field that it is an appropriate case to bring to court. This proposal, which is now part of Pennsylvania State procedure, would be expanded federally, thus reducing claims and saving costs. While most malpractice cases are won by defendants, the high cost of litigation drives up OB/GYN malpractice premiums and other premiums. The proposed certification would reduce plaintiff's joinder of peripheral defendants and cut defense costs.

Further savings could be accomplished through patient safety initiatives identified in a report of the Institute of Medicine. On November 29, 1999, the Institute of Medicine, IOM, issued a report entitled: To Err is Human: Building a Safer Health System. The IOM report estimated that between 44,000 and 98,000 hospitalized Americans die each year due to avoidable medical mistakes. However, only a fraction of these deaths and injuries are due to negligence; most errors are caused by

system failures. The IOM issued a comprehensive set of recommendations, including the establishment of a nationwide mandatory reporting system; incorporation of patient safety standards in regulatory and accreditation programs; and the development of a nonpunitive culture of safety in health care organizations. The report called for a 50 percent reduction in medical errors over 5 years.

The Appropriations Subcommittee on Labor, Health and Human Services and Education, which I chair, held three hearings to discuss the IOM's findings and explore ways to implement the recommendations outlined in the IOM report. The fiscal year 2001 Labor-HHS appropriations bill contained $50 million for a patient safety initiative and directed the Agency for Healthcare Research and Quality, AHRQ, to develop guidelines on the collection of uniform error data; establish a competitive demonstration program to test best practices; and research ways to improve provider training. These initiatives were funded at $55 million in fiscal years 2002 and 2003, and $84 million in fiscal years 2004, 2005, and 2006, for a total of $412 million.

There is some evidence that increases in OB/GYN insurance premiums and other premiums have been caused, at least in part, by insurance company losses, the declining stock market of the past several years, and the general rate-setting practices of the industry. As a matter of insurance company calculations, premiums are collected and invested to build up an insurance reserve where there is considerable lag time between the payment of the premium and litigation which results in a verdict or settlement. When the stock market has gone down, for example, that has resulted in insufficient funding to pay claims and the attendant increase in OB/GYN insurance premiums. A similar result occurred in Texas on homeowners insurance where cost and availability of insurance became an issue because companies lost money in the market and could not cover the insured losses on hurricanes.

In structuring legislation to put caps on jury verdicts in malpractice cases, due regard should be given to the history and development of trial by jury under the common law where reliance is placed on average men and women who comprise a jury to reach a just result reflecting the values and views of the community.

Jury trials in modern tort cases descend from the common law jury in trespass, which was drawn from and intended to be representative of the average members of the community in which the alleged trespass occurred. This coincides with the incorporation of negligence standards of liability into trespass actions.

This ''representative'' jury right in civil actions was protected by consensus among the state drafters of the U.S. Constitution's Bill of Rights. The explicit trial by jury safeguards in the Seventh Amendment to the Constitution were adaptations of these common law concepts harmonized with the Sixth Amendment's clause that local juries be used in criminal trials. Thus, from its inception at common law through its inclusion in the Bill of Rights and today, the jury in tort/negligence cases is meant to be representative of the judgment of average members of the community, not of elected representatives.

The right to have a jury decide one's damages has been greatly circumscribed in recent decisions of the United States Supreme Court. An example is the analysis that the court has applied to limit punitive damage awards.

The Court has shifted its Seventh Amendment focus away from two centuries of precedent in deciding that federal appellate review of punitive damage awards will be decided on a de novo basis and that a jury's determination of punitive damages is not a finding of fact for purposes of the re-examination clause of the Seventh Amendment—''no fact tried by a jury shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law.'' Then, in 2003, the Court reasoned that any ratio of punitive damages to compensatory damages greater than 9:1 will likely be considered unreasonable and disproportionate, and thus constitute an unconstitutional deprivation of property in non-personal injury cases. Plaintiffs will inevitably face a vastly increased burden to justify a greater ratio, and appellate courts have far greater latitude to disallow or reduce such an award.

These decisions may have already, in effect, placed caps on some jury verdicts in malpractice cases which may involve punitive damages.

The pending bills are a starting point for analysis, discussion, debate and amendment. I am prepared to proceed with the caveat that there is much work to be done before the Senate would be ready, in my opinion, for consideration of final passage.

Mr. WARNER. Mr. President, I rise today, once again, in support of health care liability reform.

I have long been a major supporter of reforming our medical malpractice laws in an effort to stem the astronomical increases in health care costs. In fact, in the 108th Congress, I was pleased to offer my own amendment on health care liability reform called the Protect the Practice of Medicine Act.

While my amendment was supported by the American Medical Association, the American College of Surgeons, and a number of other associations representing the men and women in our medical profession, unfortunately, a procedural move by opponents prevented my amendment from receiving an up-or-down vote.

In fact, opponents of health care liability reform have been using procedural tactics in the Senate to prevent an up-or-down vote on this issue for years now. The consequences are grave: men and women, who have invested years of their lives training to become doctors and hundreds of thousands of dollars on their education, continue to leave the practice of medicine due to the high cost of malpractice insurance.

Opponents of reform argue that the cost of medical malpractice insurance is stabilizing and that the increases in malpractice premiums are not as dramatic as they were a few years ago. The truth is that these premiums remain extremely high. Having rates stabilize does not mean that those rates have gone down. Time and time again, doctors come into my office and tell me that they are having a difficult time making a living and keeping quality staff because of the staggering amounts they are paying for medical liability insurance.

I have received numerous letters from medical professionals in the Commonwealth of Virginia and from across the Nation that share with me the very real difficulties they are encountering with malpractice insurance and the consequences of this problem. Let me read part of one those letters that was sent to me by a doctor in Virginia. The doctor writes:

> I am writing you to elicit your support and advice for the acute malpractice crisis going on in Virginia. . . . I am a 48-year-old single parent of a 14 and 17 year old. After all the time and money spent training to practice OB/GYN, I find myself on the verge of almost certain unemployment and unemployability because of the malpractice crisis. I have been employed by a small OB/GYN Group for the last 7 years. . . . Our malpractice premiums were increased by 60 percent . . . The reality is that we will not be able to keep the practice open and cover the malpractice insurance along with other expenses of practice.

Out of respect for this doctor's privacy, I will not share the doctor's name, but I do keep her letter in my files.

According to the American College of Surgeons, many surgeons are being forced to retire earlier, stop providing high-risk procedures, or move to States where strong medical liability reforms are in place.

On March 16, 2006, Norfolk, VA's, newspaper, the Virginian-Pilot, featured the story of Dr. Shawne Bryant, an OB/GYN in Kempsville, VA. Dr. Bryant explained that she stopped performing surgery in 2003, citing high malpractice insurance rates. She redirected her talent into quiltmaking.

Dr. Bryant, who has been in the field of obstetrics and gynecology for 21 years, said, ''I used to be in the operating room two to three days a week. This [quiltmaking] is an outlet for me because I'm still working with my hands.'' Since giving up the practice of surgery, Bryant has made eight quilts.

Both Time Magazine and Newsweek have thoroughly detailed the crisis doctors are facing across America.

In June of 2003, Time Magazine had a cover story on the affects of rising malpractice insurance rates. The story, entitled ''The Doctor is Out,'' discusses

several doctors, all across America, who have had to either stop practicing medicine or have had to take other action due to increased insurance premiums.

One example cited in Time's article is the case of Dr. Mary-Emma Beres. Time reports that, ''Dr Mary-Emma Beres, a family practitioner in Sparta, N.C., has always loved delivering babies. But last year Beres, 35, concluded that she couldn't afford the tripling of her $17,000 malpractice premium and had to stop. With just one obstetrician left in town for high risk cases, some women who need C-sections now must take a 40-minute ambulance ride.''

Dr. Beres' case makes clear that not only doctors are being affected by the medical malpractice insurance crisis—patients are as well. With increased frequency, due to rising malpractice rates, more and more patients are not able to find the medical specialists they need.

Newsweek also had a cover story on the medical liability crisis. That cover story was entitled ''Lawsuit Hell.'' I was particularly struck by the feature in this magazine about a doctor from Ohio who saw his malpractice premiums rise in one year from $12,000 to $57,000 a year. As a result, this doctor, and I quote from the article, ''decided to lower his bill by cutting out higher-risk procedures like vasectomies, setting broken bones and delivering babies—even though obstetrics was his favorite part of the practice. Now he glances wistfully at the cluster of baby photos still tacked to a wall in his office, 'I miss that terribly,' he says.''

Without a doubt, the cost of medical malpractice insurance premiums are having wide-ranging effects. It is a national problem, and it is time for a national solution.

President Bush has indicated that the medical liability system in America is largely responsible for the rising costs of malpractice insurance. The American Medical Association and the American College of Surgeons agree with him, as does almost every doctor in Virginia with whom I have discussed the issue.

Let me state unequivocally that I agree with our President, with the AMA, with the American College of Surgeons, and with the vast majority of doctors all across Virginia.

I am pleased that S. 23, the Healthy Mothers and Health Babies Access to Care Act, reduces the excessive burden the liability system places specifically on the delivery of obstetrical and gynecological services. And I am pleased that S. 22, the ''Medical Care Access Protection Act of 2006'' or ''MCAP Act,'' extends liability protections to all health care providers and health care institutions.

These bills are a commonsense solution to a serious problem, and it is time for us to vote up or down on this legislation.

Mr. FEINGOLD. Mr. President, once again we are faced with ill-advised medical malpractice bills coming to the Senate floor without any committee consideration. Some argue that we have a malpractice insurance crisis that is driving doctors from the practice of medicine, particularly in the field of obstetrics and gynecology, or OB/GYN. But we haven't yet explored these issues in the Senate at all. No committee has held hearings or marked up a bill on this topic. Instead, extreme proposals have been brought directly to the floor and Senators are expected to vote for them. Indeed, motions to proceed to two different bills are being considered at the same time because no one really expects them to succeed. This is just a show. That is not how the legislative process should work on an issue of importance to so many people. I will vote no on cloture, as I have repeatedly in the past and will do in the future, until this issue is addressed in a serious way.

I would like very much for Congress to address the problem of malpractice insurance premiums once we understand the causes of the problem and the effectiveness of the proposed solutions. But by bringing these bills directly to the floor, the majority simply demonstrates that it is not serious about addressing the problem. It just wants to play a political card. To the extent that there really is a malpractice insurance problem, what is going on here is a cynical exercise, designed only to fail and to provide fodder for political attacks.

These bills, in my judgment, will not solve the problem that they supposedly have been designed to address. What they will surely do is harm innocent Americans who have suffered horrible and permanent injury at the hands of negligent medical practitioners.

There are many provisions of S. 22 and S. 23 with which I have serious disagreement. Let me just mention a few. In a provision called the ''fair share rule,'' the bills eliminate joint and several liability in the lawsuits covered by the bills. What that means is that if one responsible defendant is insolvent and has no insurance coverage, the victim of malpractice ends up without a full recovery of his or her damages. This is not fair. Most state laws provide that the risk of one defendant being insolvent or judgment-proof is borne by the other responsible defendants. There is no reason to change this longstanding principle of law. All it does is make it more likely that injured mothers and children will not recover the damages that a court has decided they are due.

Another problem with these bills is a new statute of limitations that applies only in States that are more protective of the injured party than the new Federal standard. Shorter statutes of limitation don't discourage frivolous claims, they encourage them. Lawyers facing a looming statute of limitations are more likely to file lawsuits to protect their clients' options. Imposing a statute of limitations of as little as one year, as these bills do, does not allow adequate time to investigate a case and determine if it really should be brought.

But perhaps the most ill-advised provision in these bills is the cap on noneconomic damages. These caps have been modified from previous bills and are designed to look more generous, although they actually won't be in most cases. Indeed, it will be very rare for a plaintiff to reach the new maximum caps because most lawsuits don't name at least one doctor, and least two hospitals or other institutions as defendants.

We have held no hearings on the medical malpractice issue in this Congress, but at the one hearing held on this issue in the last Congress, the Judiciary and HELP Committees heard from Linda McDougal, a 46-year-old Navy veteran from Woodville, WI. Several years ago, Ms. McDougal underwent a double mastectomy after her biopsy results were switched with those of another patient. She didn't have cancer, she never had cancer. We can be thankful for that. But her life, and her family's life, will never be the same.

I hope everyone in the Senate will read Linda McDougal's testimony and learn about her experience. It is a powerful cautionary tale for those of us who are charged with voting on legislation concerning medical malpractice.

I find it hard to believe that anyone in this body can look Linda McDougal or any of the thousands of victims of catastrophic medical malpractice in the eye and say, ''all your pain and suffering is worth only $250,000, or maybe $750,000 if you sue enough people.'' Would any of us be able to tell our mothers or our wives or our daughters that their damages should be limited in this arbitrary way if they were the victims of the unspeakable pain and lifelong sadness that Linda McDougal will endure? Remember, Linda McDougal didn't have extraordinary medical bills or lost wages. Her damages are noneconomic. But her loss is real, it is permanent, it is unfathomable.

There is no question that we have a problem in this country over the cost of malpractice insurance. But the solution cannot be to penalize innocent victims like Linda McDougal, to prolong and extend their suffering by denying them adequate compensation.

Caps on noneconomic damages are a cruel hoax. They are advertised as a disincentive to frivolous lawsuits. But they have the most impact on the most serious and nonfrivolous cases, cases where unimaginable pain has been inflicted on someone by a careless health professional.

In addition, we have virtually no evidence that caps on economic damages will actually lower insurance rates. Indeed, in States that have caps on noneconomic damages, insurance premiums increased 48 percent from 1991 to 2002. But in States without caps, the increase has been only 36 percent. So the case has simply not been made that

the caps in this bill will lower malpractice premiums. But more importantly, the case has not been made, and in my view cannot be made, that these caps are fair to victims like Linda McDougal.

There very well may be solutions that we in the Senate can develop to address the cost of medical malpractice insurance in this country and the effect on patient care that rising premiums are causing. And there certainly are things we can do to address the disturbing problem of medical error in this country. The Institute of Medicine estimates that between 44,000 and 98,000 adverse medical events occur in hospitals every year. Other studies suggest that those numbers may be a vast underestimate.

If we want to reduce malpractice insurance premiums we must address these problems as well as looking closely at the business practices of the insurance companies. What we shouldn't do is limit the recovery of victims of horrible injury to an arbitrarily low sum.

This is obviously a complicated issue. This is the kind of issue that needs to be explored in depth in our committees so that a consensus can emerge. It is certainly not the kind of issue that should be brought directly to the floor with such a great gulf between supporters and opponents. So I will vote no on cloture today on both S. 22 and S. 23, and I hope that these bills will go through the HELP Committee and the Judiciary Committee before we begin floor consideration of this important topic.

CLOTURE MOTION

The PRESIDING OFFICER (Mr. BURR). Under the previous order, pursuant to rule XXII, the Chair lays before the Senate the pending cloture motion, which the clerk will report.

The legislative clerk read as follows:

CLOTURE MOTION

We the undersigned Senators, in accordance with the provisions of rule XXII of the standing rules of the Senate, do hereby move to bring to a close debate on the motion to proceed to S. 22: A bill to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system.

