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House of Representatives

The House was not in session today. Its next meeting will be held on Wednesday, September 4, 2002, at 2 p.m.

Senate

TUESDAY, JULY 30, 2002

The Senate met at 10:30 a.m. and was called to order by the Honorable HILLARY RODHAM CLINTON, a Senator from the State of New York.

PRAYER

The Chaplain, Dr. Lloyd John Ogilvie, offered the following prayer:

Father, You have created us to love and praise You. You desire an intimate, personal relationship with all of us. Praise surges from our hearts for what You are to us and thanksgiving for what You promise for us. We say with the psalmist,

I will praise You, O Lord, with my whole heart. I will tell of Your marvelous works. I will be glad and rejoice in You; I will sing praise to Your name.—(Psalm 9:1,2).

When we are yielded to You, our faltering, fallible, human nature is invaded by Your problem-solving, uplifting presence. We want to glory only in our knowledge of You and Your wisdom. We commit our minds, emotions, wills, and bodies so that we may be used by You. Fill us with Your supernatural power so that we may be equipped to face the ups and downs, the pleasures and pressures of this day. We will remember that whatever the circumstances, praise and thanksgiving will usher us into Your heart where alone we can find the guidance and grace we so urgently need. You have given the day; now show the way. Through our Lord and Saviour. Amen.

PLEDGE OF ALLEGIANCE

The Honorable HILLARY RODHAM CLINTON 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.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The assistant legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, July 30, 2002.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable HILLARY RODHAM CLINTON, a Senator from the State of New York, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mrs. CLINTON thereupon assumed the Chair as Acting President pro tempore.

RECOGNITION OF THE ACTING MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The Senator from Nevada is recognized.

ORDER OF PROCEDURE

Mr. REID. Madam President, I ask unanimous consent that the time from 10:40 a.m. until 11:10 a.m. be under the control of Senator BYRD; that the next 35 minutes be under the Republicans' control for morning business; that the Senate resume consideration of S. 812 at 11:45 a.m., with the time until 12:45 equally divided between Senators KENNEDY and MCCONNELL or their designees; and that the previously ordered recess begin at 12:45 p.m. instead of 12:30 p.m.

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

Mr. REID. Madam President, there are two cloture motions that were filed last evening—first on the Dorgan amendment and second on the generic drug bill. Therefore, Senators have until 12:45 p.m. today to file first-degree amendments.

RESERVATION OF LEADER TIME

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

The Senator from Michigan is recognized.

PRESCRIPTION DRUG COSTS

Ms. STABENOW. Madam President, I want to take a few moments, as we are working in earnest this week to complete the session and focus on where we are as it relates to the critical issue of prescription drug coverage and making sure that our seniors have help in Medicare and also that we are lowering prices for everyone. This has been quite a challenge for us.

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

We knew when we started, we were facing daunting odds; that the system, as it is situated right now, heavily favors the industry and that as a result of the fact that it heavily favors them, and the rules favor them and allow them to stop competition and to be able to set prices on Americans much higher than in other countries, we knew this was going to be an uphill battle.

We often talk about the fact that there are six drug company lobbyists for every one Member of the Senate and what that means in terms of challenges. But we have an opportunity today, and many of us have been working across the aisle in good faith. In fact, I would say everyone has been working in good faith. There are different philosophies—two very different approaches—that are being developed. But everyone is working in good faith to try to get something done. I think today is the day when we really decide are we going to at least take the first step. If we can't get all the way there, to give comprehensive Medicare coverage for all seniors and disabled, we have to at least begin the process to do that.

We are being called upon by AARP and the other senior groups to at least take the first step. So we are working hard today. I commend my colleagues on both sides of the aisle who have been working with us to be able to do that. We still have two different philosophies—one put forward predominantly by our colleagues on the other side of the aisle and by the House Republicans, which I believe moves us in the direction of privatizing Medicare. It would use private sector insurance, HMOs, as the mechanism for providing prescription drug coverage.

In my home State, we have seen Medicare+Choice, basically a failure in terms of covering people, pulling out. My own mother was in the program and lost her HMO coverage. We have seen over and over again where the private sector market has not worked for our seniors as it relates to Medicare.

I argue that it is the wrong direction to go to try to prop up this system—private sector HMOs. There have been proposals that would prop them up to the tune of Medicare paying 99 percent—covering 99 percent of the risk in order to go through private insurance companies. To me, that seems a little ridiculous.

What we should be doing is what seniors across the country are asking us to do and that is update Medicare. We have had colleagues who have called Medicare a big government program. As I have said before, I believe it is a great American success story—Medicare and Social Security.

So we have an opportunity today to begin to modernize Medicare. I hope we are going to do that. Ultimately, we know that Medicare—the health care system for older Americans—needs to cover prescription drugs for everyone on Medicare. But at a minimum, we need to start with our lower income seniors, who are deciding: Do I eat or get my medicine? Do I pay the utility bills or pay the rent? Maybe I should cut my pills in half. Maybe I should ask for a 1-week supply instead of a month. Maybe I will share them with my spouse because we both need the same blood pressure medicine.

There are so many real stories. I have read many of them on the floor of the Senate—real-life stories of people in Michigan who are struggling to make life-and-death decisions.

We have an opportunity at least to do something for them. We have an opportunity also for those who are the sickest, who have the biggest bills, who are finding themselves trying to decide between having their home, their retirement, being able to have any life whatsoever, or having thousands and thousands of dollars in drug bills. We have the opportunity to, as well, put in place for everybody the ability to know that they will not lose their home or their retirement and savings as a result of the cost of their medicine.

If we could simply start with the neediest and the sickest under Medicare, I believe that would be a wonderful first step for us and something we could do today in a bipartisan way within the integrity of Medicare.

I hope, Madam President, we will take the challenge that the seniors are calling on us to do across the country: To step up and provide leadership, to do more than talk, and begin to get something done for the seniors and others on Medicare.

I yield the floor.

The ACTING PRESIDENT pro tempore. Under the previous order, the time from 10:40 a.m. to 11:10 a.m. shall be under the control of the Senator from West Virginia.

Mr. BYRD. I thank the Chair.

CREATION OF A NEW DEPARTMENT OF HOMELAND SECURITY

Mr. BYRD. Madam President, later this week, the Senate is expected to begin debate on the creation of a new Department of Homeland Security. The debate, however, will not be about whether to create a new Department, but rather how to create a new Department.

Since the President unveiled his legislative proposal 6 weeks ago, the Congress seems unwilling—or unable, perhaps—to resist the stampede moving it towards the creation of this new Department. Indeed, the momentum behind the idea seems almost unstoppable.

With the level of endorsement the Congress has given to this idea, one would think that the proposal for a new Homeland Security Department had been engraved in the stone tablets that were handed down to Moses at Mount Sinai. But in reality, the idea was developed by four Presidential staffers—four—in the basement of the White House. For all we know, it could have been drafted on the back of a cocktail napkin.

The administration did not consult with Members of Congress about the President's proposal. We were not asked for our input. The week the President unveiled his proposal to the American people, only a select circle of Washington insiders were even aware of its existence.

I remember the events of that week. The administration was under fire about whether U.S. intelligence agencies had adequate information to prevent the September 11 attacks. FBI whistlerblower Coleen Rowley was testifying before the Senate Judiciary Committee—the same day, in fact, that the President addressed the Nation to announce this new Department. The President's poll numbers were dropping as the American public began to question the effectiveness of the administration's plan to protect our homeland.

The Congress was taking the initiative on the homeland security front. Senator LIEBERMAN's proposal to create a new Department of Homeland Security was slowly gaining momentum in the media. White House Press Secretary Ari Fleischer just a few weeks earlier criticized the Lieberman plan by saying that ''a [new] cabinet post doesn't solve anything.'' That was Mr. Fleischer talking: ''a new Cabinet post doesn't solve anyting.''

This was the political environment in which the President unveiled his hasty proposal, and that proposal was widely reported in the media as helping the administration to retake the initiative in protecting the homeland. The President's address to the Nation helped to restore the confidence of the American public in the administration's efforts to protect the homeland, and even provided the President with a boost in his approval ratings.

So the President's proposal was crafted in the bowels of the White House, cloaked in secrecy, and presented by an administration trying to regain political ground. Those are hardly the conditions that should inspire the Congress to rally around a Presidential proposal, but that is exactly what is happening.

The Congress is coming around, rallying around a massive, massive governmental reorganization with little discussion about whether such a reorganization is desirable or even necessary. What is worse, the Congress is so eager to show itself united beside the administration in our Government's efforts to protect the homeland, that it has committed itself to a timetable that would allow for only minimum debate about the President's proposal—a plan of dubious origins—so that we can expedite its passage before the 1-year anniversary of the September 11 attacks. Think of that!

Have we all completely taken leave of our senses?

The President is shouting ''Pass the bill! Pass the bill! Pass the bill.'' The administration's Cabinet Secretaries

are urging the adoption of the President's proposal without any changes. And the House of Representatives eagerly complied last week by passing legislation that essentially mirrors—mirrors—the President's plan.

If ever there was a need for the Senate to throw a bucket of cold water on an overheated legislative process that is spinning out of control, it is now—now. But what are we doing instead?

In the Senate, the Governmental Affairs Committee marked up its legislation just 5 weeks after receiving the President's legislative proposal. Until last week, Senators were being urged to finish consideration of the bill before the August recess begins this Friday. Think of that. The Senate would have had just 1 week to consider this bill, before it passed and was sent to conference before the August break. Considering that the committee-reported bill was only made available yesterday afternoon, this schedule would have given Senators only 4 days to read and understand what was crafted by the Governmental Affairs Committee. And to finish the bill within a week, Senators would certainly have been discouraged from offering amendments and debate would have been stifled.

That was the process being urged by some for the Congress' ''deliberative body''—the greatest deliberative body in the world.

I certainly understand that no Senator wants to be seen as delaying our Government's efforts to protect our homeland. But in trying to avoid being labeled as obstructionists, we must not be willing to ignore even the most pertinent questions about the proposal—such as will a new Homeland Security Department actually make the public safer from terrorists?

Prior to the President's address, there were at least eight different proposals pending before the Congress to reorganize the Government to better protect the homeland. Those proposals ranged from creating a homeland security czar to establishing an independent Homeland Security Office to authorizing in statute certain powers for the White House Office of Homeland Security. All of them have been trumped by visions of political advertisements attacking Members of Congress for not moving fast enough to create a new Homeland Security Department.

If we are going to be totally honest here, we need to put aside visions of campaign ads and do some good old-fashioned thinking.

This proposed merger constitutes the largest—the largest—Government restructuring in our Nation's history—bringing together pieces of 22 agencies, involving as many as 170,000 or more Federal employees from perhaps over 100 bureaus and branches. A governmental reorganization of this size involves more than just reorganizing the Federal Government on a flow chart. It means physically moving the bureaus and agencies to a new Department, transplanting tens of thousands of people, desks, computers and phones, hooking them together and making them work again. It also means changing the culture, power structures, and internal dynamics of the relevant agencies and bureaus. It means dealing with confusion, bureaucratic conflict, and unclear lines of authority.

As Norman Ornstein recently wrote in The Washington Post: ''This would be a Herculean task for even one agency. It is beyond Herculean for twenty-two agencies.''

If we take this giant step, our homeland defense system will likely be in a state of chaos for the next few years, and amid this upheaval, we run the risk of creating gaps in our homeland defenses. If our enemies are planning to attack the seams in our defenses, this massive reorganization will likely provide them with some excellent opportunities. That helps to explain, in part, why the much touted reorganization that consolidated the armed forces within the Defense Department took place after World War II, and not immediately after the attack on Pearl Harbor.

Even then, it took a number of years and a number of legislative efforts to get that reorganization into decent, effective working order.

How long will it be before this new Homeland Security Department is in decent, effective working order? What if Osama bin Laden does not wait until we have finished restructuring? What if bin Laden is tempted to strike at the exact moment that these agency officials are dragging their desks up Pennsylvania Avenue to their new office assignments? I would like to see a risk analysis regarding the creation of the DHS. Will Americans be exposed to more risk for an unknown time period as a result of establishing an additional mammoth bureaucracy?

The Brookings Institution emphasized this point in a report issued this month urging the Congress to move cautiously as it considers the creation of a new department. ''The danger,'' the report states, ''is that top managers will be preoccupied for months, if not years, with getting the reorganization right—thus giving insufficient attention to their real job: taking concrete action to counter the terrorist threat at home.''

The Wall Street Journal agreed in an editorial this month saying that ''The middle of a crisis, and only weeks before an election, isn't the optimal time to debate and pass the biggest transformation of Government in fifty years. The Administration has plenty else to focus on before rearranging the bureaucracy.''

If the purpose of this reorganization is to increase accountability for our homeland defense agencies, then it doesn't make any sense to provide those agency chiefs with opportunities for new excuses. How easy would it be for the INS Commissioner to blame that agency's next high profile blunder on problems associated with the transition to the new department?

The Congress hasn't even developed a standard to determine which agencies should be moved to the new department—contributing to a growing concern that too many agencies are being shifted around, with too little focus on preventing future attacks. A strong case can be made for consolidating the Immigration and Naturalization Service, the Customs Service, and other border security agencies, but the arguments for moving the Secret Service, for example, are hardly compelling. The litmus test for moving these agencies does not appear to be why, but rather why not.

Another point the Congress needs to remember is that this new department will assume the non-homeland security related functions of the agencies that are transferred to it. But if we are unhappy with the Treasury Department's oversight of the Customs Service's efforts to inspect the cargo entering U.S. ports, we will probably be just as unhappy with the Homeland Security Department's oversight of the Customs Service's efforts to enforce our trade laws. Creating a new Department is unlikely to solve the problem of departments neglecting key functions of their agencies; it only alters which functions are likely to be neglected.

These are basic problems which the Congress appears ready to push aside in order to meet the administration's call for quick action on this legislation. And this is not exactly an administration that has been open with the Congress about its plans for reorganizing the Federal Government.

The administration has not issued a cost estimate of the President's proposed merger and insists that the transition costs will be kept to a minimum. Meanwhile, the Congressional Budget Office estimates that the President's proposed merger will cost $3 billion, with a capital ''B,'' over 5 years. The White House says not to worry, however, because the transition costs will be repaid through long-term savings. That sounds like a neat trick. The administration wants to create a new bureaucracy with a secretary, a deputy secretary, five undersecretaries, 16 assistant secretaries, and as many as 500 senior appointees, without appropriating any additional money to finance the transition. The new managerial level alone will cost scores of millions of dollars.