Bill Frist, Johnny Isakson, Sam Brownback, John Thune, Thad Cochran, Wayne Allard, John Ensign, Pat Roberts, Larry Craig, Ted Stevens, David Vitter, John McCain, Lamar Alexander, Norm Coleman, Judd Gregg, John Sununu, Craig Thomas.

The PRESIDING OFFICER. By unanimous consent, the mandatory quorum call has been waived.

The question is, Is it the sense of the Senate that debate on the motion to proceed to S. 22, a bill to improve patient access to health care services and provide improved medical care by reducing excessive burden the liability system places on the health care delivery system, shall be brought to a close?

The yeas and nays are mandatory under the rule.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. The following Senators were necessarily absent: the Senator from Kansas (Mr. BROWNBACK), the Senator from Montana (Mr. BURNS), the Senator from Oklahoma (Mr. COBURN), and the Senator from Arizona (Mr. MCCAIN).

Mr. REID. I announce that the Senator from Delaware (Mr. BIDEN), the Senator from Illinois (Mr. DURBIN), the Senator from Vermont (Mr. JEFFORDS), the Senator from Illinois (Mr. OBAMA), the Senator from West Virginia (Mr. ROCKEFELLER) are necessarily absent.

I also announce that the Senator from North Dakota (Mr. CONRAD) is absent due to illness in the family.

I further announce that, if present and voting, the Senator from Delaware (Mr. BIDEN) would vote ''nay.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The yeas and nays resulted—yeas 48, nays 42, as follows:

[Rollcall Vote No. 115 Leg.]

YEAS—48

Alexander	Dole	McConnell
Allard	Domenici	Murkowski
Allen	Ensign	Roberts
Bennett	Enzi	Santorum
Bond	Frist	Sessions
Bunning	Grassley	Smith
Burr	Gregg	Snowe
Chafee	Hagel	Specter
Chambliss	Hatch	Stevens
Cochran	Hutchison	Sununu
Coleman	Inhofe	Talent
Collins	Isakson	Thomas
Cornyn	Kyl	Thune
Craig	Lott	Vitter
DeMint	Lugar	Voinovich
DeWine	Martinez	Warner

NAYS—42

Akaka	Feinstein	Menendez
Baucus	Graham	Mikulski
Bayh	Harkin	Murray
Bingaman	Inouye	Nelson (FL)
Boxer	Johnson	Nelson (NE)
Byrd	Kennedy	Pryor
Cantwell	Kerry	Reed
Carper	Kohl	Reid
Clinton	Landrieu	Salazar
Crapo	Lautenberg	Sarbanes
Dayton	Leahy	Schumer
Dodd	Levin	Shelby
Dorgan	Lieberman	Stabenow
Feingold	Lincoln	Wyden

NOT VOTING—10

Biden	Conrad	Obama
Brownback	Durbin	Rockefeller
Burns	Jeffords	
Coburn	McCain	

The PRESIDING OFFICER. On this vote, the yeas are 48, the nays are 42. Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is rejected.

HEALTHY MOTHERS AND HEALTHY BABIES ACCESS TO CARE ACT—MOTION TO PROCEED—Resumed

CLOTURE MOTION

The PRESIDING OFFICER. Under the previous order, the clerk will report the motion to invoke cloture on the motion to proceed to S. 23.

The legislative clerk read as follows:

CLOTURE MOTION

We the undersigned Senators, in accordance with the provisions of rule XXII of the standing rules of the Senate, do hereby move to bring to a close debate on the motion to proceed to S. 23: A bill to improve women's access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the delivery of obstetrical and gynecological services.

Bill Frist, Johnny Isakson, Sam Brownback, John Thune, Thad Cochran, Wayne Allard, John Ensign, Pat Roberts, Larry Craig, Ted Stevens, David Vitter, John McCain, Lamar Alexander, Norm Coleman, Judd Gregg, John Sununu, Craig Thomas.

The PRESIDING OFFICER. By unanimous consent, the mandatory quorum call has been waived.

The question is, Is it the sense of the Senate that debate on the motion to proceed to S. 23, a bill to improve women's access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the delivery of obstetrical and gynecological services, shall be brought to a close? The yeas and nays are mandatory under the rule.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. The following Senators were necessarily absent: the Senator from Kansas (Mr. BROWNBACK), the Senator from Montana (Mr. BURNS), and the Senator from Arizona (Mr. MCCAIN).

Mr. DURBIN. I announce that the Senator from Delaware (Mr. BIDEN), the Senator from Vermont (Mr. JEFFORDS), and the Senator from West Virginia (Mr. ROCKERFELLER) are necessarily absent.

I also announce that the Senator from North Dakota (Mr. CONRAD) is absent due to illness in family.

I further announce that, if present and voting, the Senator from Delaware (Mr. BIDEN) would vote ''nay.''

The yeas and nays resulted—yeas 49, nays 44, as follows:

[Rollcall Vote No. 116 Leg.]

YEAS—49

Alexander	Dole	Murkowski
Allard	Domenici	Roberts
Allen	Ensign	Santorum
Bennett	Enzi	Sessions
Bond	Frist	Smith
Bunning	Grassley	Snowe
Burr	Gregg	Specter
Chafee	Hagel	Stevens
Chambliss	Hatch	Sununu
Coburn	Hutchison	Talent
Cochran	Inhofe	Thomas
Coleman	Isakson	Thune
Collins	Kyl	Vitter
Cornyn	Lott	Voinovich
Craig	Lugar	Warner
DeMint	Martinez	
DeWine	McConnell	

NAYS—44

Akaka	Crapo	Inouye
Baucus	Dayton	Johnson
Bayh	Dodd	Kennedy
Bingaman	Dorgan	Kerry
Boxer	Durbin	Kohl
Byrd	Feingold	Landrieu
Cantwell	Feinstein	Lautenberg
Carper	Graham	Leahy
Clinton	Harkin	Levin

Lieberman	Nelson (NE)	Sarbanes
Lincoln	Obama	Schumer
Menendez	Pryor	Shelby
Mikulski	Reed	Stabenow
Murray	Reid	Wyden
Nelson (FL)	Salazar	

NOT VOTING—7

Biden	Conrad	Rockefeller
Brownback	Jeffords	
Burns	McCain	

The PRESIDING OFFICER (Mr. VITTER). On this vote, the yeas are 49, the nays are 44. Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is rejected.

Mr. BYRD. Mr. President, last Wednesday, Senator ENSIGN introduced S. 22, the Medical Care Access Protection Act of 2006, a bill that would ''cap'' legal damages awarded to victims of medical malpractice. Senators SANTORUM and GREGG similarly, just last week, introduced S. 23, the Healthy Mothers and Healthy Babies Access to Care Act, a bill to limit legal damages in cases involving obstetrical and gynecological services.

Today I voted not to invoke cloture on the motions to proceed to these two bills, because there has been no debate of these particular measures in the 109th Congress. There have been no hearings scheduled or held on the bills this year, and their provisions raise questions to which West Virginians deserve complete and well-considered responses.

The situation in West Virginia today is not as it was several years ago, when the State legislature enacted medical liability tort reform. At that time, there was a perceived crisis based on the escalating costs of medical insurance premiums, and there were serious concerns that doctors and other health care providers may have been leaving the State to avoid the expenses they incurred in protecting themselves from legal liability. Today, however, even the West Virginia State Medical Association, a strong supporter of medical liability reform, advises that, based on the significant changes passed by the West Virginia State Legislature in 2003, the State has ''already seen positive results with recent decreases in insurance premiums and an increase in the ability to recruit physicians to the state.''

Based on the acknowledged success of West Virginia's legislative enactments in this area, it would be irresponsible, if not downright foolhardy, to enact S. 22 and S. 23 with little examination and no recent debate, particularly when the provisions of these bills would explicitly preempt certain State laws. In addition, the bills shorten the time during which patients can bring cases; they limit punitive damages; they exempt from product liability lawsuits health care providers who have prescribed drugs or devices approved by the FDA; and they generally revamp our Nation's medical liability system in the wink of an eye, though the bills' provisions have been subject to little, if any, serious scrutiny.

Based on the changes that have occurred in our medical liability system since 2003, legislation of this importance requires careful consideration by the Senate's relevant committees of jurisdiction. To give such important provisions such short shrift, particularly in this changed environment, would do a tremendous disservice to medical providers and patients throughout both West Virginia and the Nation.

Mr. KOHL. Today the Senate once again considered medical liability reform bills—S. 22 and S. 23—both of which would impose an arbitrary cap on the amount of noneconomic damages—pain and suffering awards—an injured patient can receive in a medical malpractice lawsuit.

This is not the first time the Senate has dealt with such legislation. In years past, there were real problems with skyrocketing premiums that insurance companies were charging doctors. Even then, imposing damage caps was the wrong approach to address the issue and remains just as wrong today. A so-called reform based on arbitrarily capping pain and suffering awards is not a panacea. Studies show that passing a Federal medical malpractice law with damage caps will likely have no impact on runaway insurance premiums. Further, there is no promise that any savings insurance companies realize from such a law would be passed on to doctors.

Moreover, we find that medical malpractice premiums have leveled off or are no longer increasing in both States with and without caps on noneconomic damages. A reasonable person could question why we are even considering this legislation when it appears the problem is abating. Nonetheless, some insist against all evidence that we need to pass these bills to save the health care system. Just as I have opposed similar damage cap bills in the past, I will oppose both S. 22 and S. 23.

Wisconsin has thoroughly addressed this issue with great success. As a result, we do not have a medical liability insurance crisis like some other States. Wisconsin has a noneconomic cap and a system that works for doctors and patients alike. Specifically, Wisconsin limits the amount of liability insurance a medical professional must obtain, and beyond that, Wisconsin's Patient Compensation Fund ensures that injured patients are fully reimbursed for their damages. I oppose doing anything to upset the delicate balance the State has found.

Though neither S. 22 nor S. 23 would preempt Wisconsin's damage caps, Wisconsin law would be overturned in several other areas. For example, Wisconsin law grants children the right to sue, better ensures that victims fully recover their damages from defendants, and does not limit attorney fees as much as the Federal proposal. I will not support a Federal solution that undoes Wisconsin's law.

To be sure, the larger issue of medical liability reform deserves a serious debate instead of the resurfacing of a one-sided solution. We might want to look to Wisconsin as a model.

Mr. CHAFEE. Mr. President, today I voted in favor of invoking cloture on S. 22, the Medical Care Access Protection Act of 2006, and S. 23, the Healthy Mothers and Healthy Babies Access to Care Act. I have concerns about various aspects of the legislation including the specific levels of the proposed damage caps. However, I do believe that reform of the medical malpractice system should be considered by the Senate to discourage frivolous lawsuits and to ensure that individuals are able to access affordable health care. For these reasons, I voted to invoke cloture on both of these bills in an effort to move this important debate forward.

The PRESIDING OFFICER. The Senator from Wyoming.

MORNING BUSINESS

Mr. ENZI. Mr. President, I ask unanimous consent that there now be a period of morning business, with Senators permitted to speak for up to 10 minutes each.

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

SMALL BUSINESS HEALTH PLANS

Mr. ENZI. Mr. President, I rise today to support action on health care this week. There is a bill that will be voted on tomorrow morning that I think is extremely critical to the health of the Nation.

As chairman of the Committee on Health, Education, Labor, and Pensions, I can attest that access to affordable health care is the No. 1 issue for working families who contact my committee. I do need to explain where we are in this process.

We have a bill that made it out of committee to provide for small business health plans. There has been unanimous consent requested to proceed to the debate. That was denied. That is just the right to debate the bill, but it was denied. So a cloture motion was put in, and we will vote on that cloture motion tomorrow. That will be the 3 days after the cloture motion was filed. So that is a 3-day delay that we already have in solving small business health plan problems.

Tomorrow morning we will vote at 10. I can't imagine anybody voting against better health for people who work in small businesses. I am anticipating that we will get 60 votes. When we get 60 votes, we still will not get to debate the bill. We will have 30 hours of debate on that cloture vote before we will get to offer any amendments. Thirty hours. That could easily be 3 days. It could easily be Thursday before we get to offer the first amendment. I hope the other side will help to get cloture so that we can proceed to the debate. Then I hope that they would agree to shorten that time significantly so we could actually get to amendments and debate the bill.

We need to have a debate over the rising cost of health care. More importantly, we need to take action. Americans are tired of the status quo. They are tired of more of the same from the Senate. They are tired of excuses. They do want to see change for the better.

The majority leader announced his intention to bring a bill before the Senate that would allow small businesses to band together across the country and negotiate for better health care benefits at better prices. This bill sets up a system where we get a little bit of uniformity out there for the small businesses to band together across State lines and form a big enough pool that they have some power to negotiate against the insurance companies.

It is probably important to do that vote. I have some actuarial studies that show how many more people will be brought into the system, and CBO has done some evaluations of how many more people will be able to be insured and what kind of savings there will be. But I don't think they have the numbers right. The numbers are far greater than what they list.

Here is the reason I believe that. I had a lot of people call me Friday and Saturday and Sunday and let me know about the ads being run across the country. They are not referring to it as the small business health plans or even the Health Insurance Marketplace Modernization and Affordability Act. They are not even referring to it as S. 1955. They are referring to it as the Enzi bill. It is not the Enzi bill. It is the small business health plan bill. There are even Web sites set up. Thousands, if not millions, of dollars are being spent on advertising against it, which tells me that perhaps the ability for small companies to get together and negotiate against the insurance companies might be worth a lot more than anybody anticipated. That is where the ads are coming from.

Tomorrow morning we will be voting on the motion to proceed to the consideration of S. 1955. The bill will reduce the cost of health care, especially for America's small business owners and working families. Today, of the 45 million people without health insurance, 22 million own or work for small business, according to the Small Business Committee definition of a small business, or they live in families that depend on that small business for wages. Besides the 22 million out of the 45 million, there is another 5 million who are self-employed who could take advantage of this bill. That makes 27 million people who can't afford decent health insurance right now.

It is long past time for Congress to take action. The American people aren't going to accept excuses any longer. It is time for the Senate to take the first major step in nearly 15 years toward more affordable health insurance options for small businesses and working families.

There has been a bill on the House side that has passed 8 times in the last 12 years for association health plans. The Senate has never gotten any kind of a bill like that out of committee until now. This bill is not quite like that bill. This bill was derived by talking to the insurance companies, talking to the insurance commissioners, having them sit down with the associations and try to find a workable way that would not unlevel the playing field so that some people would be paying more for their health insurance while others were paying less. They worked for almost a year with me. All of them were convinced that something needed to be done. All of them were willing to work in a positive manner to come up with a bill that would work. That is what we have before us now.

That is not to say that the bill won't be changed through the debate, if we can get to the debate. There probably will be changes. There can be amendments to the bill. One of the things I have learned being in the State legislature as well as in Congress is that quite often amendments do help make a bill better. I do know that the American people support giving small businesses the same power that big businesses have had to negotiate for better benefits and better prices.

The fact that it has taken us so long to get to this point has to be frustrating for our constituents and the small businessmen. That is most of the people in the United States. They are either small business or they work in small businesses. When they work in a small business, they understand the plight of the business much better than in a big business. We already gave big business a lot more opportunity to negotiate than what we have in this bill for small business. This is a great start for small businesses to bring those costs down.

Small business owners and working families do want an up-or-down vote on small business health plans. They think they deserve it, and I believe they deserve it. I believe almost everybody here thinks they deserve a vote on whether they ought to be able to have a fraction of what the big companies have as an advantage in working with the insurance companies.

For years the small business owners have been asking the Senate to grant them the power that the big businesses have so they can secure affordable health care for their employees and their families. For the first time in over a decade, the Senate committee has reported a bill that gives small business owners the power they are seeking. Americans have sent hundreds of thousands of letters, petitions, phone calls, e-mails, faxes to the Senate over the past few weeks in support of small business health plans. The National Federation of Independent Businesses, one of the associations interested in this, delivered 500,000 petitions from across the United States asking us to do something. The people have taken time out of their busy days to demand action, and they deserve that up-or-down vote.

I remember getting permission, shortly after I got to the Senate, to hold a small business hearing in Casper, WY. That is the big city in the center of Wyoming. I held that hearing. I was pleased. I had about 100 small businessmen show up to lend their support and express their needs.

Afterward, one of the reporters asked: Aren't you disappointed you only had 100 people show up?

I said: Actually, this is small business. I am kind of surprised that 100 showed up because in small business, if you have an extra person who can spend a day at a hearing, you would probably fire them because you would have one more person than you needed.

In small business, they don't have nearly the diversity or the specialization, but they have a lot of personal ability and flexibility to take their product to market and to make a difference against the big companies that way. But they need some extra help. I know the minority leader will want an up-or-down vote on a bill sponsored by Senators DURBIN and LINCOLN. I believe the minority leader should get that up-or-down vote, even though I don't believe the bill he supports would provide the kind of change small business owners want and need. I know what the support is for that bill. I would love to do the comparisons between what we are trying to do in small business health plans and that. Let's see what the will of the Senate is, and let's not resort to blocking consideration through procedural motions.

I am sure some of my Democratic colleagues will want to use their share of the 30 hours of debate after this vote to discuss a variety of health care issues. Some Members of the minority will want to discuss the Medicare drug benefit. I have heard that on the floor in this preliminary time. Some will want to talk about drug importation. Some will want to talk about stem cell research. I know that from the debate we have had on the floor today. It is their right under the Senate rules.

I am not sure how I would go about explaining that to the small business owners and the working families who work in those small businesses. I suppose that the vast majority of those small business owners are going to be too busy during the day and night to watch the Senate debate on C–SPAN2. But those who do will understand that the issues we are talking about are not the solution they are expecting, and that they are external to the bill we are debating at this time. Those are important issues. But if they are just being done to block a bill—and that will be the way it will be termed by small business—I suspect there will be a price to pay for that kind of action.

I hope, for all our sakes, that the TVs in hospital emergency rooms are not tuned to C–SPAN. Some of those Americans who depend on small business and are in the emergency room may have no health insurance. Maybe their company dropped the coverage last year or

maybe the company could not afford health insurance in the first place.

What would they say if they were watching us this week? After all, the caption on the screen will read that we are supposed to be debating health insurance for working families. But instead of debating two competing visions for providing more affordable health care options for small businesses, we will be talking about Democratic amendments on a number of issues, including the Medicare drug benefit, which has already been done, and people are signing up in numbers that had not been anticipated. There is also already enough competition out there that it has driven the prices down. That is what competition does. It is working for seniors and they are saving money.

But instead of talking about things that are working for Americans, we should be debating the challenges that still face us, such as the rising cost of health care for America's working families.

Every day, emergency rooms treat more than 30,000 uninsured Americans who work for or depend on small business. That is at least 30,000 reasons why we should move right away to the consideration of S. 1955 to create small business health plans.

For the first time in more than a decade, the Senate has been presented with a bill that would create a whole new set of affordable health care choices through small business health plans.

Is it the perfect bill? No. I have never seen one in my 9 years in the Senate. We won't get to see anything even near perfect if we don't get to debate it. I believe most of my colleagues like the concept of getting as much perfection through amendments as possible and do want to work with me on it. Procedural votes won't get that done.

If we are waiting for the perfect bill, the one true and comprehensive solution to fix our health care system, then someone needs to bring us a tent, flashlights, and field rations, because we are going to be a very long time waiting for that. I am hoping it is not a series of 30-hour waits to debate things that won't have anything to do with getting small business health plans for small businesses. Americans are never waiting for perfection from Congress. They have given up on that long ago. But they do want action.

We have a good bill before us. We have a bipartisan bill before us. I am a former small business owner and I know something about the struggle to provide affordable health care to my family and to my work families.

Senator BEN NELSON, who coauthored this bill, is a former State insurance commissioner, so he knows something about the importance of protecting consumers. Senator NELSON and I have spoken about this bill with just about every Member of the Senate. We think it is a very good bill, and we have reached out to our colleagues over the last several months to take their concerns into account as we put the bill together.

Some of our colleagues will have amendments they believe will make it even better, and they should have the opportunity to offer those amendments. Neither Senator NELSON nor I are afraid of that, nor are we afraid of any alternative bills that Members might want to propose.

I urge my colleagues to set aside tomorrow's motion to proceed to the consideration of the bill. Let's get on with it, debate it, and have some amendments. We can have constructive votes on the floor on a number of issues that will improve this bill. But if we have to go through the procedural motions, let's keep in mind those 27 million uninsured Americans who work for or depend on small businesses. Those are 27 million Americans who are counting on the Senate to act now—not next month, not next year, but now.

Let's take the step toward more affordable health care for all Americans by giving small business owners the power to create small business health plans for themselves, their families, and their workers. Give them the chance they are seeking, instead of more of the same excuses for not acting. I don't think they will buy that.

I am hoping some of the media that is doing coverage will do a little bit better job than I happened to see last weekend. PBS did a special. They forgot to talk to anybody who worked on the bill. They talked about some problems with California's health care and attributed it to this bill. This bill cannot be the cause of that yet because it is not in California.

There have been concerns by a number of other groups. One was the attorneys general for a number of States. Again, it would have been nice if they would have talked to us to be sure they had the right bill and had read it before they took their action. So we will be covering that in the next few days.

If we have to talk for 30 hours, we will be plenty willing to do that. There are a lot of people in small businesses who see this as a primary concern and need, and they wish to see it done as soon as possible. They will not be very forgiving if people are holding things up to try to defeat the bill instead of making constructive progress.

I appreciate all those who have worked with me and all of those who are still working on amendments. Particularly, I would appreciate it if they would talk to me. There are some good ideas out there, things that would work. Many are for clarification. It will make a difference to small business. I hope everybody will get past this motion to proceed and the 30 hours of debate will get finished.

NATIVE HAWAIIAN GOVERNMENT REORGANIZATION ACT OF 2005

Mr. ALEXANDER. Mr. President, today the U.S. Civil Rights Commission announced its opposition to S. 147, the Native Hawaiian Government Reorganization Act of 2005, which the Commission found to ''discriminate on the basis of race.''

It is possible that the Senate will be asked in the next few weeks to consider this legislation. I hope my colleagues will agree with the Civil Rights Commission and oppose this legislation.

Here is what the Commission had to say:

> The Commission recommends against passage of the Native Hawaiian Government Reorganization Act of 2005, or any other legislation that would discriminate on the basis of race or national origin and further subdivide the American people into discrete subgroups accorded varying degrees of privilege.

S. 147, the act to which the Commission refers, would create a separate, independent, race-based government for native Hawaiians. It would undermine our unity in this country. It would undermine our history of being a nation based not on race but upon common values of liberty, equal opportunity, and democracy.

The question the bill poses is thus one that is fundamental to the very existence of our country. It creates a new government based on race. Our Constitution guarantees just the opposite—equal opportunity without regard to race.

Hawaiians are Americans. They became United States citizens in 1900. They have saluted the American flag, paid American taxes, fought in American wars. In 1959, 94 percent of Hawaiians reaffirmed that commitment to become Americans by voting to become a state. Like citizens of every other state, Hawaii votes in national elections.

Becoming an American has always meant giving up allegiance to your previous country and pledging allegiance to your new country, the United States of America.

This goes back to Valley Forge when George Washington himself signed and then administered this oath to his officers: ''I . . . renounce, refuse, and abjure any allegiance or obedience to [King George III]; and I do swear that I will to the utmost of my power, support, maintain and defend the said United States. . . .''

America is different because, under our Constitution, becoming an American can have nothing to do with ancestry. That is because America is an idea, not a race. Ours is a nation based not upon race, not upon ethnicity, not upon national origin, but upon our shared values, enshrined in our founding documents, the Declaration of Independence and the Constitution, upon our history as a nation, and upon our shared language, English. An American can technically become a citizen of Japan, but would never be considered ''Japanese.'' But if a Japanese person wants to become a citizen of the United States, he or she must become an American.

That's who we are as Americans, and when we forget that, we run the risk of

undermining our greatest strength. Some say that diversity is our greatest strength. And it is a great strength, but hardly our greatest. Jerusalem is diverse. The Balkans are diverse. Iraq is diverse. Our greatest strength is that we have taken all that magnificent diversity and forged it into one Nation.

My heritage is Scotch-Irish. In early America, the Scotch-Irish referred to themselves as a race of people. But despite Scotch-Irish contributions to American independence and some injustices before independence, they did not ask for a separate nation based on race.

It is suggested that ''native Hawaiians'' are different because they lived on the islands of Hawaii before Asian and white settlers came there, and that their previous government was undermined by Americans who came. So, the argument goes, they should be treated as an American Indian tribe.

But U.S. law has specific requirements for recognition of an Indian tribe. A tribe must have operated as a sovereign for the last 100 years, must be a separate and distinct community, and must have had a preexisting political organization. Native Hawaiians do not meet those requirements. In 1998 the State of Hawaii acknowledged this in a Supreme Court brief in Rice v. Cayetano, saying: ''The tribal concept simply has no place in the context of Hawaiian history.''

If the bill establishing a ''native Hawaiian'' government were to pass, it would have the dubious honor of being the first to create a separate nation within the United States. While Congress has recognized pre-existing American Indian tribes before, it has never created a new one. This is a dangerous precedent. This is not much different than if American citizens who are descended from Hispanics that lived in Texas before it became a republic in 1836 created their own tribe, based on claims that these lands were improperly seized from Mexico. Or it could open the door to religious groups, such as the Amish or Hassidic Jews, who might seek tribal status to avoid the constraints of the Establishment Clause of the Constitution. If we start down this path, the end may be the disintegration of the United States into ethnic enclaves.

Hawaii itself is a proud example of the American tradition of diversity. According to the 2000 Census, 40 percent of Hawaiians are of Asian descent. Twenty-four percent are white. Nine percent said they were Native Hawaiian or Pacific Islanders. Seven percent claimed Hispanic ethnicity and 2 percent were black. Twenty-one percent of Hawaiians reported two or more racial identities. Their two Senators are of native Hawaiian and Japanese ancestry. Their Governor is white and also happens to be Jewish. But what unites Hawaii is not its diversity, but its common Hawaiian traditions and the fact that Hawaiians are all Americans.

The proposed new government for ''native Hawaiians'' would be based solely upon race. S. 147 makes individuals eligible to be ''native Hawaiian'' specifically by blood. Surely we have by now learned our lesson about treating people differently based upon race. Our most tragic experiences have occurred when we have treated people differently based upon race, whether they were African-Americans, Native American, or of other descent.

In the documents to which we have pledged allegiance, the way we have sought to right those wrongs is to guarantee respect for each American as an individual, regardless of his or her race. This legislation instead would compound those old wrongs. It would create a separate government, and separate rules—perhaps later even separate schools—based solely upon race.

To destroy our national unity by treating Americans differently based upon race is to destroy what is most unique about our country. It would begin to make us a United Nations instead of the United States of America.

The Senate should heed the advice of the U.S. Commission on Civil Rights and defeat this legislation that would discriminate on the basis of race or national origin and further subdivide the American people into discrete subgroups accorded varying degrees of privilege and create a new, separate, race-based government for those of native Hawaiian descent.

This idea is the reverse of what it means to become an American. Instead of making us one nation indivisible, it divides us. Instead of guaranteeing rights without regard to race, it makes them depend solely upon race. Instead of becoming ''one from many,'' we would become many from one.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. AKAKA. Mr. President, I rise in response to my good friend and colleague, the junior Senator from Tennessee, who spoke about legislation that is critical to the people of Hawaii, S. 147, the Native Hawaiian Government Reorganization Act of 2005.

S. 147 would extend the Federal policy of self-governance and self-determination to Hawaii's indigenous peoples, the native Hawaiians, by authorizing a process for the reorganization of a native Hawaiian governing entity for the purposes of a government-to-government relationship with the United States.

My colleague raised the actions by the U.S. Commission on Civil Rights last week. The Commission issued a report in opposition to S. 147. The report was based on a briefing that was conducted on January 20, 2006.

I am seriously concerned about the lack of objectivity in the Commission's review. The Commission never contacted its Hawaii advisory committee, which includes members who are experts in Hawaii's history and Indian law. Not once was the advisory committee informed of the briefing or allowed to contribute to the Commission's report.

Further, despite the fact that the Commission was provided with the substitute amendment which reflects negotiations with the executive branch, the Commission chose to issue its report based on the bill as reported out of committee. The substitute amendment to S. 147 will be offered when we consider the bill and reflects negotiations with the officials from the Department of Justice, Office of Management and Budget, and the White House.

The substitute amendment satisfactorily addresses the concerns expressed by the Bush administration regarding the liability of the U.S. Government, military readiness, civil and criminal jurisdiction, and gaming. The amendment has been publicly available since September 2005 and has been widely distributed.

I applaud the efforts of Commissioners Arlen Melendez and Michael Yaki who voted in opposition to the report and tried to inject objectivity and fairness into this process. It really saddens me when an independent commission begins to act in a politically motivated manner.

Despite this fact, I remain committed to my constituents and the people of Hawaii. I will continue to work to bring this bill to the Senate floor as it has been promised by the majority leader and the junior Senator from Arizona. The people of Hawaii deserve no less than a debate and a vote on an issue of critical importance to them and to their State.

When I first started my career in Congress over 30 years ago, there was a protocol and a courtesy. If legislation was going to impact a particular State, and the leaders of that State all supported the issue, it was protocol that other Members would not interfere or obstruct efforts to legislate on behalf of that State. Unfortunately, this longstanding protocol and courtesy, I am ashamed to say, no longer exists.

S. 147 is widely supported in Hawaii—widely supported in Hawaii. The bill enjoys the bipartisan support of my colleagues, Senators CANTWELL, COLEMAN, DODD, DORGAN, GRAHAM, INOUYE, MURKOWSKI, SMITH, and STEVENS. It is strongly supported by Hawaii's first Republican Governor in 40 years, Linda Lingle. She supports this bill. It is supported strongly by Hawaii's State Legislature which has passed three resolutions in favor of extending the Federal policy of self-governance and self-determination to native Hawaiians. It is supported by almost every single political leader in Hawaii. S. 147 is also supported by native Hawaiians and nonnative Hawaiians.

Why, you might ask? Because in Hawaii, native Hawaiian issues are nonpartisan. We have tremendous respect for the indigenous peoples who have shared their lands, traditions, and cultures with the rest of us.

Mr. President, I have been patient, and the people of Hawaii have been patient. For the past 3 years, the majority and Democratic leaders have been

working with me to uphold a commitment that was made at the end of the 108th Congress that we would consider and vote on this bill. Unfortunately—again, unfortunately—their efforts have been thwarted by a handful of colleagues who have taken it upon themselves to block this bill despite the widespread support from the State of Hawaii.