And there is the rub. Protecting our homeland requires resources and personnel, and they cost money. We have to pay our border patrol agents, our sky marshals, and our national guardsmen. But this administration, in trying to appease its own party base, is refusing to spend the money necessary to make America safer, and instead is pushing for this reorganization of Government. But this massive governmental reorganization is going to be costly. It is going to require the investment of real money, your money. It

cannot be done with the kind of creative accounting gimmicks you might expect to find at Halliburton Company and Harken Energy Corporation.

When the White House makes these kinds of ridiculous comments about long-term savings, the Congress and the American people better get ready because the White House has got something up its sleeve.

The Bush administration has already sought a blanket waiver of civil service law to set up a new personnel system for the new Department. The President's proposal would give the new Secretary broad power to overhaul the pay, benefits, and workplace rules for over 200,000 Federal workers. The proposal would also exempt the new Department from procurement laws, such as the Competition in Contracting Act and the Contract Disputes Act. This sounds to me like an attempt to contract out homeland security-related services so that the administration can make the artificial claim that they are shrinking Government and reducing Federal costs.

My larger concerns, however, reside deeper in the administration's recent comments on managing the new Department. These comments, I fear, indicate that the administration has something far more unpalatable up its sleeve.

The President said in a pep rally for Federal workers this month that the administration needs the ''freedom to manage'' the new Department. To clarify those comments, Homeland Security Director Tom Ridge said that ''we need all of the flexibility we can get,'' and suggested that close congressional oversight could cripple the new Department's ability to respond to terrorism.

That kind of a statement from an administration official ought to make us all very nervous.

To make the point crystal clear, the OMB Director said last week, ''Our adversaries are not encumbered by a lot of rules. Al-Qaida doesn't have a three-foot-thick code. This department is going to need to be nimble.'' Ha-ha. How nimble was the administration when we sought to pass the supplemental appropriations bill, with $3 billion more money for homeland security above the President's budget proposal? How nimble was the agency? How nimble was the administration? They held us up for 5 months.

Rules like holding this new department accountable to the Congress and the American people, Mr. OMB Director? Al-Qaida may not be encumbered by constitutional limitations on its powers, but, unlike the OMB Director, I would scarcely argue that al-Qaida sets an example for this Government to follow.

I find comments like that to be incredibly ignorant. For all of their blustering about how al-Qaida is determined to strike at our freedoms, this administration shows little appreciation for the constitutional doctrines and processes that have preserved those freedoms for more than two centuries.

This administration has made clear its intent to ''reassert'' executive authority, and, to date, it has aggressively tried to curtail Congress's powers of oversight. The President refused to allow the director of the Office of Homeland Security to testify before the Senate Appropriations Committee and other committees, in his capacity as our chief homeland security official.

The administration has been secretly planning to introduce special operations troops into Iraq without the consent of the Congress. We had better watch that one, too. That's to say nothing of this administration's attempts to block congressional access to information about executive actions.

In reorganizing the Federal Government, the Congress has a responsibility to guard against attempts to also reorganize the checks and balances of the constitutional system. The greatest risk in moving too quickly is that we will grant unprecedented powers to this administration that would weaken our constitutional system of government.

Pay attention, the Congress should be seriously concerned about the transfer authority that is being sought by this Administration. The President's proposal provides that ''not to exceed five percent'' of any appropriation available to the Secretary of Homeland Security in any fiscal year may be transferred between such appropriations, provided that at least 15 days' notice—that is all that Congress gets—15 days' notice is given to the Appropriations Committees prior to the transfer. No congressional approval is required after these 200 years.

In addition, the President's plan would authorize the Secretary of Homeland Security to allocate or reallocate functions and to ''establish, consolidate, alter, or discontinue'' organizational units within the Department, even if established by statute, simply by notifying Congress ninety days in advance. Again, no congressional approval is required. Again, no congressional approval is required.

These provisions make clear the administration's attempt to erode Congress' ''power of the purse''.

I identified these problems in the President's proposal and wrote to Senator LIEBERMAN and Senator STEVENS, ranking member of the Appropriations Committee joined, requesting that these powers not be included in his proposal. What concerns me most is not those problems that I have identified, but rather the assaults on the legislative branch which still remain hidden inside the administration's proposal and are on track to being adopted by the Congress.

I am not the only Senator who believes that this process is moving along too quickly. We are all talking about this in the privacy of our offices, behind the closed doors of elevators and in our hideaways. But we ought to come out onto the Senate floor and discuss it before the American people. We are rushing ahead to pass legislation, which many of us think is bad policy. We are rushing headlong to pass a massive bill that few if any of us fully understand.

The executive branch is flexing its muscles and worrying about its political backside. The legislative branch needs to protect our constitutional system and consider what will truly protect the homeland and the safety of our people. We must flex our brainpower and analyze this idea carefully.

We cannot be brain dead on these vital issues. The stakes are too important.

Madam President, I know the administration will be out there across the country saying, let's pass this homeland security bill, and the Senate will be criticized, the Senate leader will be criticized, I will be criticized, other Senators will be criticized, for not having taken up this behemoth proposal and passed it before we close business this week.

When the President signs the supplemental, he will have 30 days to decide whether to designate over $5.1 billion as an emergency. That is $5.1 billion. We so designated it. If the President designates one item of that $5.1 billion, he has to designate all items. I have heard that he is not going to sign that; I have heard that he is not going to release that $5.1 billion, by his signature, making it an emergency. The Congress provided that it had to be all or nothing.

That is what the Senate and House did to President Clinton when he was President. I voted for that provision. He had to sign all or nothing. I voted for it. And now we have put that same provision in this bill.

There is $5.1 billion available to the President upon his signing that as an ''emergency.'' What are we talking about? Within the $5.1 billion is nearly $2.5 billion for homeland security. If the President does not make the designation ''emergency''—get this—the President and others in the administration will lambast the Senate for not having passed the homeland security bill before it goes out for the recess. But what the Senate did pass is a bill, the supplemental bill, which makes available for homeland security at least $2.5 billion of homeland defense funding. All the President has to do is designate it as an ''emergency''.

Here is what is involved in the $2.5 billion: Firefighting grants, $150 million; nuclear security improvements, $235 million; $100 million for grants to make police and fire equipment interoperable; port security grants, $125 million; airport security, $480 million; Coast Guard for port security, $373 million; Secret Service, combating electronic crimes, $29 million; law enforcement resources for State and local government—hear this—$150 million; $82 million for the FBI for counterterrorism and information technology

enhancement; $54 million for urban reserve and rescue teams; $147 million for cybersecurity improvements to protect our economy; food and water security, $165 million; border security, $78 million; dam and reservoir security, $108 million; the Customs Service, to increase inspections, $39 million.

And homeland security is not the only issue, when the President makes the decision to do the ''emergency'' designation. If he decides not to make the emergency designation, he will be blocking funding for the following activities: Election reform, $400 million; combating AIDS, tuberculosis, and malaria overseas, $200 million; flood prevention and mitigation in response to recent flooding, $50 million; Department of Defense, over $1 billion for the National Guard and Reserve for chemical demilitarization and for classified projects; for foreign assistance, including embassy security and aid to Israel and disaster assistance to Palestinians, $437 million.

For assistance to New York City—I see that one of the distinguished New York Senators has just been presiding. Let me remind her that in this ''emergency'' designation package, the assistance to New York City in response to the attacks of September 11, including funds to monitor the long-term health consequences of the World Trade Center attacks on the health of police, fire, and other first responders, and for recovery costs for the Securities and Exchange Commission office that was in the World Trade Center, there is $99 million.

Hello, Governor of New York! Get in touch with the administration. Urge the President to sign his name to the package that should be designated ''emergency''. It should be designated emergency by the President so that the moneys will be released for New York. Firefighting suppression funding, $50 million; emergency highway repair funding, including funds to repair the I–40 bridge that was recently destroyed in Oklahoma.

Hello, Oklahoma! Get in touch with the White House about this. Ninety-eight million dollars!

Hello Oklahoma, are you listening?

I ask for an additional 30 seconds.

The PRESIDING OFFICER (Ms. LANDRIEU). Without objection, it is so ordered.

Mr. BYRD. Assistance to victims of the Sierra Grande fires, $61 million; veterans medical care—Hi there, veterans, get in touch with the White House. Tell the President to sign his name on that emergency designation package because it includes $275 million for veterans medical.

Madam President, I thank all Senators for listening. I will have more to say, the Lord willing, in due time.

(Applause in the Visitors' Galleries.)

The PRESIDING OFFICER. Expressions of approval are not permitted by the galleries.

Under the previous order, the time from 11:10 to 11:45 shall be under the control of the Republican leader or his designee. The Senator from Iowa.

Mr. GRASSLEY. Madam President, it is my understanding staff arranged for me to have 20 minutes of that 45 minutes.

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

ONE-YEAR ANNIVERSARY OF BIPARTISAN TAX RELIEF

Mr. GRASSLEY. Madam President I rise today to discuss the one year anniversary of the bipartisan tax relief package. On June 7, 2001, President Bush signed the legislation. On Friday, June 7 of this year, the President marked the first anniversary of that event in Des Moines, Iowa. I was pleased to join the President for that anniversary celebration.

One year ago this week, the Treasury Department started sending out rebate checks to every American taxpayer. I ask unanimous consent to have printed in the RECORD an announcement from the Treasury Department dated July 26, 2001.

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

[From the Office of Public Affairs]

TREASURY TO MAIL OUT 8.1 MILLION CHECKS ON FRIDAY

(July 26, 2001)

Tomorrow the Treasury Department will send out 8.1 million advance payment checks to taxpayers for more than $3.4 billion in tax relief. These checks will be sent to taxpayers whose last two digits of their Social Security numbers are 10–19.

Week Two (July 27) Social Security Numbers 10–19
Number of Checks 8.1 million
Amount of Relief $3.4 billion
Week One (July 20) Social Security Numbers 00–09
Number of Checks 7.9 million
Amount of Relief $3.3 billion

The Treasury Department will announce every week the number of checks that are being mailed out for that week, and the amount of tax relief that is being sent to taxpayers. Checks will be mailed over a ten-week period, according to the last two digits of the taxpayers Social Security number. Notices from the Internal Revenue Service that tells taxpayers the amount of their check and when they should expect it have been mailed. Single taxpayers will get a check up to $300, head of household up to $500 and married couples filing jointly will get up to $600.

Because the Social Security number determines when checks are mailed, taxpayers may receive their checks at different times than their neighbors or other family members. On a joint return, the first number listed will set the mailout time.

If the last two digits of your Social Security number are	You should receive your check the week of
00–09	July 23.
10–19	July 30.
20–29	August 6.
30–39	August 13.
40–49	August 20.
50–59	August 27.
60–69	September 3.
70–79	September 10.
80–89	September 17.
90–99	September 24.

Mr. GRASSLEY. Those checks represented the first broad-based tax relief in nearly a generation. Generally, single taxpayers got a $300 check and married couples got a $600 check.

What I would like to do today is first put the tax cut in historical context. Second, I would like to set the record straight in terms of the progressivity of the tax relief and its budget effects. Finally, I would like to illustrate what the tax relief legislation means in terms of typical families across America.

I am going to use a series of charts as I move through the discussion.

Let's start with historical context. In the last 20 years, there have been several pieces of major tax legislation. When I use the term major, I am referring to net tax hikes or net tax cuts in the neighborhood of $100 billion or more.

In the last generation, frankly, the American taxpayer has come out on the short end of the deal. By and large, the tax-and-spend Washington crowd prevailed. There have been four major tax increase bills. There have been three major tax cut bills, with one of those, the 1997 tax relief package, barely breaking into the major category.

Let's take a look at the tax increase bills first. There were No. 1, ''TEFRA'' in 1982, No. 2, ''DEFRA'' in 1984, No. 3, ''OBRA'' in 1990, and, as then Finance Chairman Pat Moynihan said, No. 4, the ''world record tax increase'' of President Clinton's 1993 tax package. Senator Moynihan's description was verified by a Joint Committee on Taxation estimate. It showed the 1993 tax increase raised taxes by over $1 trillion.

In the same generation, taxpayers have received net tax cuts three times. The three events occurred in 1981, in 1997, and last year. In 1981, the Reagan tax cuts brought down the top rate of 70 percent to 50 percent. In 1997, modest bipartisan tax relief, had, as its centerpiece, the $500 per child tax credit. Of course, last year, all taxpayers received a tax relief.

When you look over the last generation, the bipartisan tax relief of last year, in effect, helped tip the balance back a little bit toward the American taxpayer. I say a little bit, because, by any reckoning, even when fully in effect, last year's bill still leaves the balance toward higher taxes and more government. More on that in a minute.

For another point of historical context, take a look back at the fundamental tax reform of 1986. You will recall that effort was a grand compromise between liberals, led by Congressman Rostenkowski, and conservatives, led by President Reagan. We came up with a revenue neutral package by broadening the tax base by shutting down tax shelters. The revenue raised was used to create two rates—15 percent and 28 percent. In addition, millions of low income families ceased paying income tax.

During the tax reform debate, today's House Democratic Leader, Congressman GEPHARDT, pursued a tax reform plan with former Senator Bradley. The Bradley-Gephardt plan contained three rates of tax. The three rates were 35 percent, 25 percent, and 15 percent. Former Senator Mitchell, who would become the Democratic Leader and a great champion of the liberal wing of the Democratic Caucus, supported a top rate of 35 percent as well. Indeed, the House, at that time controlled by Democrats, passed a tax reform bill with a top rate of 35 percent.

So, at the watershed event of 1986, the leaders of the Democratic Caucuses, said individual income tax rates should not exceed 35 percent. As everyone knows, 35 percent is the top rate when the bipartisan tax relief package is in full effect in 2006. I guess I find it a bit ironic that today the Democratic Leadership says individual tax rates must be above 35 percent.

It makes you wonder why today's Democratic Leadership, in historical context, is so fixated on higher taxes. Why is Congressman GEPHARDT, the House Democratic Leader, insisting on tax rates at higher levels than his 1986 era plan? Why is Senator DASCHLE, today's leader of the Democratic Caucus, insisting on tax rates at higher levels than his predecessor, Senator Mitchell?

Isn't 35 percent of a person's income enough of a contribution for their share of the burden of the Federal Government?

That is where the Democratic Leaders were during tax reform. That is where the bipartisan tax relief plan leaves us when fully in effect in 2006. Unfortunately, that's not where the Democratic Leaders are today.

The question of why 35 percent isn't enough leads in the second part of my discussion. What I would like to do is set the record straight on the progressivity and budget effects of the bipartisan tax relief plan.