After 7 years of delay by a few of my colleagues, it is time we are provided with the opportunity to debate this bill in the open. I will be coming to the floor to talk about my bill every day until we begin debate on the bill. I will use every day to talk about what my bill does and does not do and to respond to the outright untruths that have been spread about the legislation. I will use every day to help share Hawaii's history with my colleagues as the opponents of this legislation have taken it upon themselves to rewrite the tragedies of Hawaii's history in a manner that suits them for the purposes of opposing this legislation.

I am deeply saddened by their tactics, but I am committed to ensuring that the Members of this body and all of the citizens in the United States understand Hawaii's history and the importance of extending the Federal policy of self-governance and self-determination to Hawaii's indigenous peoples, the native Hawaiians.

VOTE EXPLANATION

Mr. DURBIN. Mr. President, on vote No. 115, I was necessarily absent, due to a mechanical problem with the plane on my United flight 115 from Chicago. Had I been present for that vote, I would have voted against the motion to invoke closure.

Mr. OBAMA. Mr. President, on vote No. 115—the motion to invoke cloture on the motion to proceed to S. 22—I was necessarily absent due to a delay with my flight back from Chicago. Had I been present for that vote, I would have voted against the motion to invoke cloture.

HONORING OUR ARMED FORCES

MARINE LANCE CORPORAL STEPHEN BIXLER

Mr. DODD. Mr. President, it is with a heavy heart that I rise today to honor the memory of Marine LCpl Stephen Bixler, of Suffield, CT, who was killed last week while serving our Nation in Iraq. He was 20 years old.

Tragically, Corporal Bixler's life was cut short when an improvised explosive device detonated while he was on patrol in Iraq's Al Anbar province. He was on his third tour of duty with the Marine Corps, having served previous tours in Haiti and Iraq. His heroic service is remembered today by a grateful nation.

Service and leadership. These are the traits that best defined Stephen Bixler—as a talented runner on his high school cross-country team and as senior patrol leader in Boy Scout Troop 260. He was awarded the rank of Eagle Scout after working hard to improve the Jesse F. Smith Memorial Forest. He decided early on in high school that he wanted to serve his country, and shortly after graduating in 2003 he joined the Marines.

Stephen returned home during the holidays last year and took the time to speak to students at his former high school about his experiences overseas and his pride in serving his country. Friends remember him as an intelligent, dedicated young man who was truly patriotic and possessed a self-confidence and leadership ability beyond his years.

All of us in Connecticut and across America owe a deep and solemn debt of gratitude to Stephen Bixler and to his family for his tremendous service to our country. On behalf of the United States, I offer my deepest condolences to Stephen's parents, Richard and Linda, his twin sister Sandra, and to everyone who knew and loved him.

ALTERNATIVE PLURIPOTENT STEM CELL THERAPIES ENHANCEMENT ACT

Mr. SPECTER. Mr. Presidemt, I have sought recognition to cosponsor and speak in support of legislation introduced by Senator SANTORUM called the Alternative Pluripotent Stem Cell Therapies Enhancement Act. This bill would authorize research into deriving stem cells using alternative methods that would not result in the destruction of a human embryo.

This legislation, which Senator SANTORUM and I have drafted in close partnership, represents a good faith effort to find common ground among those who support human embryonic stem cell research and those who do not. This bill is fully complementary to legislation that Senators HARKIN, HATCH, FEINSTEIN, SMITH, AND KENNEDY have introduced—the Stem Cell Research Enhancement Act of 2005—which would allow Federal funding for research on additional human embryonic stem cell lines. It will move forward research that could potentially eliminate the objections that some have to embryonic stem cell research while achieving the same goals. However, let me be clear, this legislation is not a substitute for supporting H.R. 810, the House-passed version of the Stem Cell Research Enhancement Act of 2005.

I believe medical research should be pursued with all possible haste to cure the diseases and maladies affecting Americans. In my capacity as Chairman of the Labor, Health and Human Services, and Education Appropriations Subcommittee, I have backed up this belief by supporting increases in funding for the National Institutes of Health. I have said many times that the NIH is the crown jewel of the Federal Government—perhaps the only jewel of the Federal government. When I came to the Senate in 1981, NIH spending totaled $3.6 billion. In fiscal year 2006, NIH received a little over $29 billion to fund its pursuit of life-saving research. The successes realized by this investment in NIH have spawned revolutionary advances in our knowledge and treatment for diseases such as cancer, Alzheimer's disease, Parkinson's disease, mental illnesses, diabetes, osteoporosis, heart disease, ALS and many others. It is clear to me that Congress's commitment to the NIH is paying off. This is the time to seize the scientific opportunities that lie before us, and to ensure that all avenues of research toward cures—including stem cell research—are open for investigation.

In 1998, I learned of the discovery of human embryonic stem cells. These cells have the ability to become any type of cell in the human body. Another way of saying this is that the cells are pluripotent. The consequences of this unique property of stem cells are far-reaching and are key to their potential use in therapies. Scientists and doctors with whom I spoke—and who have since testified before my Appropriations Subcommittee at 17 stem cell-related hearings—were excited by this discovery. They believed that these cells could be used to replace damaged or malfunctioning cells in patients with a wide range of diseases, This could lead to cures and treatments for maladies such as Juvenile Diabetes, Parkinson's disease, Alzheimer's disease, cardiovascular diseases, and spinal cord injury.

Senator HARKIN and I took the lead on making Federal funding available for this promising research. On the issue of funding human embryonic stem cell research, I along with Senators HARKIN, HATCH, FEINSTEIN, SMITH, and KENNEDY are the Senate sponsors of the Stem Cell Research Act of 2005, which we hope will soon be coming up for a vote in the Senate. That critical bill would enable Federal funding of stem cell research with new human embryonic stem cell lines.

Embryonic stem cells are derived from embryos that would otherwise have been discarded. During the course of in vitro fertilization—IVF—therapies, sperm and several eggs are combined in a laboratory to create 4 to 16 embryos for a couple having difficulty becoming pregnant. The embryos grow in an incubator for 5 to 7 days until they contain approximately 100 cells. To maximize the chances of success, several embryos are implanted into the woman. The remaining embryos are frozen for future use. If the woman becomes pregnant after the first implantation, and does not want to have more pregnancies, the remaining embryos are in excess of clinical need and can be donated for research. Embryonic stem cells are derived from these embryos—destroying the embryo in the process. This process raises concerns for some, including my distinguished colleague Senator SANTORUM.

Although I disagree with the calculus that embryos should be discarded rather than used in research, I recognize and appreciate these deeply felt objections. In fact, I took the lead on creating an embryo adoption awareness campaign in fiscal year 2002, and continue to include $2 million for that campaign in the HHS appropriation. If these embryos are likely to be donated to families that cannot conceive, I want this to be the first choice. However, with 400,000 frozen embryos in IVF clinics around the country, the supply far exceeds the demand and embryos are being discarded. Nonetheless, I want to pursue this and other options to address the objections of some of my colleagues.

When the President's Council on Bioethics reported on several theoretical methods for deriving stem cells without destroying embryos, I immediately scheduled a hearing to investigate these ideas. On July 12, 2005, the Labor-HHS Subcommittee heard testimony from five witnesses describing several theoretical techniques for deriving stem cells without destroying embryos. All five witnesses supported moving forward with the alternative methods without abandoning embryonic stem cell research. The alternative stem cells would theoretically also have the key ability to become any type of cell. Let me briefly mention several of the techniques discussed at the hearing.

Dr. Robert Lanza of Advanced Cell Technologies claims to have derived stem cells from a single cell extracted from 2-day-old, eight-celled mouse embryos. This single cell is called a blastomere and its removal from human embryos does not destroy the original embryo. Scientists know a single cell can be taken from a 2-day-old embryo without destroying it, because it is routinely done in pre-implantation genetic diagnosis.

Dr. William Hurlbut, a Stanford University bioethicist, supports a technique where a cloned embryo would be created whose DNA is mutated such that it cannot develop into a baby. This altered embryo would be destroyed for its stem cells. Since the embryo never had the potential to produce a baby, some of the objections normally raised with embryonic stem cell research would be circumvented.

Several scientists have suggested deriving stem cells from technically dead embryos. When embryos frozen during in-vitro fertilization are thawed, some never resume dividing and thus are discarded.

Many scientists are attempting to turn back the clock on older cells so they again become ''pluripotent,'' the scientific term for the ability to turn into any tissue. Scientists already are trying to do this to some degree through ''adult stem cell'' research, such as turning blood-making cells into cells that produce liver or muscle tissues.

The legislation, which Senator SANTORUM and I have drafted, is meant to encourage these alternative methods for deriving stem cells without harming human embryos. The act amends the Public Health Service Act by inserting a section that:

(1) Mandates that the Secretary of Health and Human Services shall support meritorious peer-reviewed research to develop techniques for the derivation of stem cells without creating or destroying human embryos.

(2) Requires the Secretary to issue guidelines within 90 days to implement this research and to identify and prioritize the next research steps.

(3) Requires the Secretary to consider techniques outlined by the President's Council on Bioethics, such as altered nuclear transfer and single cell derivation.

(4) Requires the Secretary to report yearly on the activities carried out under this authorization.

(5) Includes a ''Rule of Construction'' stating: ''Nothing in this section shall be construed to affect any policy, guideline, or regulation regarding embryonic stem cell research, human cloning by somatic cell nuclear transfer, or any other research not specifically authorized by this section.''

(6) Defines ''human embryo'' by reference to the latest definition contained in the appropriations act for the Department of Health and Human Services.

(7) Authorizes ''such sums as may be necessary'' for fiscal years 2007 through 2009.

Knowing that scientists never know exactly which research will lead to the next great cure, I have always supported opening as many avenues of research as possible. Based on that line of reasoning, I have always supported human embryonic, adult, and cord blood stem cell research. My goal is to see cures for the various afflictions that lower the quality of life—or end the lives—of Americans.

The Santorum/Specter bill focuses attention on one of those avenues of research. I must emphasize that this bill is not a substitute for support of human embryonic stem cell research or support for H.R. 810. The two bills are complementary in their scope and together will advance our understanding of biomedical science and bring us another step closer to the cures and treatment that we all desire.

MONTANA'S NATIONAL GUARD

Mr. BAUCUS. Mr. President, I rise today to pay tribute to the 1–163rd infantry battalion of Montana's National Guard for their continued contribution to our Nation. In peacetime, these soldiers have performed admirably at home in Montana, but in wartime the members of the first of the 163rd infantry battalion truly deserve recognition.

For 18 months, they were deployed to Iraq where, on a daily basis, they risked their lives to defend our Nation's core beliefs—freedom, justice, and equality. In November of 2005, 700 troops returned home to Montana.

While serving abroad, these men and women spent the majority of their time at 3 forward operating bases in northern Iraq. They bravely undermined insurgency in the largest and most dangerous area in the 116th Brigade's area of operations.

These Montanans risked their lives daily during their field operations. In total, the 1–163rd infantry battalion performed 6,400 patrols where they encountered frequent attacks. During their deployment, the 1–163rd engaged in over 35 direct battles with members of the Iraqi insurgency and received small arms fire over 130 times. The battalion also defused almost 200 improvised explosive devices, IEDs, and experienced 359 IED detonations.

In addition to the routine patrols that the unit regularly performed, the battalion also conduced 35 task force level operations, 10 joint task force air assault missions, and 120 deliberate company-level operations.

Despite the dangerous conditions, the 1–163rd infantry battalion still made considerable advances in neutralizing their area of operations. The battalion was able to reduce the number of arms and insurgents in the area. Hundreds of Iraqi weapon systems were confiscated, including AK–47s, rocket propelled grenades and mortar tubes, and over 100 insurgents were detained. These efforts were critical in minimizing the likelihood of future attacks in the area.

Not only did the 1–163rd improve the overall safety of northern Iraq, but this infantry battalion also participated in the extensive reconstruction effort. In total, 68 projects worth $7.5 million were successfully implemented by the battalion. Countless improvements to municipalities in northern Iraq are directly attributable to the 1–163rd.

Today I wish to especially commend two members of the 1–163rd who did not return home but instead gave their lives in service to this great Nation. SGT Travis Arndt, 23, from Great Falls, MT, was killed in action near Kirkuk, Iraq, on September 21, 2005. MSG Robbie McNary, 42, died in combat in Hawijah, Iraq, on March 31, 2005, leaving behind his wife and three children in Lewistown, MT. Let us remember them for their honorable service and ultimate sacrifice.

As a Montanan, an American, and a Senator, I would like to truly thank and commend the first of the 163rd infantry battalion of the Montana's National Guard for their excellent performance during this last deployment and their impressive dedication and loyalty to this nation.

In November, when the 1–163rd returned to Montana from their 18-month deployment, they were applauded for their success, but I would like to keep that recognition alive. Long after this war on terror is over, we will remember their contribution to our most valuable freedom and security. Thank you.

ADDITIONAL STATEMENTS

CELEBRATING THE 100TH BIRTHDAY OF NANCY IRISH

• Mr. LIEBERMAN. Mr. President, I would like to wish a happy birthday to Nancy Irish of Stafford Springs, CT. Nancy will be celebrating her 100th birthday on May 9. While the birthday itself is, of course, worthy of much celebration, those who know Nancy well—her friends, relatives, coworkers and neighbors—would all tell you that Nancy deserves the most congratulations for the life she has led over the past 100 years.

Born May 9, 1906, to Italian immigrant parents, Nancy lived in New York until she and her family moved to Massachusetts when she was a teenager. On July 12, 1924, she married Daniel Woods Irish, and together they moved to Connecticut. They had three children, Daniel, Darian, and Dolores. When her husband Daniel tragically passed away early, Nancy worked very hard to provide for her family. Throughout her life, she held a variety of jobs, including working in the Tobacco Valley cigar industry and, at one time, running a taxi business and a rooming house. After years of hard work, Nancy retired to Florida for over 20 years before moving back to Connecticut. She is currently enjoying a well-deserved retirement and loves spending time with her family, including two surviving children, five grandchildren, nine great-grandchildren and a great-great-grandson.

Nancy Irish has lived a long, remarkable life and has touched many people's lives. If you consider the strength, determination, and hard work she has demonstrated throughout her life, can it really be any shock that she has lived such a long, fulfilling life? Happy birthday, Nancy Irish. May your 100th year be your best yet.•

CELEBRATION OF NAVY WEEK

• Mr. OBAMA. Mr. President, I rise today to speak about the Illinois celebration of ''Navy Week,'' which will occur this year during the week of May 15, 2006. This celebration recognizes the men and women who have served and sacrificed on behalf of this country both at home and abroad.

The strength and bravery of the U.S. Navy played an integral role in the creation and development of the United States during its struggle for freedom and American sovereignty. Many brave Illinois citizens have served and continue to serve honorably in the U.S. Navy.

There are more than 350,000 active duty and more than 135,000 Ready Reserve Navy personnel in the U.S. Navy, serving the Nation in support and defense of the values and freedom that all people in the United States cherish.

This week, members of the Navy in Illinois will spend time serving their country and community in other ways. The Navy band will perform in city parks throughout Chicago, and Navy personnel will work at food banks and travel to the Great Lakes Veterans Hospital to support those who are a part of the great history of the U.S. Navy.

In addition, the Navy will participate in Habitat for Humanity, building houses around Illinois, and they will work with the Chicago Christian Industrial League to help the homeless of Chicago and those suffering from substance abuse.

Recognizing ''Navy Week'' will allow us to celebrate the strength and bravery displayed by members and veterans of the U.S. Navy and the role they have played throughout our history.•

CONGRATULATING JOHN FALES

• Mr. AKAKA. Mr. President, I rise today to congratulate Mr. John Fales for receiving the American Legion National Commander's Public Relations Award for 2006. John has a long and distinguished military career and has continued his service to this great Nation as an unwavering supporter of veterans as a journalist and advocate.

During his military career, John served more than 27 years on active duty for the U.S. Navy and Marine Corps. He is highly decorated with awards including the Purple Heart, Vietnam Service Medal, Vietnam Campaign Medal, National Defense Service Medal, Armed Forces Expeditionary Service Medal, New York State Conspicuous Service Medal, Presidential Unit Citation, Combat Action Ribbon, and South Vietnamese Cross of Gallantry. He earned these decorations as he defended our Nation's freedoms and liberties.

Today, John helps our veterans access care and benefits. To the many readers of his column, he is known as Sergeant Shaft, the witty newspaper columnist that provides information affecting the veterans' community. His column helps veterans and their families navigate the highly complicated VA system to obtain the care and benefits they have earned through their service. John is also the president of the Blinded American Veterans Foundation which advocates for sensory disabled veterans and provides outreach efforts to ensure sensory disabled veterans are able to lead productive lives.

John Fales's service and patriotism are beyond question. He is a deserving recipient of the American Legion National Commander's Public Relations Award for 2006. Once again, I congratulate John for his commendation.•

EMMANUEL OFOSU YEBOAH'S DISABILITIES LEADERSHIP

• Mr. OBAMA. Mr. President, I rise today to honor and congratulate Emmanuel Ofosu Yeboah for his leadership and dedication to raising awareness about disabilities around the world.

Emmanuel was born without a tibia in his right leg, leaving it useless and severely deformed. This would have been an enormous obstacle for anyone in our society to overcome. But he was not born here—he was born in Ghana, where historically the disabled were often poisoned or left to die. At the time, it was believed that a child was born disabled due to a sin the mother had committed. Because of his son's deformed leg, Emmanuel's father abandoned his family, and his mother's friends encouraged her to kill or, at the very least, abandon her disabled son.

Instead, she chose to nurture and encourage him, making the radical decision to send him to primary school, rather than sending him to the streets as a beggar.

Unfortunately, his mother died when he was 13, and Emmanuel was forced to drop out of school. His only option for survival was to shine shoes for a living—earning the equivalent of only 2 dollars a day.

Despite his struggle, Emmanuel's story is a successful one. He refused to resort to begging, and instead chose to focus the attention of his countrymen on the issue of discrimination of the disabled in Ghana. His method: biking across Ghana—with one leg. The only problem was that he didn't own a bicycle.

After seeking support from the Challenged Athlete Foundation in the United States in 2002, Emmanuel began his journey through Ghana, garnering media attention with every mile. By the time he reached his destination, Emmanuel was a national hero.

After 2003, when he competed in a triathlon, riding a 56-mile bike segment as part of a relay team, he was given a whole new life. Doctors were able to free him from his crutches by partially amputating his leg and applying a prosthetic one.

Emmanuel has since dedicated his life to improving the lives of Ghana's many disabled citizens. In conjunction with the Free Wheelchair Mission, Emmanuel has helped provide free wheelchairs to disabled people around the world. He has started a cycling team, a wheelchair basketball team, and a running team for physically challenged athletes, and is currently working on starting a sports academy for disabled athletes in Ghana.

Today, of the 20 million people living in Ghana, 2 million are disabled. Thanks to the efforts of Emmanuel Ofosu Yeboah, Ghanaians with physical disabilities are living their lives with purpose, dignity, and value.•

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Thomas, 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.)

NOTIFICATION OF THE CONTINUATION OF AN EXECUTIVE ORDER BLOCKING THE PROPERTY OF CERTAIN PERSONS AND PROHIBITING THE EXPORT OF CERTAIN GOODS TO SYRIA—PM 47

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Banking, Housing, and Urban Affairs.

To the Congress of the United States:

Section 202(d) of the National Emergencies Act (50 U. So. C. 1622 (d)) provides for the automatic termination of a national emergency unless, prior to the anniversary date of its declaration, the President publishes in the Federal Register and transmits to the Congress a notice stating that the emergency is to continue in effect beyond the anniversary date. In accordance with this provision, I have sent to the Federal Register for publication the enclosed notice, stating that the national emergency declared in Executive Order 13338 of May 11, 2004, and expanded in scope in Executive Order 13399 of April 25, 2006, authorizing the blocking of property of certain persons and prohibiting the exportation and reexportation of certain goods to Syria, is to continue in effect beyond May 11, 2006. The most recent notice continuing this emergency was published in the Federal Register on May 10, 2005 (70 FR 24697).

The actions of the Government of Syria in supporting terrorism, interfering in Lebanon, pursuing weapons of mass destruction and missile programs, and undermining United States and international efforts with respect to the stabilization and reconstruction of Iraq, pose a continuing unusual and extraordinary threat to the national security, foreign policy, and economy of the United States. For these reasons, I have determined that it is necessary to continue in effect the national emergency authorizing the blocking of property of certain persons and prohibiting the exportation and reexportation of certain goods to Syria and to maintain in force the sanctions to respond to this threat.

GEORGE W. BUSH.

THE WHITE HOUSE, *May 8, 2006*.

MESSAGE FROM THE HOUSE

At 3: 13 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 4954. An act to improve maritime and cargo security through enhanced layered defenses, and for other purposes.

The message also announced that pursuant to 22 U.S.C. 276d, clause 10 of rule I, and the order of the House of December 18, 2005, the Speaker appoints the following members of the House of Representatives to the United States Delegation of the Canada-United States Interparliamentary Group: Mr. MANZULLO of Illinois, Chairman, Mr. MCCOTTER of Michigan, Vice Chairman, Mr. DREIER of California, Ms. SLAUGHTER of New York, Mr. PETERSON of Minnesota, Mr. ENGLISH of Pennsylvania, Mr. GUTKNECHT of Minnesota, Mr. SOUDER of Indiana, Mr. TANCREDO of Colorado, Mr. BROWN of South Carolina, and Mr. LIPINSKI of Illinois.

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–6771. A communication from the Deputy Assistant Secretary for Export Administration, Bureau of Industry and Security, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Chemical Weapons Convention Regulations'' (RIN0694–AB06) received on May 1, 2006; to the Committee on Commerce, Science, and Transportation.

EC–6772. A communication from the Deputy Assistant Secretary for Export Administration, Bureau of Industry and Security, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Entity List: Addition'' (RIN0694–AD66) received on May 1, 2006; to the Committee on Commerce, Science, and Transportation.

EC–6773. A communication from the Chief, Pricing Policy Division, Wireline Competition Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Request to Update Default Compensation Rate for Dial-Around Calls from Payphones'' (WC Docket No. 03–225) received on May 1, 2006; to the Committee on Commerce, Science, and Transportation.

EC–6774. A communication from the Associate Bureau Chief, Wireless Telecommunications Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Part 97 of the Commission's Rules to Implement Certain World Radio Conference 2003 Final Acts'' (WT Docket No. 96–86) received on May 1, 2006; to the Committee on Commerce, Science, and Transportation.

EC–6775. A communication from the Legal Advisor, Wireless Telecommunications Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Implementation of the Commercial Spectrum Enhancement Act and Modernization of the Commission's Competitive Bidding Rules and Procedures, Second Report and Order and Second Further Notice of Proposed Rule Making'' (WT Docket No. 05–211) received on May 1, 2006; to the Committee on Commerce, Science, and Transportation.

EC–6776. A communication from the Attorney, Pipeline and Hazardous Materials Safety Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Hazardous Materials: Requirements for Lighters and Lighter Refills'' (RIN2137–AD88) received on April 28, 2006; to the Committee on Commerce, Science, and Transportation.

EC–6777. A communication from the Attorney Advisor, Federal Motor Carrier Safety Administration, Department of Transportation, transmitting, pursuant to law, the report of a vacancy in the position of Administrator, received on May 1, 2006; to the Committee on Commerce, Science, and Transportation.

EC–6778. A communication from the Acting Director, Office of Sustainable Fisheries, National Oceanic and Atmospheric Administration, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the Northeastern United States; Atlantic Mackerel, Squid, and Butterfish Fisheries; Closure of the Quarter II Fishery for Loligo Squid'' (I.D. No. 041406A) received on May 1, 2006; to the Committee on Commerce, Science, and Transportation.

EC–6779. A communication from the Acting Director, Office of Sustainable Fisheries, National Oceanic and Atmospheric Administration, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the Exclusive Economic Zone Off Alaska; Groundfish by Vessels Using Non-Pelagic Trawl Gear in the Red King Crab Savings Subarea'' (I.D. No. 040406) received on May 1, 2006; to the Committee on Commerce, Science, and Transportation.

EC–6780. A communication from the Acting Director, Office of Sustainable Fisheries, National Oceanic and Atmospheric Administration, transmitting, pursuant to law, the report of a rule entitled ''Fisheries Off West Coast States and in the Western Pacific; Pacific Coast Groundfish Fishery; Annual Specifications and Management Measures; Inseason Adjustments; Pacific Halibut Fisheries'' (I.D. No. 041906A) received on May 1, 2006; to the Committee on Commerce, Science, and Transportation.

EC–6781. A communication from the Acting Deputy Assistant Administrator for Regulatory Programs, Office of Sustainable Fisheries, National Oceanic and Atmospheric Administration, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the Exclusive Economic Zone Off Alaska; Groundfish Retention Standard'' (RIN0648–AT04) received on May 1, 2006; to the Committee on Commerce, Science, and Transportation.

EC–6782. A communication from the Chairman, Dwight D. Eisenhower Memorial Commission, transmitting, pursuant to law, the Fifth Report of the Dwight D. Eisenhower Memorial Commission; to the Committee on Rules and Administration.

EC–6783. A communication from the Secretary of the Treasury, transmitting, pursuant to law, a six month periodic report on the national emergency with respect to Sudan that was declared in Executive Order 13067; to the Committee on Banking, Housing, and Urban Affairs.

EC–6784. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Citrus from Peru'' (Docket No. 03–113–3) received on May 3, 2006; to the Committee on Agriculture, Nutrition, and Forestry.

EC–6785. A communication from the Administrator, Agricultural Marketing Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Milk in the Northeast et al; Final Rule'' (Docket No. DA–06–06; AO–14–A75, et al.) received on May 3, 2006; to the Committee on Agriculture, Nutrition, and Forestry.

EC–6786. A communication from the Secretary of Agriculture, transmitting, a report relative to seven separate user fee proposals which would shift the funding of the covered activities from the government to the beneficiaries of the activities; to the Committee on Agriculture, Nutrition, and Forestry.

EC–6787. A communication from the Acting Principal Deputy for Personnel and Readiness, Office of the Under Secretary of Defense for Personnel and Readiness, transmitting, pursuant to law, a report of the closure of the Defense commissary stores at Giebelstadt and Kitzingen, Germany, on August 1, 2006; to the Committee on Armed Services.

EC–6788. A communication from the Deputy Executive Director, Pension Benefit Guaranty Corporation, transmitting, pursuant to law, the report of a rule entitled ''Benefits Payable in Terminated Single-Employer Plans; Allocation of Assets in Single-Employer Plans; Interest Assumptions for Valuing and Paying Benefits'' (29 CFR Parts 4022 and 4044) received on May 3, 2006; to the Committee on Health, Education, Labor, and Pensions.

EC–6789. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Regulation of Fuels and Fuel Additives: Removal of Reformulated Gasoline Oxygen Content Requirement and Revision of Commingling Prohibition to Address Non-Oxygenated Reformulated Gasoline; Partial Withdrawal; Correction'' (FRL No. 8167–4) received on May 3, 2006; to the Committee on Environment and Public Works.

EC–6790. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Update of Continuous Instrumental Test Methods'' (FRL No. 8165–1) received on May 3, 2006; to the Committee on Environment and Public Works.

EC–6791. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Regulation of Fuels and Fuel Additives: Removal of Reformulated Gasoline Oxygen Content Requirement'' (FRL No. 8167–5) received on May 3, 2006; to the Committee on Environment and Public Works.

EC–6792. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Virginia: Final Authorization of State Hazardous Waste Management Program Revisions'' (FRL No. 8165–7) received on May 3, 2006; to the Committee on Environment and Public Works.

EC–6793. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Maryland; Amendments to Stage II Vapor Recovery at Gasoline Dispensing Facilities'' (FRL No. 8165–2) received on May 3, 2006; to the Committee on Environment and Public Works.

EC–6794. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Standards of Performance for New Stationary Sources and Emission Guidelines for Existing Sources: Large Municipal Waste Combustors'' (FRL No. 8164–9) received on May 3, 2006; to the Committee on Environment and Public Works.

EC–6795. A communication from the Regulations Coordinator, Center for Medicare Management, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Annual Payment Rate Updates, Policy Changes, and Clarification'' (RIN 0938–AO06) received on May 3, 2006; to the Committee on Finance.

EC–6796. A communication from the Chief, Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Modifications to the Subpart F Treatment of Aircraft and Vessel Leasing Income'' (Notice 2006–48) received on May 3, 2006; to the Committee on Finance.

EC–6797. A communication from the Chief, Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Interim Guidance with Respect to the Application of Treas. Reg. 1.883–3'' (Notice 2006–43) received on May 3, 2006; to the Committee on Finance.

EC–6798. A communication from the Chief, Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Revenue Procedure: Competent Authority Procedures with Respect to the U.S. Possessions'' (Notice 2006–23) received on May 3, 2006; to the Committee on Finance.

EC–6799. A communication from the Director, Executive Secretariat, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''Making Pictures, Television Productions, or Sound Tracks on Certain Areas Under the Jurisdiction of the Department of the Interior'' (RIN1093–AA10) received on May 3, 2006; to the Committee on Energy and Natural Resources.

EC–6800. A communication from the Attorney, Office of Assistant General Counsel for Legislation and Regulatory Law, Department of Energy, transmitting, pursuant to law, the report of a rule entitled ''Guidelines for Voluntary Greenhouse Gas Reporting'' (RIN1901–AB11) received on May 3, 2006; to the Committee on Energy and Natural Resources.

EC–6801. A communication from the Deputy Assistant Secretary, Fish and Wildlife and Parks, National Park Service, transmitting, pursuant to law, the report of a rule entitled ''Bighorn Canyon National Recreation Area, Personal Watercraft Use'' (RIN1024–AC96) received on May 3, 2006; to the Committee on Energy and Natural Resources.

EC–6802. A communication from the Deputy Assistant Secretary, Fish and Wildlife and Parks, National Park Service, transmitting, pursuant to law, the report of a rule entitled ''Pictured Rocks National Lakeshore, Personal Watercraft Use'' (RIN1024–AC93) received on May 3, 2006; to the Committee on Energy and Natural Resources.

EC–6803. A communication from the Deputy Assistant Secretary, Fish and Wildlife and Parks, National Park Service, transmitting, pursuant to law, the report of a rule entitled ''Gulf Islands National Seashore, Personal Watercraft Use'' (RIN1024–AD21) received on May 3, 2006; to the Committee on Energy and Natural Resources.