It seems to me that the Democratic leadership has moved its tax reform target away from tax relief for a very simple reason. The reason is to provide resources to grow the Federal Government by increasing spending.

It is part of a larger of agenda of moving a society, America the engine of capitalism, to look more like European socialism. It means more Government and less individual responsibility. It means less reward for work and more money from the pockets of working people for the Federal Government. It means opportunity defined less by a dynamic market and more by political criteria.

Now, a lot of inaccurate information has been spread about the bipartisan tax relief package. At the head of this campaign, is the Democratic Leadership. Perhaps unwittingly, perhaps by design, much of the media has worked hand in glove with this partisan campaign.

The misinformation comes forward in three bogus assertions. The first incorrect assertion is that the bipartisan tax relief was a partisan Republican product. The second is that the bipartisan tax relief package is the source of our current budget problems. The third incorrect assertion is that the tax relief favored the wealthy over low and middle income taxpayers.

I would like to turn to the first incorrect assertion. Often we hear the phrase Republican tax cut or partisan tax cut. In fact, the tax cut was bipartisan. Twelve Democratic Senators voted for the conference report. Senator JEFFORDS also voted for the conference report. That is over one-fourth of the Democratic Caucus.

The tax relief legislation was bipartisan by design. In a Senate divided down the middle, the tax relief had to be bipartisan to pass. There was no other way.

Democratic members of the Finance Committee played a key role in crafting the bill. LEd by our current Chairman, MAX BAUCUS, they insisted on a bill that reflected their priorities. Senators BREAUX, TORRICELLI, LINCOLN, all contributed to the formation of this bill. Republican moderates like Senator SNOWE also played a key role. Without these Senator's input and support, we would not have the tax relief in place.

Anyone who characterizes the tax relief as partisan is flat out wrong.

I would like to move on the second incorrect assertion. How many times have we heard on this floor or seen written in the media the charge that the bipartisan tax relief caused the current and projected deficits. If I have a dollar for every time I've heard or read this point, I could put the budget in balance.

Cold hard numbers tell a different story. Cold hard numbers from the Congressional Budget Office, the Office of Management and Budget, and private sector sources reveal the truth.

Here is what the numbers say. You can check it out on the CBO website.

According to CBO's January baseline, for the current fiscal year, the tax cut represents barely 14% of the total change in the budget since last year. For instance, for the same period, increased appropriations outranked the tax cut by $6 billion. So, spending above baseline, together with lower projected revenues, accounted for 89 percent of the change in the budget picture. Let me repeat that. Bipartisan tax relief was a minimal, 11 percent factor, in the change in the surplus.

Over the long-term, the tax cut accounts for 45 percent of the change in the budget picture. Stated another way, the 10 year surplus declined from $5.6 trillion to $1.6 trillion. Of that $4.0 trillion change, the tax cut represented about $1.7 trillion of the decline. That is less than one-half of the change. Let me repeat that for our friends in the Democratic Leadership and their allies in the media. The tax relief package accounts for less than 45 percent of the decline in the surplus.

The second incorrect assertion, that the tax cut ate the surplus, is incorrect, according to CBO.

I would like to turn to the third incorrect assertion about the bipartisan tax relief package. That assertion is that the tax relief package was a tax cut only for the wealthiest Americans.

How many times have we heard the statistic that 40 percent of the benefits of the tax cut went to the top 1 percent of taxpayers?

Where did the statistic come from? Did it come from the non-partisan Joint committee on Taxation? The answer is no. The statistic cited by the media and the Democratic Leadership came from the liberal think tank known as the Center on Budget Policy and Priorities. How do they get their numbers? Here's an example. Let us talk about how they distribute the benefits of the death tax. The liberal think tank assumes that the person benefitting from death tax relief is the dead person. Imagine that. Only in Washington, D.C. do they assume you can take the benefit of tax relief with you to the grave.

It takes these kinds of distortions in methodology to get the conclusion the liberal think tank wants. That's why our friends in the Democratic Leadership rely on the Center for Budget Policy and Priorities. Unfortunately, some in the media accept these statistics at face value.

Once again, facts can be ugly things for harsh critics of the bipartisan tax relief package. According to the Joint Committee on Taxation, Congress' official non-partisan scorekeeper, the tax code is more progressive with the tax relief package. Let me repeat that fact. Joint Tax, not a liberal or conservative think tank, says the bipartisan tax relief package made the Tax Code more progressive.

I ask unanimous consent to place in the RECORD a distribution analysis, prepared by Joint Tax.

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

DISTRIBUTIONAL EFFECTS OF THE CONFERENCE AGREEMENT FOR H.R. 1836[1]

Income category[2]	Change in Federal taxes[3]		Federal taxes[3] under present law		Federal taxes[3] under proposal		Effective tax rate[4]	
	Millions	Percent	Billions	Percent	Billions	Percent	Present law (percent)	Proposal (percent)
CALENDAR YEAR 2001								
Less than $10,000	−$75	−1.0	$7	0.4	$7	0.4	8.7	8.6
10,000 to 20,000	−2,989	−11.5	26	1.5	23	1.4	7.5	6.7
20,000 to 30,000	−5,790	−9.4	62	3.5	56	3.3	13.4	12.2
30,000 to 40,000	−5,674	−6.4	89	5.1	83	4.9	16.1	15.1
40,000 to 50,000	−5,490	−5.4	102	5.9	97	5.7	17.4	16.4
50,000 to 75,000	−11,546	−4.5	256	14.6	244	14.4	19.1	18.3
75,000 to 100,000	−8,488	−3.5	244	13.9	235	13.9	21.7	21.0
100,000 to 200,000	−10,488	−2.6	408	23.3	397	23.5	24.2	23.6
200,000 and over	−6,997	−1.3	555	31.7	548	32.4	27.8	27.4
Total, All Taxpayers	−57,536	−3.3	1,748	100.0	1,690	100.0	21.4	20.7
CALENDAR YEAR 2002								
Less than $10,000	−75	−1.0	7	0.4	7	0.4	9.2	9.1
10,000 to 20,000	−3,596	−13.3	27	1.5	23	1.3	7.6	6.6
20,000 to 30,000	−7,124	−11.3	63	3.4	56	3.2	13.5	12.0
30,000 to 40,000	−6,849	−7.6	91	4.9	84	4.8	16.1	14.8
40,000 to 50,000	−6,198	−5.8	106	5.8	100	5.7	17.5	16.5
50,000 to 75,000	−13,251	−5.0	267	14.5	254	14.4	19.0	18.0
75,000 to 100,000	−10,227	−4.0	255	13.9	245	13.9	21.7	20.8
100,000 to 200,000	−14,416	−3.3	442	24.1	427	24.3	24.2	23.4
200,000 and over	−16,557	−2.9	578	31.5	562	32.0	27.9	27.1
Total, All Taxpayers	−78,294	−4.3	1,836	100.0	1,758	100.0	21.5	20.6
CALENDAR YEAR 2003								
Less than $10,000	−83	−1.1	8	0.4	8	0.4	9.7	9.6
10,000 to 20,000	−3,516	−12.9	27	1.4	24	1.3	7.6	6.6
20,000 to 30,000	−7,135	−11.0	65	3.3	58	3.1	13.6	12.1
30,000 to 40,000	−6,946	−7.5	93	4.8	86	4.6	16.0	14.8
40,000 to 50,000	−6,155	−5.7	108	5.6	101	5.5	17.4	16.4
50,000 to 75,000	−13,554	−4.9	279	14.4	266	14.3	18.9	18.0
75,000 to 100,000	−10,553	−4.0	265	13.7	255	13.8	21.7	20.8
100,000 to 200,000	−15,487	−3.2	479	24.8	464	25.1	24.2	23.4
200,000 and over	−17,453	−2.9	609	31.5	591	31.9	28.1	27.3
Total, All Taxpayers	−80,882	−4.2	1,933	100.0	1,852	100.0	21.5	20.6
CALENDAR YEAR 2004								
Less than $10,000	−69	−0.9	8	0.4	8	0.4	10.0	9.9
10,000 to 20,000	−3,429	−12.6	27	1.3	24	1.2	7.6	6.6
20,000 to 30,000	−7,121	−10.8	66	3.3	59	3.1	13.6	12.2
30,000 to 40,000	−6,964	−7.3	96	4.7	89	4.6	16.0	14.8
40,000 to 50,000	−6,320	−5.8	110	5.4	103	5.3	17.4	16.4
50,000 to 75,000	−15,049	−5.2	288	14.2	273	14.2	18.7	17.8
75,000 to 100,000	−12,913	−4.6	279	13.8	266	13.8	21.5	20.5
100,000 to 200,000	−22,095	−4.3	512	25.2	490	25.3	24.1	23.0
200,000 and over	−21,671	−3.4	642	31.6	620	32.1	28.2	27.3
Total, All Taxpayers	−95,630	−4.7	2,028	100.0	1,932	100.0	21.6	20.6
CALENDAR YEAR 2005								
Less than $10,000	−76	−1.0	8	0.4	8	0.4	10.1	10.0
10,000 to 20,000	−3,867	−14.0	28	1.3	24	1.2	7.6	6.5
20,000 to 30,000	−7,937	−11.6	68	3.2	60	3.0	13.7	12.1
30,000 to 40,000	−7,720	−7.9	98	4.6	90	4.4	16.0	14.7
40,000 to 50,000	−6,945	−6.2	112	5.3	105	5.2	17.2	16.2
50,000 to 75,000	−16,630	−5.5	303	14.2	286	14.1	18.7	17.6
75,000 to 100,000	−14,709	−5.1	287	13.5	273	13.5	21.4	20.3
100,000 to 200,000	−24,654	−4.5	547	25.7	522	25.8	24.0	22.9
200,000 and over	−21,182	−3.1	678	31.9	657	32.4	28.3	27.4
Total, All Taxpayers	−103,720	−4.9	2,129	100.0	2,025	100.0	21.6	20.6
CALENDAR YEAR 2006								
Less than $10,000	−76	−0.9	8	0.4	8	0.4	10.4	10.3
10,000 to 20,000	−3,789	−13.6	28	1.2	24	1.1	7.6	6.6
20,000 to 30,000	−7,853	−11.4	69	3.1	61	2.9	13.7	12.2
30,000 to 40,000	−7,839	−7.9	99	4.4	91	4.4	16.0	14.7
40,000 to 50,000	−7,570	−6.5	116	5.2	108	5.2	17.2	16.0
50,000 to 75,000	−18,755	−6.0	313	14.0	294	14.0	18.6	17.5
75,000 to 100,000	−17,212	−5.8	297	13.3	280	13.3	21.3	20.0
100,000 to 200,000	−30,208	−5.1	588	26.3	558	26.6	23.9	22.7
200,000 and over	−44,177	−6.1	719	32.1	675	32.1	28.3	26.6
Total, All Taxpayers	−137,476	−6.1	2,238	100.0	2,100	100.0	21.7	20.3

[1] Includes provisions affecting the child credit, individual marginal rates, a 10% bracket, limitation of itemized deductions, the personal exemption phaseout, the standard deduction, 15% bracket and EIC for married couples, deductible IRAs, and the AMT.

[2] The income concept used to place tax returns into income categories is adjusted gross income (AGI) plus: [1] tax-exempt interest, [2] employer contributions for health plans and life insurance, [3] employer share of FICA tax, [4] worker's compensation, [5] nontaxable Social Security benefits, [6] insurance value of Medicare benefits, [7] alternative minimum tax preference items, and [8] excluded income of U.S. citizens living abroad. Categories are measured at 2001 levels.

[3] Federal taxes are equal to individual income tax (including the outlay portion of the EIC), employment tax (attributed to employees), and excise taxes (attributed to consumers). Corporate income tax and estate and gift taxes are not included due to uncertainty concerning the incidence of these taxes. Individuals who are dependents of other taxpayers and taxpayers with negative income are excluded from the analysis. Does not include indirect effects.

[4] The effective tax rate is equal to Federal taxes described in footnote (3) divided by: income described in footnote (2) plus additional income attributable to the proposal.

Source: Joint Committee on Taxation. Detail may not add to total due to rounding.

TAX CODE BECAME MORE PROGRESSIVE—1979–2000

[In percent]

Income category	1979	2000	Change
$0–$10,000	0.6	0.4	−0.2
$10,000–$20,000	2.3	1.5	−0.8
$20,000–$30,000	5.4	3.6	−1.8
$30,000–$40,000	7.8	5.1	−2.7
$40,000–$50,000	10.2	6.4	−3.8
$50,000–$75,000	24.6	16.8	−7.8
$75,000–$100,000	14.8	13.0	−1.8
$100,000–$150,000	12.5	14.4	−1.9
$150,000–$200,000	5.1	6.9	−1.8
$200,000–Over	16.7	32.0	−15.3
Total	100	100	

Source: CBO, October 2001, Table H–1b.

BIPARTISAN TAX RELIEF MADE TAX CODE MORE PROGRESSIVE—2001

[In percent]

Income category	2006 w/o tax cut	2006 w/ tax cut	Change
$0–$10,000	0.4	0.4	0.0
$10,000–$20,000	1.2	1.1	−0.1
$20,000–$30,000	3.1	2.9	−0.2
$30,000–$40,000	4.4	4.4	0.0
$40,000–$50,000	5.2	5.2	0.0

BIPARTISAN TAX RELIEF MADE TAX CODE MORE PROGRESSIVE—2001—Continued

[In percent]

Income category	2006 w/o tax cut	2006 w/ tax cut	Change
$50,000–$75,000	14.0	14.0	0.0
$75,000–$100,000	13.3	13.3	0.0
$100,000–$200,000	26.3	26.6	0.3
$200,000–Over	32.1	32.1	0.0
Total	100	100	

Source: JCT, May 2001, JCX 52–01.

Mr. GRASSLEY. Madam President, some might ask how does Joint Tax conclude that the bipartisan tax relief made the tax code more progressive.

The answer is that the bipartisan tax relief returns to taxpayers, on a progressive basis, a small portion of the record level of Federal taxes.

Take a look at this chart. It shows that the largest tax cut went to taxpayers in the lower and middle income brackets. For instance, taxpayers with incomes between $10,000 and $20,000, will see their taxes reduced by almost 14 percent when the tax cut is fully in effect. Taxpayers with over $200,000 will see their taxes reduced by barely 6 percent.

The Democratic Leadership and many in the media, will focus, not on the burden taxpayers bear, but on the benefits of the tax cut. In other words, they will try to ignore the progressive nature of our current system and use isolated examples. For instance, they will say that a taxpayer at $50,000 of income gets more of a tax cut than a taxpayer at $10,000 of income. In fact, a taxpayer at $50,000 of income, pays considerably more tax than a taxpayer at $10,000 of income. Comparing two different taxpayers' tax relief benefits without looking at the burden is comparing apples to oranges.