EC–6804. A communication from the Deputy Assistant Secretary, Fish and Wildlife and Parks, National Park Service, transmitting, pursuant to law, the report of a rule entitled ''Fire Island National Seashore, Personal Watercraft Use'' (RIN1024–AC94) received on May 3, 2006; to the Committee on Energy and Natural Resources.

EC–6805. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a report on D.C. Act 16–366, ''Uniform Family Support Amendment Act of 2006'' received on May 5, 2006; to the Committee on Homeland Security and Governmental Affairs.

EC–6806. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a report on D.C. Act 16–367, ''Child Support Guideline Revision Act of 2006'' received on May 5, 2006; to the Committee on Homeland Security and Governmental Affairs.

EC–6807. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a report on D.C. Act 16–368, ''Scrap Vehicle Title Authorization Act of 2006'' received on May 5, 2006; to the Committee on Homeland Security and Governmental Affairs.

EC–6808. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a report on D.C. Act 16–369, ''Tenant Evictions Reform Amendment Act of 2006'' received on May 5, 2006; to the Committee on Homeland Security and Governmental Affairs.

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. 2757. A bill to temporarily increase the standard mileage rate for use of an automobile for purposes of certain deductions allowed under the Internal Revenue Code of 1986 and to temporarily increase the reimbursement rate for use of an automobile by Federal employees; to the Committee on Finance.

By Mr. LIEBERMAN:

S. 2758. A bill to amend the Federal Cigarette Labeling and Advertising Act with respect to the labeling of cigarette packages, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. SMITH (for himself and Mr. BINGAMAN):

S. 2759. A bill to provide for additional outreach and education related to the Medicare program and to amend title XVIII of the Social Security Act to provide a special enrollment period for individuals who qualify for an income-related subsidy under the Medicare prescription drug program; to the Committee on Finance.

By Mrs. FEINSTEIN (for herself, Mr. KYL, and Mr. SUNUNU):

S. 2760. A bill to suspend the duty on imports of ethanol, and for other purposes; to the Committee on Finance.

By Mr. ALLARD (for himself and Mr. SALAZAR):

S. 2761. A bill to authorize the Secretary of the Army to acquire land for the purpose of expanding Pinon Canyon Maneuver Site, and for other purposes; to the Committee on Armed Services.

By Mr. AKAKA:

S. 2762. A bill to amend title 38, United States Code, to ensure appropriate payment for the cost of long-term care provided to veterans in State homes, and for other purposes; to the Committee on Veterans' Affairs.

By Mr. SCHUMER:

S. 2763. A bill to suspend temporarily the duty on ethanol; to the Committee on Finance.

By Mr. REID (for himself and Mr. ENSIGN):

S. 2764. A bill to amend Public Law 108-67 to correct a provision relating to the conveyance of the Lake Tahoe Basin Management Unit; to the Committee on Energy and Natural Resources.

By Mr. KERRY:

S.J. Res. 36. A joint resolution providing a strategy for stabilizing Iraq and withdrawing United States troops; to the Committee on Foreign Relations.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. LIEBERMAN (for himself, Mr. MARTINEZ, Mr. NELSON of Florida, Mr. MENENDEZ, Mr. ENSIGN, Mr. MCCAIN, and Mr. BIDEN):

S. Res. 469. A resolution condemning the April 25, 2006, beating and intimidation of Cuban dissident Martha Beatriz Roque; to the Committee on Foreign Relations.

By Mr. KERRY:

S. Res. 470. A resolution promoting a comprehensive political agreement in Iraq; to the Committee on Foreign Relations.

ADDITIONAL COSPONSORS

S. 22

At the request of Mr. ENSIGN, the names of the Senator from Alabama (Mr. SESSIONS) and the Senator from Mississippi (Mr. LOTT) were added as cosponsors of S. 22, a bill to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system.

S. 23

At the request of Mr. SANTORUM, the names of the Senator from Alabama (Mr. SESSIONS), the Senator from Mississippi (Mr. LOTT) and the Senator from South Dakota (Mr. THUNE) were added as cosponsors of S. 23, a bill to improve women's access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the delivery of obstetrical and gynecological services.

S. 58

At the request of Mr. INOUYE, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 58, a bill to amend title 10, United States Code, to permit former members of the Armed Forces who have a service-connected disability rated as total to travel on military aircraft in the same manner and to the same extent as retired members of the Armed Forces are entitled to travel on such aircraft.

S. 241

At the request of Ms. SNOWE, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 241, a bill to amend section 254 of the Communications Act of 1934 to provide that funds received as universal service contributions and the universal service support programs established pursuant to that section are not subject to certain provisions of title 31, United States Code, commonly known as the Antideficiency Act.

S. 311

At the request of Mr. SMITH, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 311, 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. 333

At the request of Mr. SANTORUM, the names of the Senator from Missouri (Mr. BOND), the Senator from Nevada (Mr. REID) and the Senator from Rhode Island (Mr. REED) were added as cosponsors of S. 333, a bill to hold the current regime in Iran accountable for its threatening behavior and to support a transition to democracy in Iran.

S. 537

At the request of Mr. BINGAMAN, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 537, a bill to increase the number of well-trained mental health service professionals (including those based in schools) providing clinical mental health care to children and adolescents, and for other purposes.

S. 728

At the request of Mr. BOND, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 728, a bill to provide for the consideration and development of water and related resources, to authorize the Secretary of the Army to construct various projects for improvements to rivers and harbors of the United States, and for other purposes.

S. 811

At the request of Mr. DURBIN, the names of the Senator from Vermont (Mr. JEFFORDS) and the Senator from Washington (Ms. CANTWELL) were added as cosponsors of S. 811, a bill to require the Secretary of the Treasury to mint coins in commemoration of the bicentennial of the birth of Abraham Lincoln.

S. 1008

At the request of Mr. SANTORUM, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of S. 1008, a bill to amend the Internal Revenue Code of 1986 to add meningococcal vaccines to the list of taxable vaccines for purposes of the Vaccine Injury Compensation Trust Fund.

S. 1035

At the request of Mr. INHOFE, the names of the Senator from North Dakota (Mr. DORGAN) and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of S. 1035, a bill to authorize the presentation of commemorative medals on behalf of Congress to Native Americans who served as Code Talkers during foreign conflicts in which the United States was involved during the 20th century in recognition of the service of those Native Americans to the United States.

S. 1046

At the request of Mr. KYL, the name of the Senator from Mississippi (Mr. LOTT) was added as a cosponsor of S. 1046, a bill to amend title 28, United States Code, with respect to the jurisdiction of Federal courts over certain cases and controversies involving the Pledge of Allegiance.

S. 1062

At the request of Mr. KENNEDY, the name of the Senator from Delaware (Mr. BIDEN) was added as a cosponsor of S. 1062, a bill to amend the Fair Labor Standards Act of 1938 to provide for an increase in the Federal minimum wage.

S. 1221

At the request of Mr. DEWINE, his name was added as a cosponsor of S. 1221, a bill to amend chapter 81 of title 5, United States Code, to create a presumption that a disability or death of a Federal employee in fire protection activities caused by any of certain diseases is the result of the performance of such employee's duty.

S. 1619

At the request of Mr. LAUTENBERG, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of S. 1619, a bill to amend the Federal Insecticide, Fungicide, and Rodenticide Act to require local educational agencies and schools to implement integrated pest management systems to minimize the use of pesticides in schools and to provide parents, guardians, and employees with notice of the use of pesticides in schools, and for other purposes.

S. 1621

At the request of Ms. COLLINS, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 1621, a bill to amend the Internal Revenue Code of 1986 to increase the above-the-line deduction for teacher classroom supplies and to expand such deduction to include qualified professional development expenses.

S. 2025

At the request of Mr. BAYH, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 2025, a bill to promote the national security and stability of the United States economy by reducing the dependence of the United States on oil through the use of alternative fuels and new technology, and for other purposes.

S. 2079

At the request of Mr. SMITH, the name of the Senator from Minnesota (Mr. COLEMAN) was added as a cosponsor of S. 2079, a bill to improve the ability of the Secretary of Agriculture and the Secretary of the Interior to promptly implement recovery treatments in response to catastrophic events affecting the natural resources of Forest Service land and Bureau of Land Management Land, respectively, to support the recovery of non-Federal land damaged by catastrophic events, to assist impacted communities, to revitalize Forest Service experimental forests, and for other purposes.

S. 2429

At the request of Mr. LUGAR, the names of the Senator from Missouri

(Mr. BOND) and the Senator from Ohio (Mr. DEWINE) were added as cosponsors of S. 2429, a bill to authorize the President to waive the application of certain requirements under the Atomic Energy Act of 1954 with respect to India.

S. 2503

At the request of Mrs. LINCOLN, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 2503, a bill to amend the Internal Revenue Code of 1986 to provide for an extension of the period of limitation to file claims for refunds on account of disability determinations by the Department of Veterans Affairs.

S. 2548

At the request of Mr. STEVENS, the name of the Senator from West Virginia (Mr. BYRD) was added as a cosponsor of S. 2548, a bill to amend the Robert T. Stafford Disaster Relief and Emergency Assistance Act to ensure that State and local emergency preparedness operational plans address the needs of individuals with household pets and service animals following a major disaster or emergency.

S. 2554

At the request of Mr. ENSIGN, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 2554, a bill to amend the Internal Revenue Code of 1986 to expand the permissible use of health savings accounts to include premiums for nongroup high deductible health plan coverage.

S. 2563

At the request of Mr. COCHRAN, the names of the Senator from Alaska (Ms. MURKOWSKI) and the Senator from Georgia (Mr. ISAKSON) were added as cosponsors of S. 2563, a bill to amend title XVIII of the Social Security Act to require prompt payment to pharmacies under part D, to restrict pharmacy co-branding on prescription drug cards issued under such part, and to provide guidelines for Medication Therapy Management Services programs offered by prescription drug plans and MA-PD plans under such part.

S. 2642

At the request of Mrs. FEINSTEIN, the names of the Senator from North Dakota (Mr. DORGAN) and the Senator from New Mexico (Mr. BINGAMAN) were added as cosponsors of S. 2642, a bill to amend the Commodity Exchange Act to add a provision relating to reporting and recordkeeping for positions involving energy commodities.

S. 2652

At the request of Mr. ALLEN, his name was added as a cosponsor of S. 2652, a bill to amend chapter 27 of title 18, United States code, to prohibit the unauthorized construction, financing, or, with reckless disregard, permitting the construction or use on one's land, of a tunnel or subterranean passageway between the United States and another country.

S. 2695

At the request of Mr. CORNYN, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 2695, a bill to provide for Federal agencies to develop public access policies relating to research conducted by employees of that agency or from funds administered by that agency.

S. 2703

At the request of Mr. LEAHY, the names of the Senator from Washington (Ms. CANTWELL), the Senator from New Mexico (Mr. BINGAMAN) and the Senator from Michigan (Mr. LEVIN) were added as cosponsors of S. 2703, a bill to amend the Voting Rights Act of 1965.

S. 2720

At the request of Mr. BAUCUS, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 2720, a bill to amend the Internal Revenue Code of 1986 to provide incentives to improve America's research competitiveness, and for other purposes.

S. 2721

At the request of Mr. SCHUMER, the name of the Senator from Georgia (Mr. ISAKSON) was added as a cosponsor of S. 2721, a bill to simplify the taxation of business activity, and for other purposes.

S. 2747

At the request of Mr. BINGAMAN, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 2747, a bill to enhance energy efficiency and conserve oil and natural gas, and for other purposes.

S. 2748

At the request of Mr. BINGAMAN, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 2748, a bill to amend the Internal Revenue Code of 1986 to provide tax incentives to promote energy production and conservation, and for other purposes.

S. CON. RES. 16

At the request of Mr. BINGAMAN, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. Con. Res. 16, a concurrent resolution conveying the sympathy of Congress to the families of the young women murdered in the State of Chihuahua, Mexico, and encouraging increased United States involvement in bringing an end to these crimes.

S. RES. 320

At the request of Mr. ENSIGN, the names of the Senator from Washington (Ms. CANTWELL) and the Senator from Kansas (Mr. BROWNBACK) were added as cosponsors of S. Res. 320, a resolution calling the President to ensure that the foreign policy of the United States reflects appropriate understanding and sensitivity concerning issues related to human rights, ethnic cleansing, and genocide documented in the United States record relating to the Armenian Genocide.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. SMITH (for himself and Mr. BINGAMAN):

S. 2759. A bill to provide for additional outreach and education related to the Medicare program and to amend title XVIII of the Social Security Act to provide a special enrollment period for individuals who qualify for an income-related subsidy under the Medicare prescription drug program; to the Committee on Finance.

Mr. SMITH. Mr. President, today I am proud to file the Medicare Part D Outreach and Enrollment Enhancement Act of 2006. This timely piece of legislation addresses two very targeted administrative issues that have come to light since Medicare's new prescription drug benefit became effective earlier this year. I am also pleased that Senator BINGAMAN is joining on this bill.

With more than 30 million beneficiaries now receiving coverage through Medicare Part D, the program is well on its way to helping deliver much needed access to lower cost prescription drugs. And with the close of the initial enrollment period on May 15 looming, the Centers for Medicare and Medicaid Services (CMS) and advocacy organizations across the country are working diligently to provide last minute assistance to those beneficiaries still wishing to enroll.

However, even after the May 15 deadline passes, beneficiaries will still need counsel on the program's benefits, including the availability of the low-income subsidy. For instance, dual eligible beneficiaries and those who previously received assistance through a Medicare Savings Program have the ability to change their prescription drug plan monthly. This particularly vulnerable group of beneficiaries likely will need extra assistance in choosing a plan that more appropriately meets their medical and financial needs.

There also are those beneficiaries who will age into Medicare throughout the year. They will be provided an initial enrollment period to choose a prescription drug plan once they turn age 65. And with the first regular enrollment cycle beginning in November, many beneficiaries will need advice as they evaluate new plan options or consider switching plans if their existing coverage has changed. We owe it to our seniors to provide them quality information so they can make the best possible prescription drug plan choice.

That is why I am asking for increased Part D outreach and education funding in the bill I am filing today. State Health Insurance Programs (SHIPs), which provide a range of valuable services, help beneficiaries select quality prescription drug plans, identify additional financial help with their drug costs, and resolve general enrollment difficulties.

This year, CMS supported the outreach work of SHIPs with a $30 million allotment. Despite this funding, there still remains a great need to raise further awareness about the new Part D benefit among beneficiaries and provide them assistance with selecting an

appropriate prescription drug plan. The Outreach and Enrollment Enhancement Act would allocate SHIPs an additional $13.5 million, bringing their total funding to $43.5 million, or, one dollar per Medicare beneficiary. To assure that the work of SHIPs is sufficiently supported in future years, the bill also creates a new funding authorization that is set to increase as the number of Medicare beneficiaries grows.

The legislation I am filing today also provides funding to the Area Agencies on Aging (AAA) and Native American aging programs that have absorbed an increased workload since the passage of the Medicare Modernization Act. In Oregon, the Multnomah County AAA has incurred $30,000 in expenses related to Medicare outreach since the beginning of this year, but they have received very little new funding in return. The bill recognizes the important role AAAs and Native American aging programs play in helping elderly Americans enroll in Medicare by providing new funding in the amount of $6.3 million this fiscal year.

Apart from increased funding for outreach and education, the bill addresses a very targeted problem with the current enrollment process that has recently become apparent. Beneficiaries who believe their income and asset levels may qualify them for extra help with their prescription drug costs may apply for a low-income subsidy (LIS) at any point during the year. If they submit an application to the Social Security Administration (SSA) during an initial enrollment period but do not receive notification of their eligibility before the enrollment deadline, they have one of two options available to them. They could enroll into a prescription drug plan before the deadline not knowing whether they will have to pay all or part of the costs of the monthly premium. This could place a beneficiary in the awkward position if they choose a plan that they ultimately are unable to afford.

Under a recent CMS administrative action, beneficiaries who have applied for the LIS subsidy could choose to delay their enrollment in the program until they receive notification of their eligibility for a subsidy. However, they still would be required to pay a late enrollment penalty. While enrolling late may allow a beneficiary to make a more informed decision regarding their prescription drug plan, it would not be fair to assess them a fee simply because there was administrative delay in processing their LIS application. Both of these scenarios place beneficiaries in an untenable position. For the enrollment process to be successful, beneficiaries need to have as much information available to them as possible so they may choose the prescription drug plan that best meets their preferences.

The Outreach and Enrollment Enhancement Act provides a solution to this dilemma. The legislation creates a special 30-day enrollment period that begins on the day a beneficiary receives a decision regarding their LIS eligibility. Most importantly, the late enrollment penalty that would be imposed upon them under current law would be waived during the special enrollment period, in addition to the time it takes SSA to process their application. This small, yet significant, change to the existing enrollment process will allow LIS beneficiaries sufficient time to effectively consider and evaluate prescription drug plan options with all necessary information. We cannot afford to undermine seniors' trust in Medicare's prescription drug program by penalizing a certain group of beneficiaries for a problem that is created by the federal government.

I understand that many of my colleagues prefer to address administrative issues with Medicare Part D at a later date, so that the initial implementation process can run its full course without undue interference from Congress. While I would agree with that argument in principle, there are a number of existing problems that only serve to tarnish Medicare's image if we allow them to linger much longer. I believe providing additional resources for outreach and educational services and correcting the LIS enrollment issue are two such problems that Congress should address immediately—before the May 15 deadline passes.

The SSA has estimated that 80,000 beneficiaries might not have been notified of their LIS eligibility by the close of the first regular enrollment period. It would be entirely unfair to assess even one of these beneficiaries a late enrollment penalty, when by their understanding, they were playing by the rules CMS and SSA set forth regarding the low-income subsidy.

I ask the Majority Leader and my colleagues to support my call for the Outreach and Enrollment Enhancement Act to be treated as an emergency measure and provide it quick passage in the Senate. By taking up this very targeted measure, Congress can demonstrate to America's seniors that we are committed to the continued success of the Medicare prescription drug program.

By Mrs. FEINSTEIN (for herself, Mr. KYL, and Mr. SUNUNU):

S. 2760. A bill to suspend the duty on imports of ethanol, and for other purposes; to the Committee on Finance.

Mrs. FEINSTEIN. Mr. President, I rise today with Senators KYL and SUNUNU to introduce a bill to strike the ethanol import tariff.

With record high gas prices and demand for ethanol growing faster than expected, I believe we need to act now to ease the ethanol supply crunch.

As many of my colleagues know, I have been strongly opposed to the ethanol mandate that was included in the energy bill enacted last August.

Today, more than ever, I believe that the time has come to end unwarranted subsidies to ethanol producers.

They include: $4.5 billion in agricultural subsidies in 2004 alone that benefit corn farmers (Environmental Working Group); a 51 cent per gallon tax credit for ethanol producers; and a 7.5 billion gallon ethanol mandate that was included in the energy bill.

The current 51 cent per gallon subsidy is costing American taxpayers $2 billion per year, and will cost even more after 2012—almost $4 billion per year—when the use of ethanol is mandated to nearly double.

Now that the ethanol mandate is law, it is time for the subsidies to cease.

I believe we need to start by striking the 54 cent per gallon ethanol import tariff.

Ethanol imports are extremely limited, even though production costs for ethanol in foreign countries are significantly lower than in the United States.

For example, according to the Congressional Research Service, Brazilian productions costs are 40 to 50 percent lower than in the United States. Yet the tariff raises the cost of ethanol enough to pose a significant barrier to imports.

It is egregious to put such a high tariff on ethanol importation. It makes it impossible for U.S. consumers to purchase the lowest-cost ethanol.

And with the refineries choosing to phase-out MTBE this year, the demand for ethanol is even greater than was expected.

It is not clear if the domestic supply will be able to meet that growing demand.

Any ethanol supply disruption will hurt drivers on the east and west coasts the most.

Right now, ethanol is produced in the Midwest and must be trucked or railed to the coasts. According to news reports, ethanol delivery from the Midwest is currently being hindered by strong demand for limited rail time and a shortage of trucks and drivers.

If we strike the tariff, refineries can have more economic and efficient access to ethanol.

So, it's time to eliminate this 54 cent tariff and give consumers a break at the pump.

And we are not alone in this effort. Just last week, the President asked that Congress consider eliminating the tariff.

If they are going to be forced to use ethanol, our refineries should have the ability to buy it from the cheapest seller. They should not be constrained by artificial protectionist tariffs.

I hope my colleagues will join with me to strike this tariff.

Mr. AKAKA:

S. 2762. A bill to amend title 38, United States Code, to ensure appropriate payment for the cost of long-term care provided to veterans in State homes, and for other purposes; to the Committee on Veterans' Affairs.

Mr. AKAKA. Mr. President, I introduce legislation today to protect the state home program and expand the

ability of states and the Department of Veterans Affairs (VA) to care for veterans. I truly believe that the state home program is an incredibly valuable asset as we grapple with how best to care for our aging veterans. The program has proven time and time again that it is cost effective.

VA involvement in the state home program dates back to 1888 when Congress first authorized Federal grants-in-aid for veterans in State homes. Today, there are 119 State-operated Veterans' Homes in 47 States and the Commonwealth of Puerto Rico. State homes provide nursing home care in 114 of these homes and domiciliary care in 52 of these locations.

As many of my colleagues know, the State home program is supported in two ways by VA—construction grants and per diem payments. Subject to available funding, VA provides construction matching-grant funding for up to 65 percent of the cost of constructing or rehabilitating homes, with at least 35 percent covered by State funding commitments.

The per diem portion of the program provides current reimbursement to State homes—currently $63.40 for a day of nursing home care. This amount equates to less than 30 percent of the total cost to provide this care. Yet, VA is currently authorized to provide up to 50 percent of States' costs.

In January of this year, Chairman CRAIG and I held field hearings in my State of Hawaii. The hearing on the island of Kauai focused exclusively on long-term care in rural settings. We heard from two witnesses who spoke about the benefits of the State home program and ways to improve upon it, so as to specifically care for rural veterans.

Tom Driskill, the President and CEO of Hawaii Health Systems Corporation, testified about the soon-to-be-built State home in Hilo. He said, ''The synergy of a combined Federal and State funding of the home has been the catalyst for making this dream a reality.'' The Hilo home will be Hawaii's first State home and will house 95 beds and will serve veterans throughout the State.

The Committee also heard testimony about an innovative approach to fill significant gaps in long-term care services to veterans due to the nature and geography of certain States. Bob Shaw, the National Legislative Chairman for the National Association of State Veterans' Homes, testified that large State homes are not appropriate for the more remote locations in Hawaii. Instead, he argued, we should look to how Alaska has managed the challenge.

Rather than building large new homes, the State of Alaska is using its own Pioneer Homes, which provide nursing care to older Alaskans, in order to care for veterans. Similarly, Hawaii could use existing beds in the community and deem such beds as part of the State home program. Doing so would trigger per diem payments from VA to help defray the cost of nursing home care.

Accordingly, my legislation would authorize VA to provide construction grants and per diem payments for small long-term care units, approximately 10 to 30 beds, in pre-existing health care facilities. Such units would address gaps in long-term care services for veterans living in remote and rural regions including Alaska, Wyoming, Idaho, Montana, Kansas and other large, rural States.

I am quite proud of the changes we made to VA long-term care as part of the Millennium Act, which provides nursing home care to veterans who are 70 percent or more service-connected. I think we can expand the locations where such mandatory nursing home care is available. Currently, there is no mechanism in current law to permit VA to pay State homes for care provided to service-connected veterans. My legislation would authorize VA to place severely disabled service-connected veterans directly in State homes and would require VA to reimburse State homes for the cost of such care.

The legislation would also authorize severely disabled, service-connected veterans in State homes to receive VA's comprehensive medication benefit. Currently, such veterans are eligible to receive VA's full medication benefit if they are residing in community nursing homes but not if they reside in State homes. We need to ensure equitable coverage of medication needs.

Finally, this legislation mandates consultation and reporting requirements for VA prior to implementation of proposed changes to the current per diem system. Such requirements should include, at a minimum, consultations with Congress, State governments, and State homes. In addition, VA should be required to report to Congress how any such proposed changes would affect the long-term viability of the State home program before any such changes take effect. As part of the FY 06 budget, the Administration proposed dramatic restrictions to current per diem payments so as to only include a small portion of the veterans currently in State homes. Such a proposal, if enacted, would have devastated care in the homes.

Mr. President, we can give States and VA more tools to deal with burgeoning long-term care needs of veterans. I urge my colleagues in the Senate to join me in supporting this legislation.

I ask unanimous consent that the text of the bill be printed in the RECORD following this statement.

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

S. 2762

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 ''Veterans Long-Term Care Security Act of 2006''.

SEC. 2. REQUIREMENT FOR REPORT TO CONGRESS BEFORE IMPLEMENTATION OF REDUCTION IN PER DIEM RATES FOR CARE PROVIDED TO VETERANS IN STATE HOMES.

(a) REQUIREMENT FOR REPORT.—Subsection (c) of section 1741 of title 38, United States Code, is amended—

(1) by inserting ''(1)'' after ''(c)''; and

(2) by adding at the end the following new paragraph:

''(2)(A) If the Secretary proposes to implement a reduction in payments made under this section with respect to a fiscal year the Secretary shall, not later than January 1 of the preceding fiscal year, submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report containing a detailed justification of such proposed reduction.

''(B) For purposes of this paragraph, a reduction in payments is—

''(i) a lack of increase in the rates paid under subsection (a) pursuant to a determination of the Secretary under paragraph (1); or

''(ii) a modification of the eligibility for veterans to receive care in State homes that would, if enacted into law, result in fewer veterans eligible to receive such care in State homes.

''(C) In preparing a report under subparagraph (A), the Secretary shall consult with the heads and appropriate officials of the State and local agencies responsible for the supervision of State homes in each State in which State homes are operated, and representatives of such other organizations with expertise in State home matters as the Secretary determines appropriate.

''(D) A report under subparagraph (A) shall include the following information:

''(i) A specific description of the degree to which the proposed reduction in payments would effect the financial well-being of each State home.

''(ii) A detailed description of the consultation with heads, officials, and representatives required under subparagraph (C), and the results of that consultation.

''(iii) A description of the intent of the Secretary to recover grant amounts under section 8136(a) of this title where a State determines, as a result of the proposed reduction in payments, to close a State home within the period prescribed under that section.

''(iv) A description of the effect of the proposed reduction in payments on the long-term care needs of veterans who receive care in State homes, including a description of the options for long-term care in reasonably proximate facilities available to such veterans and an assessment of the cost of the provision of care for such veterans in such facilities.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act, and apply with respect to per diem payments made under section 1741 of title 38, United States Code, on or after such date.

SEC. 3. NURSING HOME CARE AND PRESCRIPTION MEDICATIONS IN STATE HOMES FOR VETERANS WITH SERVICE-CONNECTED DISABILITIES.

(a) NURSING HOME CARE.—Subchapter V of chapter 17 of title 38, United States Code, is amended by adding at the end the following new section:

''§ 1744. Nursing home care and medications for veterans with service-connected disabilities

''(a)(1) The Secretary shall pay each State home for nursing home care at the applicable rate payable under section 1720 of this title

for nursing home care furnished in a non-Department nursing home (as that term is defined in subsection (e)(2) of such section), where such care is provided to any veteran as follows:

''(A) Any veteran in need of such care for a service-connected disability.

''(B) Any veteran who—

''(i) has a service-connected disability rated at 70 percent or more; and

''(ii) is in need of such care.

''(2) Payment by the Secretary under paragraph (1) to a State home for nursing home care provided to a veteran described in that paragraph constitutes payment in full to the State home for such care furnished to that veteran.''.

(b) PROVISION OF PRESCRIPTION MEDICINES.—Such section is further amended by adding at the end the following new subsection:

''(b) The Secretary shall furnish such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of illness or injury to any veteran as follows:

''(1) Any veteran in need of such drugs and medicines for a service-connected disability.

''(2) Any veteran who—

''(A) has a service-connected disability rated at 50 percent or more;

''(B) is provided nursing home care that is payable under subsection (a); and

''(C) is in need of such drugs and medicines.''.

(c) CONFORMING AMENDMENTS.—

(1) CRITERIA FOR PAYMENT.—Section 1741(a)(1) of such title is amended by striking ''The'' and inserting ''Except as provided in section 1744 of this title, the''.

(2) ELIGIBILITY FOR NURSING HOME CARE.—Section 1710(a)(4) of such title is amended—

(A) by striking ''and'' before ''the requirement in section 1710B of this title''; and

(B) by inserting '', and the requirement in section 1744 of this title to provide nursing home care and prescription medicines to veterans with service-connected disabilities in State homes'' after ''a program of extended care services''.

(d) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 of such title is amended by inserting after the item relating to section 1743 the following new item:

''1744. Nursing home care and medications for veterans with service-connected disabilities.''.

(e) EFFECTIVE DATE.—The amendment made by this section shall take effect on October 1, 2006.

SEC. 4. AUTHORITY TO TREAT CERTAIN HEALTH FACILITIES AS STATE HOMES.

(a) AUTHORITY.—Subchapter III of chapter 81 of title 38, United States Code, is amended by adding at the end the following new section:

''§ 8138. Treatment of certain health facilities as State homes

''(a) The Secretary may treat a health facility as a State home for purposes of subchapter V of chapter 17 of this title if the following requirements are met:

''(1) The facility meets the standards for the provision of nursing home care that is applicable to State homes, as prescribed by the Secretary under section 8134(b) of this title, and such other standards relating to the facility as the Secretary may require.

''(2) The facility is licensed or certified by the appropriate State and local agencies charged with the responsibility of licensing or otherwise regulating or inspecting State home facilities.

''(3) The State demonstrates in an application to the Secretary that, but for the treatment of a facility as a State home under this subsection, a substantial number of veterans residing in the geographic area in which the facility is located who require nursing home care will not have access to such care.

''(4) The Secretary determines that the treatment of the facility as a State home best meets the needs of veterans for nursing home care in the geographic area in which the facility is located.

''(5) The Secretary approves the application submitted by the State with respect to the facility.

''(b) The Secretary may not treat a health facility as a State home under subsection (a) if the Secretary determines that such treatment would increase the number of beds allocated to the State in excess of the limit on the number of beds provided for by regulations prescribed under section 8134(a) of this title.