Let us compare apples to apples. That is, the burden born by groups of taxpayers before and after the tax relief bill.

What I showed you before was the change in the tax burden for different categories of taxpayers. This chart allows you to see how progressive the current system is and how the tax relief bill made the tax system even more progressive. Keep in mind that this table includes all taxes. That's income taxes, payroll taxes, excise taxes, and corporate income taxes.

Let us compare the same two groups I talked about before. Taxpayers with incomes between $10,000 and $20,000 bore 1.2 percent of the Federal tax burden before the tax relief bill and 1.1 percent after the tax relief bill. Taxpayers with over $200,000 maintained their burden, 32.1 percent, before and after the tax relief bill.

You can see the bipartisan tax relief bill lightened everyone's Federal tax burden but did it in a progressive way.

What the tax relief bill aimed to do was send back to the American people a portion of the record-high levels of taxation. But the bipartisan tax relief bill sent the money back in a progressive manner.

Let us take a look at where we were early last year. You'll see the Federal Government was taking in record-high levels of individual income taxes. For instance in 2000, Federal taxes were taking 20.5% of GDP and individual income taxes were taking 10.2 percent of GDP.

According to CBO, those upward record-high level trends were going to continue throughout this decade. In fact, even when fully in effect, the bipartisan tax relief bill leaves both Federal and individual income taxes at near record levels.

Chairman Greenspan gave us a green light to provide broad-based tax relief because he foresaw a long-term economic problem. The record level of taxation, if left on track, would have been a drag on economic growth.

As a matter of fact, there is substantial agreement that the tax cut came at just the right time. The rebate checks and other relief arrived just as the recession started to hit home. According to the Department of Commerce, the tax relief boosted personal incomes by the highest amount in almost 10 years.

You can now see that those three widespread incorrect assertions about the bipartisan tax relief package have been countered. One, the tax relief package was bipartisan; not partisan as its critics claim. Two, the tax relief package did not cause either the short-term or long-term budget problems we face. Three, the tax relief package provides broad-based relief in a progressive fashion.

I would like to turn to the final part of my discussion. This is the most important part because it describes what the tax relief package means to typical taxpayers.

We took as a starting point President Bush's efforts to provide income tax relief to all Americans. This legislation includes the four main elements of President Bush's goals of providing tax relief to working families.

These goals are to: No. 1, provide tax relief for working families through reducing marginal rates; No. 2, reduce the marriage penalty; No. 3, expand the child tax credit; and No. 4, eliminate death taxes. Let's look at each one.

First, this legislation reduced marginal rates at all levels and creates the new 10 percent level proposed by the President. We also began to address the hidden marginal rate increases such as PEPS and PEASE that complicate the Code.

The 10 percent bracket means a tax cut for every American taxpayer. It was the source for the rebate checks that every taxpayer received last year. That's $600 for every family and $300 for every single person.

America is a society of opportunity. Over 60 percent of all families will at one time or another be in the top fifth of income in this country. A man will make more at 55, after 30 years of hard work, than he did at 25. A family should not face a crushing marginal rate tax burden when they finally get a good paycheck for a few years as a reward for years of hard work.

For those that have worked hard over the years, there is some marginal tax rate relief. Here, I am referring to small business. Small business generates 80 percent of the new jobs in this country. Small business owners receive 80 percent of the benefits of the marginal rate reductions. When fully phased in, the marginal rate paid by a successful small business will be the same as that paid by General Motors. I don't know how Senators can argue that 35 percent is an appropriate top rate for General Motors, but too low for Joe's Garage.

While I am on the topic of marginal rate relief one political development continues to surprise me. Those on the other side most opposed to the marginal rate relief come from the higher income states, the so-called high-tax or ''blue states'' that tend to be on each coast and around the Western Great Lakes. Taypayers in those states, in particular, bear the brunt of higher marginal rates.

It continues to surprise me that Senators from those high-tax paying states attempt to obstruct tax relief that is most meaningful to their constituents.

Federal taxes squeeze harder in those states where incomes are higher and the cost of living is higher. To this day, I do not understand the virgourous opposition these members have to relieving the high tax burden their constituents face. Instead, members from these states tend to focus on those who don't pay income tax. Maybe members from the other side of the aisle and who are from these states seem oblivious to this disproportionately heavy tax burden. Or maybe they think Federal taxes should be higher. Maybe it's liberal guilt. I cannot figure it out. One has to wonder what the folks in those states who work hard and pay high taxes would think if they took a look at these charts. One has to wonder what they'd think about higher taxes those on the other side seem to yearn for.

The first part of the package provides progressive income tax relief to every American that pays income tax. Let's move on to the second part.

The second part provides income tax relief for married families—for families where both spouses work and where only one spouse works. In addition, thanks to the advocacy of Senator JEFFORDS, we expanded the Earned Income Credit for married families with children. Further, there was wide bipartisan agreement to simplify the Earned Income Credit which will mean that hundreds of thousands of more children will receive the EIC benefits.

This package contains the first marriage penalty relief in 33 years. Let me repeat that. For the first time in 33 years, we're delivering marriage penalty relief.

Third, the President's desire to expand the child credit to $1000 was met

in the bipartisan tax relief package. And in response to the concerns of Senators SNOWE, LINCOLN, BREAUX, and JEFFORDS the child credit was expanded to help millions of children whose working parents do not pay income tax.

Let's take a look at an example. For a single mother with two children at $16,000 of income, this tax relief package means $600 more in her pocket for this year. That's an increase of almost 4 percent in this single mother's budget. I'm sure she can use the money.

The fourth part of the package dealt with the death tax. The death tax is reduced and finally eliminated—as called for by President Bush. We were successful in this effort due to the work of many Senators but I would particularly note the efforts of Senators KYL, PHIL GRAMM, and LINCOLN.

Thus, this legislation contained the four main elements of President Bush's efforts to provide tax relief for working families—marginal rate reduction, relief for married families, the expansion of the child credit and the reduction and ultimate elimination of the death tax.

I would remind my colleagues again that the hallmark of this legislation is that relief for low income families comes first. The marginal rate drop to 10 percent was immediate, the child credit expansion to low income families was immediate, the expansion of EIC was immediate.

The greater progressivity of the tax relief legislation is certainly due in no small part to the work of Senator BAUCUS.

Everyone knows Senator BAUCUS and other Democrats who crafted this package took a lot of heat from the liberal core of the Democratic Caucus. His objective, like mine, was a bipartisan tax relief package. It seems that while many are happy to talk about bipartisanship they can't stand to see bipartisanship practiced.

In addition to President Bush's proposals to provide tax relief to working families, the tax relief package included legislation that had been considered by the Finance Committee previously.

I believe that not all good ideas come from just one end of Pennsylvania Avenue. Thus, we included the Grassley/Baucus pension reform legislation which probably would not have made it in the bill without the longtime support of Senators HATCH and JEFFORDS.

That package means $50 billion in tax benefits for enhanced retirement security. That figure will be compounded many times over in retirement assets. A lot of folks like to play political football with retirement security issues. The bipartisan tax relief package actually moved the ball forward on retirement security.

Let's take a look at an example. Under the tax relief legislation, workers will be able to raise their IRA contributions to $5,000 annually. Workers will also be able to put away up to $15,000 annually in their 401(k) accounts.

In addition, the legislation contained over $30 billion in tax benefits targeted for education. Elements of this package included language to expand the prepaid tuition programs to help families pay for college—long advocated by Senators COLLINS, MCCONNELL, and SESSIONS. In addition, the package provided a college tuition deduction thanks to Senators TORRICELLI, SNOWE, and JEFFORDS, private activity bonds for school construction in response to Senator GRAHAM's concerns, as well as an expansion of the education savings accounts—in honor of Senator Coverdell—thanks to the work of Senator TORRICELLI and Senator LOTT.

Let's take a look at an example. Under this legislation, a young couple can contribute $2,000 per year per child to an education IRA. The account enjoys inside buildup tax-free and is available to pay tuition and other college costs.

None of us should forget the great winners of this legislation—the American taxpayer. We provided the American taxpayer the greatest amount of tax relief in a generation. And they deserve it.

With the bipartisan tax relief legislation in place, all taypaying Americans have a little bit more of their money in their pockets. Struggling families will have more money to make ends meet; parents and students will be able to more easily afford the costs of a college education; a successful business woman will be able to expand her business and hire more people; a father finally getting a good paycheck after years of work will be able to better provide for his aging mother; and, a farmer can pass on the family farm without his children having to sell half the land to pay estate taxes.

As an illustration of the breadth of this relief, I ask unanimous consent to have printed in the RECORD a State-by-State analysis of the per taxpayer benefits, prepared by the Tax Foundation.

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

BUSH 2001 TAX REDUCTION BY STATE FY 2001–2002

	Total (Dollars in millions)	Per capita	Per household
Alabama	$1,151	$257	$663
Alaska	233	363	939
Arizona	1,689	320	826
Arkansas	603	224	578
California	15,539	451	1,165
Colorado	2,044	463	1,196
Connecticut	2,558	750	1,938
Delaware	309	388	1,003
Florida	6,532	400	1,032
Georgia	2,928	350	903
Hawaii	336	272	703
Idaho	330	247	638
Illinois	5,789	465	1,201
Indiana	2,003	327	845
Iowa	852	291	752
Kansas	899	333	859
Kentucky	1,033	254	656
Louisiana	1,112	249	642
Maine	337	263	678
Maryland	2,354	438	1,130
Massachusetts	3,611	567	1,465
Michigan	3,860	388	1,001
Minnesota	2,045	411	1,063
Mississippi	584	204	527
Missouri	1,785	317	818
Montana	209	228	589
Nebraska	547	318	823
Nevada	913	436	1,127
New Hampshire	615	488	1,261
New Jersey	4,953	585	1,511
New Mexico	420	227	586
New York	9,392	496	1,283
North Carolina	2,534	310	800
North Dakota	159	248	641
Ohio	3,788	333	860
Oklahoma	819	236	611
Oregon	1,123	322	833
Pennsylvania	4,566	372	960
Rhode Island	363	344	890
South Carolina	1,081	267	689
South Dakota	228	299	772
Tennessee	1,820	316	816

BUSH 2001 TAX REDUCTION BY STATE FY 2001–2002—Continued

	Total (Dollars in millions)	Per capita	Per household
Texas	7,719	362	936
Utah	595	260	673
Vermont	197	320	828
Virginia	3,069	426	1,102
Washington	3,169	527	1,362
West Virginia	363	201	518
Wisconsin	1,888	349	902
Wyoming	207	411	1,061
District of Columbia	317	559	1,445
Total	111,571	392	1,013

Notes. Includes provisions that only affect individual income tax liabilities.

Source. Tax Foundation.

Mr. GRASSLEY. Madam President, this chart illustrates the benefits of the income tax rate reductions State by State. As you can see, all taxpaying families in all States benefit. The examples are endless of the great benefits that we realize when we give tax relief to working families.

While I am pleased about the first anniversary, I won't be satisfied until we make these bipartisan measures permanent.

Let's tell every taxpayer they can count on the 10 percent bracket 10 years from now. Let's tell the small business owner that, after 10 years of hard work, they won't face a tax rate of 39.6 percent. Let's tell the single mother with two children that her taxes won't rise by $1,200. Let's tell the newlyweds that 10 years from now they don't have to face a marriage penalty. Let's tell family farmers they won't face the death tax 10 years from now. Let's tell workers saving for retirement that they can put away $5,000 in their IRA 10 years from now. Let's tell a young couple that 10 years from now they will continue to be able to save $2,000 each year per child for college savings.

I would like to sum up. In historical context, the tax relief package provides a modest refund to all taxpayers at a level previously supported by the Democratic leadership. Over time, the Democratic leadership's notion of what the top rate of tax should be has moved up.

Three assertions about the tax relief package, repeated almost daily by its critics, are incorrect. I will correct them once again. The tax relief package is bipartisan. The tax relief package did not cause our current or long-term budget problems. The tax relief package is progressive.

Finally, and most importantly, the tax relief package provides important resources for families, small businesses, retirement security, and education. These resources are valuable and should be available to the American people on a permanent basis.

The PRESIDING OFFICER. The Senator has used his 20 minutes.

Mr. GRASSLEY. I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

ORDER OF PROCEDURE

Mr. BREAUX. Madam President, a parliamentary inquiry with regard to the time situation: Is it allocated to morning business or where am I?

The PRESIDING OFFICER. Under the previous order, the time until 11:45 is controlled by the Republican leadership.

Mr. BREAUX. Madam President, I ask then if the acting Republican leader will yield me some time.

Mr. GRASSLEY. I yield the floor.

The PRESIDING OFFICER. The Senator from Maine.

Mr. GRASSLEY. How much time is the Senator going to use?

Ms. SNOWE. Madam President, I will use 15 minutes, but I am happy to defer to the Senator from Louisiana to precede me if I may and ask unanimous consent, of course, to do so, and then I will take my 15 minutes.

The PRESIDING OFFICER. There are only 12 minutes remaining under the previous order.

Ms. SNOWE. May I ask unanimous consent to extend that by 3 minutes to 15 minutes and 5 minutes.

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

Mr. BREAUX. Parliamentary inquiry: If I understand that, it is extended by 5 minutes, that will be until 10 to noon. Let me have 5 minutes now.

Ms. SNOWE. I am glad to yield 5 minutes.

The PRESIDING OFFICER. The Senator from Louisiana.

MEDICARE

Mr. BREAUX. Madam President, today is a very important day because it is the 37th anniversary of the passing of the Medicare legislation providing universal coverage of health care for all seniors. Everybody got it. No matter what your income was, there was no gap. Those with low income got Medicare, hospital, and doctor coverage. If you were of moderate income, you got it. If you were upper income, you got it. It was a concept 37 years ago that Medicare should be a universal health care plan for all seniors.

Today, we are at some point going to be debating a fundamental change in Medicare by saying that only a portion of seniors are going to get real prescription drug coverage—not all seniors, but we are going to means test it. According to the piece of paper provided by the supporters of that approach, individuals below 200 percent of poverty—which is $13,300 for an individual—are going to have a Cadillac-type of coverage plan. But if you make $13,301, tough luck. You are going to have to pay 95 percent of your drug coverage if you are not below 200 percent of poverty until you reach a figure of about $3,300 worth of out-of-pocket drug expenses, and then the Government will make up 90 percent.

It is really interesting to see whom are we talking about covering. It is also important to think about whom we are not covering under this scaled-down version.

The average number of people in the United States below 200 percent of poverty is 30 percent. That means 70 percent of the American elderly would not qualify by being under 200 percent of poverty. These are working people who have paid taxes when they were working, who are retired, and now, because they don't qualify as being 200 percent under poverty, all of a sudden we are going to leave them out of a Medicare Program that was supposed to provide universal health coverage for all Americans. This is a fundamental break with what Medicare was all about, which was a universal plan for all seniors, not just for seniors making under 200 percent of poverty.

Seventy percent of America's elderly would not qualify for the 200 percent poverty standard. That is not what we signed into law 37 years ago and celebrate today, the advent of a Medicare Program that was universal coverage for all citizens.

I understand why we are attempting to do that. That is because we are trying to spend less money. The tripartisan plan said we could spend $370 billion and reform Medicare by giving seniors new options and also provide a universal prescription drug plan that covered all seniors, not just those under 200 percent of poverty.

If I were a senior who had an income of $13,301, according to their chart, I would be very unhappy with what the Senate is considering now. Seventy percent of America's seniors would not qualify under 200 percent of poverty. We can do better than that. We can do far better than that. We can do more for less, if we do it correctly and we do it in the proper fashion.

We had a plan under the tripartisan plan that was a comprehensive plan. It was a $24-a-month premium for seniors who have to meet a $250 deductible, and

then, after that, it was universal coverage for all seniors. They paid 50 percent coinsurance, but everybody participated. Every senior was treated equally, not just spending a substantial amount of money for a selective number of people.

Medicare is not an antipoverty program; Medicaid is. Medicare is universal coverage. It is not just saying to 70 percent of our seniors, you are not going to get any real help. Some will say we are helping those over 200 percent of poverty. You are not helping them very much when you tell them they have to pay 95 percent of the cost of their prescription drugs. Ninety-five percent, what kind of coverage is that? We are going to say: We will help you with 5 percent, but 95 percent is going to have to come out of their pocket after 200 percent of poverty. That doesn't seem to be a very good deal to me.

Then you say: When you get $3,300 worth of out-of-pocket drug costs, the Government will help you again. It is not really the best we can do. We can do far better than that. I think we ought to.

I don't know why we are actually voting. No. 1, everybody should realize the bill did not come out of the Finance Committee, where all of this type of work should have been done, where all the compromises should have been accomplished, instead of trying to go to the floor and having one bill one day without 60 votes, another bill without 60 votes, and yet today another bill that does not have 60 votes.

We are putting people on the spot unnecessarily. I suggest we put this off and begin the real work that is possible and get something that works.

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

The Senator from Maine is recognized.

Ms. SNOWE. Madam President, I ask unanimous consent to add 3 additional minutes to my 12.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Ms. SNOWE. I would be glad to yield further to my colleague from Louisiana.

Mr. BREAUX. No, thank you.

THE TRIPARTISAN PRESCRIPTION DRUG PLAN

Ms. SNOWE. Madam President, I rise today to discuss the issue of prescription drugs and how we intend to proceed on the Senate floor. I concur with my colleague from Louisiana, with whom I have had the privilege to work in crafting a tripartisan plan for more than a year, in hopes of avoiding a political showdown and confrontation on this most significant issue facing seniors in this country.

I, too, agree with my colleague from Louisiana, in the hope that we can avoid having another vote on two competing plans that will not get the necessary 60 votes to proceed. I hope we can avoid a collision at the crossroads on this most significant domestic issue facing our Nation's seniors.

We have been negotiating all weekend to try to work out an agreement. Senator GRASSLEY is here in the Chamber, the ranking member of the Finance Committee. He has been working consistently and diligently to try to negotiate an agreement. Now we are faced with a political showdown; we are faced with a decision to either vote for the lowest common denominator or for no prescription drug coverage at all.

I do not believe in letting the perfect become the enemy of the good, but we certainly should not countenance the political becoming the enemy of the practical, the attainable, and the doable. We should not find ourselves in this situation today because we have been working for more than a year and a half in developing a plan to avoid having politics undermine that process.

That is why we reached across the political aisle, Republicans to Democrats and Independents, and vice versa, so that we can begin to sort out our ideas. That is not to say we had all the right ideas, but we did it to begin that process that should have begun in the Finance Committee—to debate, to amend, to work through competing ideas in order to achieve a consensus that would give impetus to the passage of this legislation. We should have had that markup. We have been saying that for weeks. In fact, we anticipated we would have a markup on that critical legislation. But we were denied that opportunity for unknown reasons. So now we are hearing we are going to have a vote regardless—the all-or-nothing proposition that seems to overtake and mire the political process to the point that it really jams the monkey wrenches into this institution.

I hope we will avoid having another vote for the sake of having a vote, drawing lines in the sand so people's positions become more intractable. I hope we can avoid that kind of situation and confrontation. We have been spending more than a week and a half on legislation that is very important to America. Using generics would save the American Government $8 billion. It would also save our Nation's consumers more than $60 billion over 10 years. We have been spending more than 2 weeks on that proposition in the Senate. It has had consideration in the committee of jurisdiction for several days as well.

Compare that to our initiative on prescription drug coverage—no consideration in the Senate Finance Committee, up-or-down votes on the floor of the Senate on a $400 billion program—$400 billion. That is more than the annual spending of the Defense Department. It is more than the newly organized Department of Homeland Security that we will be considering as well.

So now we are being asked to have one vote, as we did last week, on each competing plan on prescription drug coverage—it will presumably cost $400 billion over the next 10 years—with no committee consideration, no up-or-down votes on the Senate floor, no ability to amend—$400 billion. When was the last time we created a domestic program that cost $400 billion, with no consideration in the committee and hardly any consideration on the floor of the Senate? When?

We have spent weeks and weeks in the committees considering the homeland security legislation. We have spent 2 weeks on the floor of the Senate on a bill that will save the Nation's consumers $60 billion over 10 years. And we have heard announced consideration for a domestic program that will cost our Government more than $400 billion. It is really hard to understand why we are in the circumstances that we are in today. That is why I ask that we put off any polarizing votes, so that we can further work to achieve a consensus on the broader plan.

There were criticisms against the tripartisan plan—that it created a donut, it created a gap in coverage between $3,450 and $3,700 under catastrophic.

The legislation being put forward by the Senator from Florida will only provide coverage to seniors at extremely high costs and low incomes, or very low income coverage. More than half of our Nation's seniors will have no coverage at all. Above 200 percent, there will be a cliff because an individual earning $17,721 will get zero coverage until they spend $3,300. A couple with an income of $23,880 will get zero coverage. So until they spend $3,300 in prescription drug coverage costs, they have no coverage whatsoever. Well, I would say that is an enormous gap in coverage.

Our plan is to the contrary. It minimizes that gap in coverage. It is 5%0 coverage above 150 percent, to $3,450; 80 percent will not even reach that benefit limit, and we provide a catastrophic coverage beginning at $3,700. Ninety-nine percent of all seniors will participate in our program, according to the Congressional Budget Office. But under the legislation proposed by the Senator from Florida, more than half of our Medicare beneficiaries will have no coverage at all. They will have no coverage at all. That is creating a huge gap in coverage. It is a huge gap, and I think we can do better.

We have worked with the Senator from Massachusetts on concerns about the delivery mechanism in our legislation. So we have agreed to modify that to provide an absolute, ironclad agreement that there will be a fallback mechanism in the event the insurance risk delivery system fails. So there will be a guarantee, regardless of where you live in America, that you will have a benefit of the standard program that we offer in our legislation.

But we even went further and agreed to increase our program from $370 billion to $400 billion. So we have been flexible. We are willing to work across

party lines to avoid the political showdown by having this up-or-down vote at all costs, not trying to search for a common ground, not having an adequate, thorough debate in the committee and on the floor, and a $400 billion program.

I would like to know, when is the last time the Senate has created a $400 billion social program that has had no consideration in the Senate Finance Committee, or any committee of the Senate, and has had virtually no consideration on the floor, no amendments, just an up-our-down vote? If you do not get your 60, tough luck: Is that what the Senate is all about, Madam President? Is that what it is all about? It is winning at all costs?

Who is going to pay for those costs? Our Nation's seniors. Our Nation's seniors are going to pay the cost—that is what this is all about—and they are going to pay a high cost because so many will either have minimal coverage or no coverage at all. This is how many people, when one looks at this chart, will be omitted from coverage in the plan offered by the Senator from Florida: 26 million Medicare beneficiaries.

I know we can do better. We worked for more than a year to create a plan that included Democrats, included our Independent, Senator JEFFORDS from Vermont, so that we could avoid this kind of impasse.

I would hope that we would avoid this unnecessary political showdown today or tomorrow. I hope we can put aside our differences and forge solutions to the problems that our Nation's seniors face when it comes to catastrophic costs for our Nation's seniors who have a chronic illness.

In fact, there was an op-ed piece in the New York Times yesterday which indicated that most people face costs of $1,200 to $1,500. They are the chronically ill. Guess what. Under the plan offered by the Senator from Florida, many of those individuals will not get any coverage until they spend $3,300. They will get no coverage whatsoever.

Won't they be surprised when we pass a so-called prescription drug benefit coverage that says the Nation's seniors are now covered and when they find out, no, not exactly. You will pay an annual fee of $25 and then discover you do not have any coverage because, if you earn $17,721 as an individual, you get zero coverage until you spend $3,300. If you are a couple and earn $23,881 in income, then you have to spend $3,300 in prescription drugs before you get any coverage. That is a huge gap in coverage.

Last week, in the two votes we did have on the two competing plans, there was a common thread. That common thread was continuing to embrace universal coverage in the Medicare Program, which is a principle that most of us—97 percent, 97 votes—supported continuing in the Medicare Program. If we take the approach of low income and catastrophic coverage solely as the kind of benefit we decide to enact in the Senate, we are abandoning the principle of universal coverage in the Medicare Program.

I hope we do not plan to move in that direction. That clearly will be the wrong approach. It will be the wrong approach for Medicare and certainly will be the wrong approach for our Nation's seniors. We can do better, and I hope we will do better. We have the ability to do better.

I urge my colleagues to reconsider and I urge the leadership to avoid any votes so we can continue to work on this issue, if it takes August and come back in September, if we cannot do it this week. But let's avoid the kind of confrontation that will manifest itself in the vote that is recommended on the one plan alone.

I thank the Chair, and I yield the floor.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is now closed.

GREATER ACCESS TO AFFORDABLE PHARMACEUTICALS ACT OF 2001

The PRESIDING OFFICER. Under the previous order, the Senate will now resume consideration of S. 812, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 812) to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals.

Pending:

Reid (for Dorgan) amendment No. 4299, to permit commercial importation of prescription drugs from Canada.

McConnell amendment No. 4326 (to amendment No. 4299), to provide for health care liability reform.

The PRESIDING OFFICER. The Republican leader.

Mr. LOTT. Madam President, I do wish to speak in behalf of the McConnell amendment. I realize time has expired, but I yield myself time under leader time.

Mr. REID. Will the Senator yield?

Mr. LOTT. Recognizing Members may be interested in what the schedule will be in the next hour and maybe even right after lunch, I will be glad to yield to Senator REID for information.

Mr. REID. Madam President, both leaders are in the Chamber. I ask unanimous consent that whatever time the Republican leader uses for his speech, the remaining time until 5 to 1 be equally divided for Senator KENNEDY and Senator MCCONNELL to speak on the pending amendment.

The PRESIDING OFFICER. Is there objection?

Mr. MCCONNELL. Reserving the right to object, I say to my friend from Nevada, I simply did not hear what he was asking.

Mr. REID. I am sorry. Morning business got a little out of hand this morning. There was too much morning business. We are now on the bill. The Republican leader wishes to speak for 5 or 10 minutes under leader time. I ask unanimous consent that the remaining time be divided equally between Senator MCCONNELL and Senator KENNEDY to speak on the McConnell amendment.

Mr. MCCONNELL. How much time is remaining?

Mr. REID. It will probably be about 50 minutes.

Mr. MCCONNELL. Fifty?

Mr. LOTT. Fifty.

Mr. MCCONNELL. Equally divided.

Mr. REID. Until 5 to 1.

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

Mr. LOTT. Madam President, I thank Senator REID for that clarification so we can get some further time for debate on this important issue and so that Senator MCCONNELL can talk more about the specifics.

I believe in this country we have a medical malpractice crisis. There is a huge problem with frivolous lawsuits being filed and large verdicts being rendered. Let me read some of what is happening in my own State where within a few days the legislature is going to have a special session to try to deal with this crisis because doctors are getting out of obstetrics; they are getting out of the business of delivering babies. And they are getting out because the doctors cannot get medical malpractice insurance coverage. As they lose their coverage they are also leaving the State. We now have huge areas of the State where there are few, if any, doctors available to deliver babies.

In Mississippi we are expected to lose an estimated 400 doctors this year because they are retiring, getting out of practice, or moving to other States, including Louisiana. Why Louisiana? Because in Louisiana they have some caps on punitive damages that help limit the size of the verdicts against doctors.

Madam President, last year, in Bolivar County, there were six doctors providing obstetrical care. Today there are three. In neighboring Sunflower County, all four doctors who delivered babies quit private practice. So there is a large area where the citizens of my state cannot get medical care for pregnant mothers and for delivering babies because their doctors cannot get or cannot afford malpractice insurance.

Some expectant mothers now have to drive 100 miles just to get to a doctor, let alone a regional hospital. In the northern half of the State last year, there were nine practicing neurosurgeons; now there are just three on emergency call. And it does not appear that the situation is going to get any better soon. The North Mississippi Medical Center, a hospital that serves 22 counties and 600,000 people, is finding it impossible to recruit new doctors.

But not only is the next generation of doctors being scared away from the

State by Mississippi's tort friendly medical malpractice environment, soaring insurance premiums, and word of multi-million dollar jury awards, so are the insurance companies themselves. There used to be 14 companies underwriting liability in my State, now there's one willing to write new policies.

And those companies that are staying in Mississippi are being forced to charge exorbitant rates to cover their liability exposure to frivolous lawsuits and large verdicts. For instance, maternity care used to make up about 30 percent of family practitioner Scott Nelson's practice in his hometown of Cleveland, MS. But Nelson got out of the business October 1 when his annual malpractice premium jumped from $30,000 to $105,000.

Had he had continued his practice, Nelson would have had to pay that even more exorbitant premiums in the future, and in these small communities, the amount of money doctors make is not so great that they can afford to pay over $100,000 in medical malpractice insurance year in and year out.