''(c) The number of beds occupied by veterans in a health facility for which payment may be made under subchapter V of chapter 17 of this title by reason of subsection (a) shall not exceed the number of veterans in beds in State homes that otherwise would be permitted in the State under regulations prescribed under section 8134(a) of this title.

''(d) The number of beds in a health facility in a State that has been treated as a State home under subsection (a) shall be taken into account in determining the unmet need for beds for State homes for the State under section 8134(d)(1) of this title.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 81 of such title is amended by inserting after the item relating to section 8137 the following new item:

''8138. Treatment of certain health facilities as State homes.''.

By Mr. REID (for himself and Mr. ENSIGN):

S. 2764. A bill to amend Public Law 108–67 to correct a provision relating to the conveyance of the Lake Tahoe Basin Management Unit; to the Committee on Energy and Natural Resources.

Mr. REID. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no oblection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2764

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CORRECTION OF CONVEYANCE.

Section 2 of Public Law 108–67 (117 Stat. 880) is amended—

(1) by striking ''Subject to'' and inserting the following:

''(a) IN GENERAL.—Subject to'';

(2) in subsection (a) (as designated by paragraph (1)), by striking ''the parcel'' and all that follows and inserting the following: ''and to a portion comprising approximately 23 acres of land of Lots 3 and 4, as depicted on the United States and Encumbrance Map, revised January 10, 1991, for the Toiyabe National Forest, Ranger District Carson–1, and more particularly described as S½NW¼SE¼ and N½SW¼SE¼ of sec. 27, T. 15 N., R. 18 E., Mt. Diablo Base and Meridian.''; and

(3) by adding at the end the following:

''(b) PUBLIC ACCESS AND USE.—Nothing in this Act prohibits any approved general public access (through existing easements or by boat) to or use of land remaining within the Lake Tahoe Basin Management Unit after the conveyance to the Secretary of the Interior, in trust for the Tribe, under subsection (a), including access to and use of the beach and shoreline areas adjacent to the portion of land conveyed under that subsection.''.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 469—CONDEMNING THE APRIL 25, 2006, BEATING AND INTIMIDATION OF CUBAN DISSIDENT MARTHA BEATRIZ ROQUE

Mr. LIEBERMAN (for himself, Mr. MARTINEZ, Mr. NELSON of Florida, Mr. MENENDEZ, Mr. ENSIGN, Mr. MCCAIN, and Mr. BIDEN) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 469

Whereas the 47-year communist dictatorship of Fidel Castro in Cuba received the lowest rating from Freedom House in its ''Freedom in the World 2005'' report for political rights and civil liberties, and is categorized by that organization as ''repressive'' and having ''virtually no freedom'';

Whereas Human Rights Watch describes Cuba in its ''World Report 2006'' as ''an undemocratic government that represses nearly all forms of political dissent'';

Whereas human rights observers have documented that the regime in Cuba attempts to intimidate human rights dissidents and their families through ''acts of repudiation,'' consisting of mobs of regime supporters screaming threats and insults;

Whereas, on April 25, 2006, an act of repudiation against Martha Beatriz Roque became violent when she was punched, knocked down, and dragged outside her home in Havana while she was leaving to attend a meeting with Michael E. Parmly, the Chief of Mission-Designate for the United States Interests Section in Havana, Cuba;

Whereas Martha Beatriz Roque is a citizen of Cuba and leader of the Assembly to Promote Civil Society in Cuba, a coalition of 365 independent civil society groups within Cuba;

Whereas, in March 2003, the regime of Fidel Castro imprisoned dozens of Cuban dissidents including Martha Beatriz Roque for their activities supporting freedom and democracy; and

Whereas Martha Beatriz Roque was released in 2005 for health reasons without a pardon or a commutation of her sentence: Now, therefore, be it

Resolved, That the Senate—

(1) condemns the brutality of the regime of Fidel Castro toward Martha Beatriz Roque, a 61-year-old woman in frail health;

(2) demands the regime of Cuba allow the people of Cuba to exercise their fundamental human rights, rather than responding to calls for freedom with imprisonment and intimidation;

(3) commends the courage and perseverance of Martha Beatriz Roque and all dissidents in Cuba;

(4) calls on the regime of Cuba to release the hundreds of political prisoners still held today and to stop the intimidation of dissidents and their families; and

(5) calls for continued international support and solidarity with pro-democracy leaders in Cuba.

SENATE RESOLUTION 470—PROMOTING A COMPREHENSIVE POLITICAL AGREEMENT IN IRAQ

Mr. KERRY submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 470

Whereas Iraq is destabilized by an ongoing insurgency and increasing sectarian violence;

Whereas General John P. Abizaid, the head of the United States Central Command, said in March 2006 that ''sectarian violence is a greater concern for us security-wise right now than the insurgency'';

Whereas General George Casey, the senior United States military commander in Iraq, and Zalmay Khalilzad, the United States Ambassador to Iraq, have stated that ''the principal threat to stability is shifting from an insurgency grounded in rejection of the new political order to sectarian violence grounded in mutual fears and recriminations'';

Whereas a national unity government and a comprehensive political agreement among Shias, Sunnis, and Kurds are essential to end sectarian violence, undermine the insurgency, and bring stability to Iraq;

Whereas, on April 22, 2006, the Iraqi National Assembly approved senior leaders of a national unity government, including Jawad al-Mailiki as Prime Minister;

Whereas, under the constitution of Iraq, the Prime Minister has 30 days to form a government;

Whereas a comprehensive political agreement must resolve fundamental issues dividing Iraqis and undermining stability, including federalism, oil revenues, the militias, security guarantees, reconstruction, and border security;

Whereas reaching a comprehensive agreement that will help bring stability to Iraq is in the best interests of Iraq's neighbors, the region, and the international community;

Whereas Iraq's neighbors, representatives of the Arab League, and the international community as represented by NATO, the European Union, and the permanent members of the United Nations Security Council can assist in the process of bringing about such a comprehensive agreement; and

Whereas the President should expedite this process by bringing together these parties and the leaders of the new Government of Iraq: Now, therefore, be it

Resolved, That it is the sense of the Senate that the President, not later than 30 days after the date of the formation of a new national unity government in Iraq, should convene a summit that includes the leaders of that government, leaders of the governments of each country bordering Iraq, representatives of the Arab League, the Secretary General of the North Atlantic Treaty Organization, representatives of the European Union, and leaders of the governments of each permanent member of the United Nations Security Council, for the purpose of reaching a comprehensive political agreement for Iraq that addresses fundamental issues including federalism, oil revenues, the militias, security guarantees, reconstruction, economic assistance, and border security.

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 May 15, 2006 at 2:30 p.m. in room SD–366 of the Dirksen Building.

The purpose of the hearing is to receive testimony relating to implementation of the Energy Policy Act of 2005's electricity reliability provisions.

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, United States Senate, Washington, DC 20510–6150.

For further information, please contact Kellie Donnelly at (202) 224-9360 or Shannon Ewan at (202) 224-7555.

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 rescheduled before the Committee on Energy and Natural Resources.

The hearing originally scheduled for Thursday, May 11, 2006 at 10 a.m. in Room SD–366 of the Dirksen Senate Office Building will now be held on Tuesday, May 16, 2006 at 10 a.m. in the same room.

The purpose of the hearing is to receive testimony regarding the status of the Yucca Mountain Repository Project within the Office of Civilian Radioactive Waste Management at the Department of Energy.

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, United States Senate, Washington, DC 20510–6150.

For further information, please contact Clint Williamson at (202) 224–7556 or Steve Waskiewicz at (202) 228–6195.

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

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. ENZI. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Monday, May 8, at 3 p.m. The purpose of this hearing is to receive testimony regarding issues associated with the implementation of the provisions of the Energy Policy Act of 2005 addressing licensing of hydroelectric facilities.

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

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. ENZI. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet on Monday, May 8, 2006, at 3:30 p.m. to consider the nomination of David L. Norquist to be Chief Financial Officer at the U.S. Department of Homeland Security.

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

AFFIRMING THAT STATEMENTS OF NATIONAL UNITY SHOULD BE IN ENGLISH

Mr. ENZI. Mr. President, I ask unanimous consent that the Judiciary Committee be discharged from further consideration and the Senate now proceed to S. Res. 458.

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

The clerk will report.

The assistant legislative clerk read as follows:

A resolution (S. Res. 458) affirming that statements of national unity, including the National Anthem, should be recited or sung in English.

There being no objection, the Senate proceeded to consider the resolution.

Mr. AKAKA. Mr. President, today I rise to oppose a resolution stating that it is the Sense of the Senate that statements of national unity, including the National Anthem, the Pledge of Allegiance, and the Oath of Allegiance sworn by new U.S. citizens should be recited or sung in English.

I agree with my colleagues that English is the common language of the United States and I join with them in urging all people who come to the U.S. and those who want to become U.S. citizens to learn the English language and understand our culture. Conversely, I believe the U.S. would benefit if its citizens knew the languages and cultures of other nations. We must develop long-term relationships with people throughout the world and learn to speak other languages, whether or not the languages spoken are considered critical for a particular situation or emergency. As 9/11 showed us, the failures of communication can do swift damage.

S. Res. 458 acknowledges that the vast majority of Americans are immigrants or descendants of immigrants, and that millions of Americans speak or study other languages. It further states that despite the linguistic and historic cultural diversity of the nation we are all Americans and our common language is English. However, even though English is our common language, the State Department offers translations of the National Anthem, the U.S. Constitution, the Pledge of Allegiance, and other U.S. documents in French, Arabic, and other foreign languages on its Web site to help people better understand America. Nor did President Bush refrain from singing the National Anthem in Spanish when he was running for office in 2000 or prevent pop star Jon Secada from singing our anthem in both English and Spanish when entertaining the President in 2001.

The resolution offered by my colleagues states that the original national motto of the United States, E Pluribus Unum—from many, one—is incorporated into the Great Seal of the United States, is printed on U.S. currency, and inscribed on the wall of the Senate Chamber. The sponsors of this resolution use these examples to argue that from many languages and backgrounds we have one language—English. However, our Nation's motto is written in Latin—not English.

The translation of key statements of national unity, such as the Pledge of Allegiance and the National Anthem, affords immigrants who have not fully learned the English language and individuals from all across the world the opportunity to better understand these symbols of America and the ideals of freedom that they represent. Such translations help those outside the U.S. to better understand our culture and our beliefs.

Last June, the Pew Global Attitudes Project released a report on America's image. Survey results from the citizens of 16 nations found that only six nations, one of which is the U.S., have a 50 percent or more favorable view of the United States. We cannot win the hearts and minds of people of other nations and promote American ideals if we close the door on people expressing their support for our country and the freedoms on which it was founded.

Our Constitution grants us the freedom of speech. This resolution, by limiting the language in which we can recite the Pledge of Allegiance or sing the National Anthem, violates the spirit of the Constitution and is antithetical to the very freedoms and beliefs that these statements of national unity represent.

To limit the ability of non-English speakers to know about the United States and, in turn, show their support for the U.S., would be a disservice to the country. Since this resolution is non-binding I will not object to it being acted upon by the Senate. However, I do not support the resolution.

Mr. ENZI. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motion to reconsider be laid upon the table.

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

The resolution (S. Res. 458) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 458

Whereas Francis Scott Key wrote the words of the Star-Spangled Banner in English in 1814, inspired by the sight of the American flag still waving at Fort McHenry after 25 hours of continual bombardment by British forces;

Whereas Congress declared the Star-Spangled Banner the National Anthem of the United States in 1931 (section 301 of title 3, United States Code);

Whereas the Pledge of Allegiance to the Flag of the United States, written in English, was first specified in law by Congress in 1942 (section 4 of title 4, United States Code);

Whereas the Oath of Allegiance, to which lawful permanent residents swear upon becoming citizens of the United States (as required under section 337 of the Immigration and Naturalization Act (8 U.S.C. 1448)), is based, in part, on language originally written in English by General George Washington and sworn by him and his general officers at Valley Forge in 1778;

Whereas the vast majority of Americans are immigrants or the descendants of immigrants, proud of their ancestral country, but prouder still to be American;

Whereas millions of Americans speak or study additional languages, but English is their common language;

Whereas the original national motto of the United States, ''E Pluribus Unum'', meaning ''from many, one'', signifies the coming together of people from many foreign countries to form one Nation, was incorporated into the Great Seal of the United States in 1776, is printed on currency of the United States, and inscribed on the wall of the Senate chamber;

Whereas the people of the United States are united not by race, ancestry, or origin, but by a common language, English, and by common belief in the principles prescribed in the founding documents of the Nation, especially the Declaration of Independence and the Constitution; and

Whereas, to become citizens of the United States, under sections 312 and 337 of the Immigration and Nationality Act (8 U.S.C. 1423 and 1448), lawful permanent residents of the United States who have immigrated from foreign countries must, among other requirements, renounce allegiance to the government of their country of origin, swear allegiance to the laws and Constitution of the United States, and demonstrate an understanding of the English language: Now, therefore, be it

Resolved, That the Senate affirms that statements or songs that symbolize the unity of the Nation, including the National Anthem, the Oath of Allegiance sworn by new United States citizens, and the Pledge of Allegiance to the Flag of the United States, should be recited or sung in English, the common language of the United States.

AUTHORIZING CORRECTION OF THE ENGROSSMENT OF THE SENATE AMENDMENT TO H.R. 4939

Mr. ENZI. Mr. President, I ask unanimous consent that the Secretary of the Senate be authorized to correct the engrossment of the Senate amendment to H.R. 4939, to reconcile the text of amendments 3728 and 3789.

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

ORDERS FOR TUESDAY, MAY 9, 2006

Mr. ENZI. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 9:45 a.m. on Tuesday, May 9. I further ask that following the prayer and the pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved, and the Senate resume consideration of the motion to proceed to S. 1955, the small business health plans bill, with a vote on the motion to invoke cloture on the motion to proceed to S. 1955 to occur at 10 a.m.; further, that the time before the vote be equally divided between the chairman and ranking member of the HELP Committee or their designees.

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

PROGRAM

Mr. ENZI. Mr. President, tomorrow morning at 10 o'clock, we will have a cloture vote on the motion to proceed to S. 1955, the small business health plans bill. I do expect we will be able to proceed to this bill, and I hope we can expedite the 30 hours of debate postcloture and get on with the bill tomorrow.

ADJOURNMENT UNTIL 9:45 A.M. TOMORROW

Mr. ENZI. Mr. President, 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 6:40 p.m., adjourned until Tuesday, May 9, 2006, at 9:45 a.m.

NOMINATIONS

Executive nominations received by the Senate May 8, 2006:

DEPARTMENT OF STATE

W. STUART SYMINGTON IV, OF MISSOURI, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF DJIBOUTI.

DEPARTMENT OF EDUCATION

TROY R. JUSTESEN, OF UTAH, TO BE ASSISTANT SECRETARY FOR VOCATIONAL AND ADULT EDUCATION, DEPARTMENT OF EDUCATION, VICE SUSAN K. SCLAFANI.

CENTRAL INTELLIGENCE AGENCY

GENERAL MICHAEL V. HAYDEN, UNITED STATES AIR FORCE, TO BE DIRECTOR OF THE CENTRAL INTELLIGENCE AGENCY, VICE PORTER J. GOSS, RESIGNED.