Madam President, the Clarion Ledger in my home state a couple of days ago quoted a report from the National Law Journal which found that of the 50 firms in America that had the largest verdicts from juries, 9 of them are in my State of Mississippi, with one firm getting 5 verdicts totaling $177.5 million, the largest of which was against Janssen Pharmceutica for $100 million. Another firm got $171.27 million, $150 million of which was from a single verdict against AC&S Manufacturing.

I ask unanimous consent that the article I am about to refer to from the Clarion-Ledger on July 28, 2002, be printed in the RECORD.

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

[From the Clarion-Ledger, July 28, 2002]

TOP 50 LAW FIRM LIST SHOWS 9 IN MISSISSIPPI

(By Sid Salter)

Mississippi takes the rap for being last in so many indices of economic and social progress. The list of ''worst firsts'' is endless.

But there is one index in which Mississippi shines like a new penny. That news comes via the pages of The National Law Journal. It's called the ''Litigation 50.''

Seems that nine of the nation's ''winningest'' 50 law firms in 2001 are in Mississippi—a measure based on The Journal's assessment of the gross amount of money awarded by juries during trials concluded between Jan. 1, 2001, and Dec. 31, 2001.

Quoth The Journal: ''A firm's rankings is based on the total amount from all cases tried to a verdict before a jury, but does not include any money obtained through settlements or through bench trials. The ranking also does not take into account any post-trial changes in the judgment.''

MEET THE TOP DOGS

Take a look at Mississippi's players in the ''Litigation 50'':

No. 11, Shannon Law Firm, Hazlehurst, five verdicts totaling $177.5 million, the largest a $100 million verdict against Janssen Pharmceutica Inc.

No. 12, Blackmon and Blackmon, Canton, six verdicts totaling $171.27 million, the largest a $100 million verdict against Janssen Pharmaceutica Inc.

No. 14, Isaac Byrd and Associates, Jackson, seven verdicts totaling $150 million, the largest a $150 million verdict against AC&S Manufacturing Inc.

No. 15, Porter and Malouf, Greenwood, two verdicts totaling $150 million, the largest a $150 million verdict against AC&S Manufacturing Inc.

No. 24, Grenfell, Sledge and Stevens, Jackson, four verdicts totaling $100 million, the largest a $100 million verdict against Janssen Pharmaceutica Inc.

No. 25, Owens Law Firm, Jackson, four verdicts totaling $100 million, the largest a $100 million verdict against Janssen Pharmaceutica Inc.

No. 26, Upshaw, Williams, Biggers, Beckham and Riddick, Greenwood, 26 verdicts totaling $100 million, the largest a $100 million verdict against Janssen Phanaceutica Inc.

No. 29, Langston Sweet & Freese, Jackson, 13 verdicts totaling $94.27 million, the largest a $71.27 million verdict against Washington Mutual Finance Group.

No. 37, former Gov. Bill Allain, one verdict totaling $77.5 million against St. Paul Fire Insurance.

BLACKMON'S OTHER JOB

Certainly, this ranking speaks volumes about every law firm represented in the ''Litigation 50'' ranking and of individual litigators employed by those firms.

But it also once again calls into question whether state Rep. Ed Blackmon—whose law firm was ranked by The Journal as the 12th most successful plaintiffs' law firm in the country in 2001—should be made co-chairman of the Mississippi Legislature's special joint committee studying tort reform.

A legislator who is a pharmacist just spent years in the courts defending a conflict of interest charge simply because his pharmacy accepted Medicaid.

But we're told by the legislative leadership that the state's business and medical community shouldn't worry when one of the nation's top trial lawyers is appointed to oversee proposed tort reforms that could take millions out of his own pockets?

Foxes? Hen houses? Bingo.

Mr. LOTT. The ability to have verdicts reach companies—even when companies are not directly involved in the alleged wrongdoing—through the use of joint and several liability is also causing huge problems in the medical malpractice and other fields. Despite the fact that they often have only tangential relationships to alleged wrongdoers, the plaintiffs' lawyers often include companies in lawsuits simply because they have the deep pockets and the companies all too often end up getting stuck having to pay the lion's share of multi-million dollar verdicts even though they actually did very little wrong.

I often wonder what government officials and responsible citizens in my State think is going to happen over the long term to companies that are faced with this kind of threat from juries in my State? What do they think is going to happen as the verdicts against doctors continue to go up and the insurance premiums to cover medical malpractice insurance costs continue to go up. They are finding out very quickly as many doctors and other medical providers are literally closing up shop and leaving town.

Madam President, this is a very important issue that is affecting health care in America, that is driving up the costs of health care all across America, that is making medical malpractice insurance unaffordable even for doctors, and which is limiting Americans' access to health care. What is the solution?

Senator MCCONNELL has the solution in his amendment. It would put reasonable limits on punitive damages. It would provide for proportional liability so one company with marginal involvement is not held responsible for the entire costs of a verdict handed down by a jury.

There are also limits on attorney's fees. That provision when you think about it is really about the patients, the people who are hurt, and not about the attorneys who get 40, 50, 60 percent of a judgment in many cases.

Senator MCCONNELL's amendment also has collateral source reform, to stop lawyer's double dipping from both their client's insurance companies and the defendants they drag into court.

The amendment also has alternative dispute resolution. Is that not a better way to go, to find a solution without having to go through the expense of trials, litigation and jackpot verdicts. Would it not be much better to first try to get a quick resolution of the matter outside of the courtroom?

Senator MCCONNELL's amendment should be included as part of this debate we are having about health care accessibility and the cost of prescription drugs. I should note that nearly identical language passed the Senate in 1995 by a vote of 53 to 47, but it was later vetoed by President Clinton.

Senator MCCONNELL's amendment is an important one. I understand that Democrats will perhaps move to try to table it, but this is a critical issue in America that has to be addressed. The American Medical Association announced last month that because of astronomical malpractice premium increases, 12 States are in a health care crisis mode, with 30 other States on the brink of crisis.

I ask unanimous consent that a compendium of news accounts about the medical malpractice crisis affecting the Nation, which was written by the Republican Policy Committee and titled ''Overzealous Trial Lawyers Are Denying Medical Care to Expectant Mothers,'' be printed in the RECORD.

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

OVERZEALOUS TRIAL LAWYERS ARE DENYING MEDICAL CARE TO EXPECTANT MOTHERS

THE NEED FOR MEDICAL LIABILITY REFORM

Mothers and children are being denied medical care because physicians' liability premiums are soaring and forcing many to move to more doctor-friendly states, curtail their practices, or close up shop entirely:

''The malpractice crisis has been building for years but culminating last December

when the country's largest medical malpractice issuers, the St. Paul Companies, dropped tens of thousands of physicians. Other issuers have also cut back on clients or jacked up premiums. A major reason is the increasing number of personal injury lawsuits—and high-priced damage awards. Last week, the American Medical Association announced that because of astronomical malpractice increases, 12 states are in a healthcare crisis mode, with 30 others on the brink of crisis.'' [Mary Brophy Marcus, ''Healthcare's 'Perfect Storm,' '' U.S. News & World Report, 7/1/02]

The states identified by the American Medical Association as facing a medical liability crisis are:

Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia.

Recent medial accounts demonstrate how this crisis is denying people medical care—particularly expectant mothers. Without medical liability reform, the situation is likely to get worse.

In the border town of Bisbee, Ariz., hospital administrators recently closed the maternity ward because its family practitioners were seeing insurance rate increases of up to 500 percent, to $88,000 a year. The hospital services 4,000 square miles. Now, hundreds of women must travel at least 60 miles to the closest hospitals, in Sierra Vista or Tucson. Since the ward's closure, four women have delivered babies en route.'' [Michael Freedman, ''The Tort Mess,'' Forbes.com, 5/13/02]

Mississippi

''Mississippi . . . is expected to lose 400 doctors this year . . . Last year Bolivar County in western Mississippi had six doctors providing obstetrical care; today it has three. . . . In neighboring Sunflower County, all four doctors who delivered babies have quit private practice. In the northern half of the state last year there were nine practing neurosurgeons; now there are three on emergency call. There used to be 14 companies underwriting liability in Mississippi; now there's one willing to write new policies.'' [Editorial, ''Lawyers vs. Patients,'' The Wall Street Journal, 5/01/02]

''The North Mississippi Medical Center, a hospital that serves 22 counties and 600,000 people, is now finding it all but impossible to recruit new doctors. They're scared away by the state's tort-friendly medical malpractice environment, soaring insurance premiums and word of the $5 million award. The hospital . . . may have to cut back on emergency services. There is now no neurosurgeon on call one of every four days. If there's a wreck on the highway that bisects town, or on any of the winding roads in northern Mississippi or Alabama, it will take at least one hour for the victim to be transported to the nearest neurosurgeon in Memphis or Jackson. That hour is crucial; it could cost a life.'' [Michael Freedman, ''The Tort Mess,'' Forbes.com, 5/13/01]

''Maternity care used to make up about 30 percent of family practictioner Scott Nelson's practice in his hometown of Cleveland, Miss. But Nelson got of that business Oct. 1, when his annual malpractice premium would have jumped from $30,000 to $105,000 had he continued to deliver babies. ''The malpractice insurance environment has literally forced me out of doing it,'' Nelson says.'' [Rita Rubin, ''You Might Feel a Bit of Pinch,'' USA Today, 12/4/01]

Nevada

''Kimberly Maugaotega of Las Vegas is 13 weeks pregnant and hasn't seen as obstetrician. When she learned she was expecting, the 33-year-old mother of two called the doctor who delivered her second child but was told he wasn't taking any new pregnant patients. Dr. Shelby Wilbourn plans to leave Nevada because of soaring medical-malpractice insurance rates there. Ms. Mavgaotega says she called 28 obstetricians but couldn't find one who would take her.'' [Rachel Zimmerman and Christopher Oster, ''Insurers' Price Wars Contributed to Doctors Facing Soaring Costs,'' The Wall Street Journal, 6/24/02]

''Half of the 93 OB–GYNs who deliver babies in Las Vegas's Clark County are no longer accepting new obstetrical patients.'' [Mary Brophy Marcus, ''Healthcare's 'Perfect Storm,' '' U.S. News & World Report, 7/1/02]

''Twice last month, Las Vegas obstetrician/gynecologist Shelby Wilbourn saw patients who's made an appointment under a false pretense. They said they were having irregular menstrual periods. But when they met Wilbourn face-to-face, they fessed up. The reason they hadn't had a period in a couple of months was because they were pregnant, not because their cycle was out of whack. I had to close the chart and say, 'Ma'am, I can't help you, because I'm not doing OB anymore,' Wilbourn says. 'They just started sobbing in the office.' . . . Last month, Wilbourn announced to tearful patients and office staff that he had accepted an offer in Belfast, a small town on the coast of Maine . . . [T]he decision to close his practice July 31 was not easy. 'I've got a lot of pregnant women I'm not going to be here for,' he says. 'I'm going to be turning them loose halfway through a pregnancy, and I can't find them a doctor.' One of them is Deanna Rood, who is due in October. Wilbourn cared for Rood when she was pregnant with her firstborn, a son who will turn 2 in August. 'I'm in a scary position right no,' Rood says. 'I'm six months pregnant, and I don't have a doctor.' '' [Rita Rubin, ''Fed-Up Obstetricians Look for a Way Out,'' USA Today, 6/30/02]

''[Las Vegas OB–GYN Shelby] Wilbourn accepted a new job in Maine last week. He wonders who will deliver the 500 babies born each week in Las Vegas and if there will be any OBs to take emergency calls like the one he recently answered. The patient was 34 weeks pregnant, in premature labor and hemorrhaging, and her baby's heartbeat was frighteningly low. Wilbourn arrived in minutes, and both mother and child made it successfully through childbirth. 'If this were next year,' he contends, 'that baby would have died.' '' [Mary Brophy Marcus, ''Healthcare's 'Perfect Storm,' '' U.S. News & World Report, 7/1/02]

''John Nowins, president of the Clark County (Las Vegas) OB–GYN Society, says that 80 percent of his members are phasing out obstetrics because of the jump in malpractice insurance premiums. . . . Nowins, a Chicago native, says he's considering moving to Indiana. 'At least they have good tort reform,' he says.'' [Rita Rubin, ''Fed-Up Obstetricians Look for a Way Out,'' USA Today, 6/30/02]

''In March, doctors at Nellis Air Force Base in Las Vegas sent a 34-year-old woman with colon cancer to Joseph Thornton, a highly experienced colon and rectal surgeon in the area. Because of the war in Afghanistan, most of Nellis's specialized surgeons are now deployed, and the remaining military doctors said they couldn't remove the cancer unless they cut out the woman's entire colon, leaving her with a colostomy bag to drag around and empty the rest of her life. They hoped that Thornton's expertise might offer a better outcome. Just one problem. Thornton, at age 56, retired on March 31 because his malpractice insurance company was closing, and he couldn't afford what the other insurers were charging. . . . The woman showed up in Thornton's office just before his retirement, but she needed chemotherapy and radiation first, and the surgery couldn't be performed before Thornton's policy expired. 'It broke my heart,' he said. 'I felt like I was planning my own funeral. . . . My broker got quotes for me and told me I should quit. And he makes a commission on insurance purchases.' '' [Marilyn Werber Serafini, ''Risky Business,'' National Journal, 5/18/02]

''In Nevada, 123 physicians have either closed their practices or are planning to do so soon.'' [Mary Brophy Marcus, ''Healthcare's 'Perfect Storm,' '' U.S. News & World Report, 7/1/02]

''A study by a University of Nevada medical school professor says 42 percent of obstetricians are making plans to move their practices out of southern Nevada. If that happens, only 78 obstetricians would be left in an area that includes Las Vegas, a city of 1.5 million with 23,000 births last year. The same study notes that 76 percent of the city's obstetricians have been sued, and 40 percent have been sued three or more times.'' [Michael Freedman, ''The Tort Mess,'' Forbes.com, 5/13/02]

New Jersey

''Last week the Garden State's largest malpractice insurer, the MIIX Group, announced it has essentially decided to fold up shop. The decision is notable because MIIX isn't just another insurance company out to make a profit. It began as an association of doctors that got into the business of insuring themselves and other doctors. The company has lost more than $200 million in the past 15 months, and its decision means that about 9,000 New Jersey doctors, 37 percent of the state total, may soon lose their insurance. . . . In 2001, three malpractice insurers stopped doing business in the state.'' [Editorial, ''Born to Sue,'' The Wall Street Journal, 5/17/02]

Pennsylvania

''Kelly Biesecker, 35, spent many extra hours on the highway this spring, driving from her home in Villanova, Pa., to Delran, N.J., so she could continue to use her obstetrician. Dr. Richard Krauss says he moved the obstetrics part of his practice from Philadelphia because malpractice rates had skyrocketed in Pennsylvania. Ms. Biesecker, who gave birth to a healthy boy on June 5, says Dr. Krauss was the doctor she trusted to guard her health and the health of her baby: 'You stick with that guy no mater what the distance.' . . . New Jersey hasn't been a panacea, however. His policy there expires July 1, and the carrier refuses to renew it.'' [Rachel Zimmerman and Christopher Oster, ''Insurers' Price Wars Contributed To Doctors Facing Soaring Costs,'' The Wall Street Journal, 6/24/02]

''Lauren Kline, 6½ months pregnant, changed obstetricians when her long-time Philadelphia doctor moved out of state because of rate increases. Now, her new doctor, Robert Friedman, may have to give up delivering babies at his suburban Philadelphia practice. His insurance expires at the end of the month, and he says he is having difficulty finding a carrier that will sell him a policy at any price.'' [Rachel Zimmerman and Christopher Oster, ''Insurers' Price Wars Contributed To Doctors Facing Soaring Costs,'' The Wall Street Journal, 6/24/02]

''High insurance rates are also plaguing hospitals, some of which are closing their riskiest services. Grand View Hospital, located in Sellersville, Pa., between Philadelphia and Allentown, is having trouble securing insurance at any price.'' [Marilyn Werber Serafini, ''Risky Business,'' National Journal, 5/18/02]

''In Philadelphia, the Methodist Hospital Division of Thomas Jefferson University Hospital will cease to deliver babies effective

June 30 . . . More than 90 full- and part-time staff positions at Methodist will disappear.'' [Marilyn Werber Serafini, ''Risky Business,'' National Journal, 5/18/02]

''Dr. John Angstadt, 44, started looking to move out of suburban Philadelphia when his insurance increased from $14,000 in 1994 to $66,000 last November. In December he joined a large practice in Savannah, Ga., where he pays just $16,000 for insurance. Now, instead of worrying about rising costs and lawsuits, he can practice medicine. 'That was missing in Philadelphia,' he says. 'I go up in the morning and the idea of facing another day was onerous.'' [Michael Freedman, ''The Tort Mess,'' Forbes.com, 5/13/02]

Texas

''C. Dale Eubank practices in Texas. . . . 'I have been named in suits, and none of them ever went anywhere,' says Eubank, who has delivered 3,000 babies since 1983. Disgusted with what he calls the 'litigious environment' in Corpus Christi, Eubank this year decided to stop delivering babies.'' [Rita Rubin, ''Fed-Up Obstetricians Look for a Way Out,'' USA Today, 6/30/02]

''Texas used to have 17 [medical liability insurance] carriers; now it has four.'' [Editorial, ''Lawyers vs. Patients,'' The Wall Street Journal, 5/1/02]

Washington

''Jen Fleming of Friday Harbor says she keeps hoping she can persuade Robert and Barbara Pringle, a husband-wife OB–GYN team, to care for her during her next pregnancy. In January 1999, Fleming delivered a stillborn daughter. A few months later, she became pregnant with her son, who is now 2. 'Now they'll have to refer me to someone else' when she gets pregnant, Fleming says. ''It's a shame, because they're the ones who got us through our second pregnancy.' The Pringles, who practice in Mount Vernon, Wash., stopped taking new OB patients a few weeks ago.'' [Rita Rubin, ''Fed-Up Obstetricians Look for a Way Out,'' USA Today, 6/30/02]

West Virginia

''The state of West Virginia, no stranger to problems, has a severe one on its hands now: a 'doctors crisis.' That's what many are calling it, and with good reason. West Virginia is losing doctors every day; communities are going without care; no doctors are coming in—it is almost impossible to recruit. The problem is the legal atmosphere: The state has earned the designation 'Tort Hell,' or, if you are a plaintiff's attorney, 'Tort Heaven.' In probably no other state is it as hard to be a doctor, or to remain one. Doctors are becoming desperate; the public, slowly—and in some areas, not so slowly—is waking up. The need for reform is crying. Of course, this need is felt all across the country; but nowhere is it felt more acutely than in West Virginia.'' [Jay Nordlinger, ''Welcome to 'Tort Hell,''' National Review, 8/20/01]

''Jane Kurucz, a general surgeon who specializes in breast diseases . . . is a typical case, but with an unusual twist: On Sunday afternoon, July 29, a rally was a staged in support of her, in a downtown park. The event was organized by a patient, unhappy at losing her doctor, and, more than unhappy, angry. Dr. Kurcuz has been practicing for 13 years. In that time, she has had one lawsuit against her (amazingly low for West Virginia), now pending. On May 1, she received a letter informing her that her insurance would not be renewed. . . . Jane Kurucz had to close up shop on August 1.'' [Jay Nordlinger, ''Welcome to 'Tort Hell,'' National Review, 8/20/01]

''Huntington is now essentially without breast surgery. It may soon be without neurosurgery. The local neurosurgeons pay over $160,000 a year in insurance, if they manage to qualify for it. And as they leave, a chain reaction occurs: The city's residency program collapses; the medical school is in jeopardy. 'The cascade effect is tremendous,' as Dr. Kurucz says.'' [Jay Nordlinger, ''Welcome to 'Tort Hell,'' National Review, 8/20/01]

''Wheeling, W. Va.'s last emergency-room neurosurgeon recently left the state, which means that people with severed hands and other traumatic injuries must be helicoptered out of state for treatment.'' [Mary Brophy Marcus, ''Healthcare's 'Perfect Storm,'' U.S. News & World Report, 7/1/02]

''In Wheeling, one of West Virginia's largest cities, all of the neurosurgeons have left. Corder says it's common for trauma patients who need a neurosurgeon to be airlifted to Pittsburgh. On one such occasion, he said, a patient was flown to Pittsburgh only to be examined and discharged 15 minutes after being seen. The cost for the helicopter ride was $4,000.'' [Marilyn Werber Serafini, ''Risky Business,'' National Journal, 5/18/02]

''In West Virginia, the sole community hospitals in Putnam and Jackson counties have closed their obstetrics units because obstetricians are facing enormous premium increases and are choosing to leave the area, according to Thomas J. Corder, chairman of the West Virginia Hospital Association and president of Camden-Clark Memorial Hospital in Parkersburg.'' [Marilyn Werber Serafini, ''Risky Business,'' National Journal, 5/18/02]

''West Virginia was good for Joe Prud'homme. The Texas native never expected to put down roots in Beckley, W. Va., where he got a temporary job after touring the world for a year. In the ensuing 6½ years, though, Prud'homme set up his own orthopedic surgery practice and married a local woman with a large extended family nearby. But last week, Prud'homme and his wife, who are expecting their first baby any day, packed up and left the state. If Prud'homme had continued practicing in Beckley, his annual premium would have doubled Nov. 1, to more than $80,000. In Blacksburg, Va., 80 miles to the southeast, he's paying $18,000. . . . Despite the inconvenience, Fran Pemberton, 50, and her mother-in-law, Betty Pemberton, 70, will make the three-hour round trip to see Prud'homme in Blacksburg. 'I have to miss a shift's work every time we go down there.' says Fram Pemberton, a high school cook. Prud'homme performed carpal-tunnel surgery on her wrists. Her mother-in-law needs knee-replacement surgery. 'We have a lot of general practitioners who are pretty good doctors,' Fran Pemberton says. 'But to have a specialist anymore, you have to go somewhere.'' [Rita Rubin, ''You Might Feel a Bit of a Pinch,'' USA Today, 12/4/01]

''Ronn Grandia, M.D., [Bruce Hoak, M.D.], and Michael Hall, M.D., saw no option but to close after liability insurance priced their three-man surgical practice out of existence. 'We just don't have the resources to pay the premium,' Dr. Hall said. . . . After practicing in Ohio for five years, Ronn Grandia, M.D., returned to West Virginia in 1996. . . . But this month he starts to practice across the state line at Holzer Clinic in Gallipolis, Ohio. He'll be able to live in the same house in West Virginia and even treat some of the same patients. But by practicing in Ohio, he can afford his professional liability insurance. . . . Bruce Hoak, M.D., the third physician at Southern Surgical Associates, is headed to his native Texas and also will pay about half the rate he would have paid in West Virginia. . . . With these three general surgeons leaving Charleston, Thomas Memorial Hospital will be left with just four general surgeons. That's down from eight. Another surgeon left earlier, also citing high insurance rates. 'Nobody has been willing to consider it a crisis until thousands of patients started losing their physicians,' Dr. Hall said. 'We are only the first wave.'' [Tanya Albert, ''Soaring Premiums Force Doctors to Close Practice,'' American Medical News, 9/10/01]

''Dr. R. Todd De Pond misses the howling new infants but not the costly insurance protection required for presiding at their births. 'I've decided not to do obstetrics at all,' Dr. De Pond said of his retreat to the gynecology half of his practice in what West Virginia medical officials warn is a statewide crisis in skyrocketing malpractice insurance rates. Scores of doctors are curtailing services by dropping high-risk obstetrical and neurosurgical procedures rather than pay premium increases of 30 percent and more, the State Medical Association says. At the same time, about 100 doctors, one in 20, have in the last two years retired early or moved from West Virginia, one of the costliest areas in the nation for malpractice coverage. . . . 'It has gotten worse every year,' said Dr. De Pond, who used to handle 15 maternity cases a month.'' [Francis X. Clines, ''Insurance-Squeezed Doctors Fold Their Tents,'' The New York Times, 6/13/02]

''Bluefield Regional Center, a major hospital in the state's hardscrabble south, lost 12 doctors in the last two years and has been able to replace only 2.'' [Francis X. Clines, ''Insurance-Squeezed Doctors Fold Their Tents,'' The New York Times, 6/13/02]

AN UNTENABLE SITUATION

How bad has the medical liability environment become? As one article states [Michael Freedman, ''The Tort Mess,'' Forbes.com, 5/13/02]:

''In some parts of the country, doctors say, it is almost better to let a patient die than to attempt heroic surgery, fail and risk a lawsuit.''

If the medical liability system is making doctors think twice about saving lives, that system needs to be reformed.

Mr. LOTT. Madam President, if we do not get some control of these outlandish lawsuits and the verdicts that are being handed down both in the field of medical malpractice and in the broader area of tort reform, the never-ending stream of lawsuits that are being filed in this country is going to continue putting good men and women out of the practice of medicine, good companies out of business, and good men and women out of work.

I yield the floor.

The PRESIDING OFFICER (Mr. JOHNSON). Under the previous order, the time until 12:55 will be equally divided and controlled by the Senator from Massachusetts and the Senator from Kentucky or their designees.

The Senator from Massachusetts.

Mr. KENNEDY. So we have how much time, Mr. President?

The PRESIDING OFFICER. Twenty-six minutes.

Mr. KENNEDY. I yield myself 7 minutes.

Mr. President, we have heard some discussion earlier today about the state of the debate on the prescription drug program. To remind all of our colleagues, that legislation would have been tied up in the Finance Committee for over 5 years. It was only because of the leadership of Senator DASCHLE that

we were able to ensure that we had some debate on the floor of the Senate on a matter of central importance to families all over this country. With the leadership of Senator GRAHAM, Senator MILLER, and others, we have had a good debate.

We had some votes in the Senate on some very important comprehensive measures. There was the vote, which I was proud to support, on Senator GRAHAM's amendment, which received 52 votes. If we had had 8 votes from that side of the aisle, this legislation would be on its way now to a conference and there would be a real possibility of gaining comprehensive coverage. That program provided a $25 premium, no deductible, and limited copays at $10 for generic drugs, $40 for brand name drugs. It also had a catastrophic program. That was the way to go. But it was defeated. No one supported it.

Now, 10 days later, can we make a difference and provide some relief to the seniors in our country? Senator GRAHAM will have the opportunity, after the disposal of this amendment, to make his case, which I intend to support for reasons I will outline during the course of that debate. But none of us should be under any illusion of where the responsibility lies in terms of our failure to get a comprehensive program. We were able to gather the support of virtually every Member on this side of the aisle for a very comprehensive program with low premiums and no deductibles, and a very reasonable copay that had the support of all of the senior groups.

When I listen to those who were opposed to it talk about their alternative, they clearly did not have the support of a single senior group.

Now let us get back to what is at hand, and that is the medical malpractice amendment introduced by my friend from the State of Kentucky.

On Friday, the sponsor of this amendment, Mr. MCCONNELL—which has also been characterized by the Senator from Tennessee—described it as ''pro-victim and pro-consumer.'' He claimed that since his amendment did not contain a cap on non-economic damages, it would not ''adversely affect'' an injured patient's ability to recover compensation for injuries caused by a health care provider. In fact, the McConnell amendment is pro-HMO, pro-drug manufacturer, and pro-insurance company, at the expense of patients.

Make no mistake about it. There is a great deal in this amendment which would deprive serious injured patients of fair compensation. At virtually every stage of the legal process, the amendment systematically rewrites the rules of civil law to tip the balance in favor of defendants. It would arbitrarily shield health care providers and their insurance companies from basic responsibility for the harm they cause.

At a time when the American people are calling for greater corporate accountability, it is unbelievable that our Republican colleagues would bring to the floor an amendment which would do just the opposite. The McConnell amendment would allow the entire health care industry to avoid accountability for the care they provide and that is not acceptable.

While those across the aisle like to talk about doctors, the real beneficiaries will be insurance companies. This amendment would enrich the insurance industry at the expense of the most seriously injured patients; men, women, and children whose entire lives have been devastated by medical neglect and corporate abuse.

This proposal would also shield HMOs that fail to provide needed care, nursing homes that neglect elderly patients, drug companies whose medicine has toxic side effects, and manufacturers of defective medical equipment.

It would drastically limit the financial responsibility of the entire health care industry to compensate injured patients for the harm they have suffered. When will the Republican Party start worrying about injured patients and stop trying to shield big business from the consequences of its wrongdoing? Less accountability will never lead to better health care.

There is no real question about the effect of their amendment. It would, in fact, place major new restrictions on the right of seriously injured patients to recover fair compensation for their injuries. Let's look at what the amendment actually does.

It abolishes joint and several liability for non-economic damages. This means the most seriously injured people may never receive all of the compensation that the court has awarded to them. Under the amendment, health care provides whose misconduct contributed to the patient's injuries will be able to escape responsibility for paying full compensation to that patient. The patient's injuries would not have happened if not for the misconduct of both defendants, so each defendant should be responsible for making sure the victim is fully compensated.

The bias in the McConnell amendment 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 had greater restrictions on patients' rights than the proposed federal law. This one-way preemption shows how result-oriented the amendment really is. It is not about fairness or balance. It is about protecting defendants.

The amendment preempts state statutes of limitation, cutting back the time allowed by many states for a patient to file suit against the health care provider who injured him.

It mandates that providers and insurance companies be permitted to pay a judgment in installments rather than all at once. Allowing health care providers, including HMO's, large drug manufacturers and their insurance companies to pay on the installment plan transfers compensatory dollars that rightfully belong to an injured patient back to the wrongdoer. If the patient does not receive the money for years, he in reality is getting less money than the court concluded that he deserves for his injuries.

The amendment makes it much harder to sue a physician for injuring a baby or its mother during the delivery process if the doctor had not previously treated the mother. It requires a much higher burden of proof, clear and convincing evidence, than is normally provided for in a civil case. There is no reason why a practicing physician should not be held to the normal standard of medical care merely because he had not previously treated the patient. Such a provision is grossly unfair to pregnant women. In essence, their doctors are held to a lower standard of care than all other medical professionals.

The places extremely restrictive limitations on when an injured patient can receive punitive damages, and how much punitive damages the victim can recover. It would cap punitive damages at twice the amount of compensatory damages, no matter how egregious the defendant's conduct and no matter how large its assets. This would destroy the deterrent effect of punitive damages in the very few cases where punitives would still be allowed.

Even more outrageous is the language on page 23 which appears to say that the government would take half of any punitive damages which the injured patient did receive. This amounts to a confiscatory tax on punitive recoveries, which is extremely unfair to the victims. It is the victims who have been harmed by the malevolent conduct. The government should not arbitrarily take half of the jury award.

It imposes unprecedented limits on the amount of the contingent fee which a client and his or her attorney can agree to. This will make it more difficult for injured patients to retain the attorney of their choice in cases that involve complex legal issues. It can have the effect of denying them their day in court. Again the provision is one-sided, because it places no limit on how much the health care provider can spend defending the case.

If we were to enact all of these arbitrary restrictions on the compensation which seriously injured patients can receive, what benefits would result in our health case system? Certainly less accountability for health care providers will never improve the quality of health care. Substandard medical care is a growing problem.

The Agency for Healthcare Research and Quality at HHS found that the number of adverse effects from medical treatment has more than doubled in recent years. These disturbing statistics make clear that we need more accountability in the health care system, not less. In this era of managed care and cost controls, it is ludicrous to suggest

that the major problem facing American health care is ''defensive medicine.'' The problem is not ''too much health care,'' it is ''too little'' quality health care.

In the time remaining, I will cover two or three other points. This chart asks, Do malpractice premiums drive up medical costs? It shows health care and malpractice inflation. Look at health care costs they have gone up 74 percent since 1988; medical malpractice costs, 5.7 percent.

For States without caps on damages, the average cost of medical malpractice insurance is $7,715 for internal medicine; in States with caps on damages, it is $7,887. For general surgery, it is $26,144 for States without and $26,746 for States with caps on damages; for OB/GYN, it is $43,000 for States without caps versus $44,000 for States with caps.

The impact on general health care issues has been considerably less. The fact remains that the number of doctors per 100,000 people in States which do have the caps versus those that do not are virtually identical. The costs of the premiums are exactly the same.

Let's get focused on where the needs are and the beneficiaries and the losers of this amendment. The beneficiaries will be the insurance companies; the losers will be the patients who are going to suffer because of negligence. That is wrong. That proposal should not be accepted.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. MCCONNELL. How much time do I have?

The PRESIDING OFFICER. Twenty-six minutes.

Mr. MCCONNELL. Mr. President, this amendment is related to the crisis of medical malpractice that we have across our country due to the failure to impose accountability and responsibility on big, powerful trial lawyers who are running roughshod over doctors and taking advantage of their clients. That is what this debate is about.

Senator HATCH is here and I yield him 2 minutes. After Senator HATCH, Senator FRIST would like 3 minutes.

Mr. KERRY. Mr. President, just to inquire, are we going to go back and forth? I didn't know the Senator had the right to yield successive periods of time.

The PRESIDING OFFICER. There is no order at this point.

Mr. MCCONNELL. Mr. President, Senator FRIST had to go to a meeting. He is only asking for 3 minutes, and Senator HATCH is only taking 2 minutes.

Mr. KERRY. I understand.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Mr. President, I listened to the impassioned speech of the Senator from Massachusetts. The fact is, there will not be any medical liability insurance companies. One major company has gone out of business because of what amounts to unreasonable litigation all over the country.

It used to be that all you had to do was show that you met the standard of practice in the community and that was enough to alleviate doctors from medical liability. When the doctor of informed consent came into being, then every case from that point went to a jury. The reason is because they could make any claim they wanted, and ingenious lawyers can write the claims so they go to the jury.

We have a crisis in this country. I estimated 15 years ago that at least $300 billion a year was being wasted in unnecessary defensive medicine. If anything, that number has gone up. Mr. President, 50.5 percent of family practitioners in Utah have given up obstetrical services or never practiced obstetrics. Of the remaining 49.5 percent still delivering babies, 32.7 percent plan to stop providing OB/GYN services within the next decade. Most plan to stop within the next 5 years.

The people who are really going to be hurt will be the most vulnerable people in our society, the children.

Frankly, we have to stop letting this medical liability situation go stock wild. It is way out of control. This is an amendment that does make intelligent approaches to trying to resolve the problems.

This is an important issue about which I have spoken on previous occasions. I am pleased to see that on July 25, President Bush announced his desire to address the medical malpractice problem. We welcome his support in this effort.

As many of you will recall, we debated, and passed, the exact provisions that are contained in the McConnell amendment during the Commonsense Product Liability and Legal Reform Act debate back in 1995. Unfortunately, the language was stripped from the bill in conference. I will say many of the same things now that I said back then, because, regrettably, they still apply and need to be said. I am sorely disappointed that in the ensuing seven years we have still not acted to address the fact that medical malpractice costs have spiraled out of control and are forcing many doctors and hospitals out of the profession. The situation has gotten worse, not better. We must act now if we are at all serious about fixing the crisis in healthcare delivery this has caused in many parts of this country.

Make no mistake, we have a healthcare crisis in this country, one that is due in large part to litigation that is out of control. Many may not be aware of just how serious the ramifications of the crisis are.

I will ask unanimous consent to have printed in the RECORD a July 18 Associated Press article, ''Soaring Malpractice Insurance Squeezes out Doctors, Clinics,'' which highlights these problems. The article points to the ''national problem that doctors say is obliging many of them to flee certain states or give up certain specialties—or the entire profession—because of skyrocketing insurance premiums linked to soaring jury awards.''

The article goes on to note that, as I am sure my colleagues from Nevada are acutely aware and Senators MCCONNELL and FRIST already mentioned—the University Medical Center trauma clinic in Las Vegas—the only Level 1 trauma center in Nevada—closed down on July 3 of this year. The 58 doctors who were associated with the trauma center had insisted on much-needed relief from the soaring cost of medical malpractice insurance. Consequently, the day after the center closed, a victim of a serious traffic accident had to be transported to the next nearest emergency room which was an hour away. The trauma center was hurriedly reopened on July 13, but with only 10–15 doctors working on a temporary basis, with limited liability, while the Governor tries to enact legislation limiting awards in medical malpractice cases. We don't know if that trauma center will be forced to close again. Commenting on the trauma center's closure, its Director, Dr. John Fildes, stated that ''the standard of care in our community was set back 25 years.''

No one knows whether the life of that tragic accident victim in Las Vegas could have been saved had he been treated at the nearby hospital. Would any of us want that to happen to our loved ones—traveling an hour to receive emergency care? I certainly wouldn't, and the Senate should take the necessary steps to ensure that it does not happen to anyone else.

The problem of providing necessary healthcare in the face of rising insurance costs and the threat of excessive litigation cuts across multiple specialties, not just emergency services.

Ensuring the availability of adequate obstetric care continues to be a rising problem. According to the same article, one Arizona hospital, a clinic in Oregon, and two Pennsylvania hospitals recently have closed their obstetrics units. Several counties in upstate New York have no obstetricians covering night shifts. There is an increasing shortage in my home state of Utah as well. Studies by both the Utah Medical Association and the Utah Chapter of the American College of Obstetricians and Gynecologists underscore the problem in my state:

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

According to this Utah Medical Association study:

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

Mr. President, ensuring the availability of quality prenatal and delivery

care for the most vulnerable members of our society is imperative for obvious reasons.

The newly-released Department of Health and Human Services report ''Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Cost by Fixing our Medical Liability System'' released by HHS Secretary Tommy Thompson includes a detailed review of recent studies on the consequences of out-of-control medical liability crisis that is threatening healthcare in many parts of America. Even volunteer medical services are threatened. According to the report, ''[m]any doctors cannot volunteer their services for a patient who cannot pay, and the proportion of the physicians who provide charity care at all has declined, because doctors cannot afford the required liability coverage.'' It further details the rising costs of insurance premiums:

Doctors alone had to pay over $6 billion in medical liability premiums last year, and premiums this year in many states have increased by more than 20 percent on average and more than 75 percent for specialties in some states. . .Excessive liability also adds $30 billion to $60 billion annually to Federal government payments for Medicare, Medicaid, the State Children's Health Insurance Program, Veterans' Administration health care, health care for Federal Employees, and other government programs.

The HHS study further details how reasonable medical malpractice reforms in some states have been working to reduce healthcare costs and improve access and quality of care. I urge my colleagues to read this report.

Our entire medical system—which everyone knows is heralded as the best in the world—is based on a total reliance on the abilities of the health care professionals who treat us, professionals who have sacrificed immeasurably to get the requisite training and credentialing. These are professionals who spend long and hard hours in school and at work to make our system the best in the world.

Will there be mistakes? Of course there will be; we are only human. And while we must strive for perfection, that by definition cannot be. My heart goes out to each and every person who has suffered an adverse medical event, whether it was caused by the medical delivery system or not.

I was a trial attorney before I came to Congress. I saw heart-wrenching cases in which mistakes were made. But I also saw heart-wrenching cases in which mistakes were not made and doctors were forced to expend valuable time and resources defending themselves against frivolous lawsuits. I have litigated these cases, both as an attorney for the plaintiff and as an attorney for the defendant.

No one in this body knows better than I—perhaps with the exception of our colleague from Tennessee, Senator FRIST—what the defects are in this system. Mr. President, I wish we could design a system which would protect each and everyone from harm, but that is not possible. Our job is to design the best system we can. But in a country as large and diverse as this one, problems are inevitable. The task before us is to make sure the system minimizes those problems. Thus the question before us is: how to design a system which protects both the patient and the provider? I do not believe that a protracted war between trial attorneys and health care professionals is the way to accomplish that goal.

Why do we need to pass this amendment dealing with medical malpractice liability? Medical liability costs are out of control, as I have already stated. President Bush's Council of Economic Advisers published a paper in April estimating that the U.S. tort system, costing $180 billion, of which medical torts comprise a large part, is the most expensive in the world as a percentage of gross domestic product, equivalent to a three percent tax on wages. Professional liability rates are rising in response to our runaway tort system. And liability costs are having a direct impact on healthcare spending.

It is often the case that doctors feel compelled to run diagnostic tests that are costly and unnecessary, in order to cover themselves—it is defensive medicine. It is wasteful, but unfortunately has become necessary. The only way to stop this is to get some reason into the system.

Senator MCCONNELL's amendment attempts to address many of the problems in this area by instilling a much needed measure of stability into our legal lottery that will benefit both patient and provider.

How? This amendment would take the following, necessary, steps: To start, the amendment sets standards for punitive damages. In order for a claimant to receive such damages, he or she must prove by clear and convincing evidence that either:

The defendant intended to injure the claimant for a reason unrelated to health care;

The defendant understood the claimant was substantially certain to suffer unnecessary injury and yet still deliberately failed to avoid such injury; or

The defendant acted with a conscious, flagrant disregard of a substantial and unjustifiable risk of unnecessary injury, which the defendant failed to avoid in a manner which constituted a gross deviation from the normal standard of conduct.

Furthermore, punitive damages would be limited to two times the sum of compensatory damages, which includes both economic and non-economic damages.

With our current system, defendants who are only one percent at fault could be held responsible for 100 percent of the award—which certainly does nothing to encourage doctors to continue to provide care. Under this amendment, there would be proportionate liability for non-economic and punitive damages, so that doctors are only liable for their actual share of damages if culpability is established. However, joint liability would remain for economic damages.

In addition, courts would be allowed to require periodic payments for large awards rather than lump sums, which makes it easier for insurers to judge their appropriate reserves. I would note that under Utah law, periodic payments for awards of over $100,000 are mandatory. This does not reduce the claimant's award. Past and current expenses will continue to be paid at the time of judgment, while future damages can be funded over time with less risk of bankrupting the defendant. Awards in malpractice cases also would be reduced by the amount of compensation received from collateral sources, in order to prevent the practice of ''double dipping.''

This amendment also limits attorneys' fees, but I think, in a reasonable manner. Attorneys' fees that could be paid out of an award would be limited to 33 percent of the first $150,000 and 25 percent of any amount awarded above that. I have to say, I am concerned about any limitation on attorneys' fees, but there have been some colossal rip-offs in this area and this appears to be a reasonable approach in the McConnell amendment. Lawyers should be compensated, and they should be fairly and reasonably compensated. But studies have shown that a surprisingly low proportion of every dollar spent on liability litigation ever reaches patients. That is a strong indication that our liability system has been turned squarely on its head. Despite all the tremendous litigation costs, the beneficiaries seem to be lawyers, not patients. This important provision ensures that the injured party will receive more of the award, and the attorney less.

The amendment would further require that a medical malpractice complaint must be filed within two years after the claimant discovered, or in the exercise of reasonable care should have discovered the injury and its cause. This is similar to the law in Utah, which provides for a 2-year statute of limitations, with a 4-year maximum.

And with regard to obstetric care, to address the rising number of lawsuits filed against emergency room doctors who deliver babies of women they have not previously treated, this amendment incorporates an amendment offered by Senator THOMPSON back in 1995 which passed overwhelmingly. Under this provision, for obstetric services, if a health care provider had not previously treated the pregnancy, the provider shall not be found to have committed malpractice unless proof of the malpractice meets the standard of clear and convincing evidence.

This amendment also encourages states to develop a state-based alternative dispute resolution mechanism to avoid the necessity of going to court. I have long felt that our fault-based liability system may not be the most equitable or the most efficient. it is expensive, time consuming, and unpredictable.

The McConnell amendment also requires that a portion of all punitive damage awards be set aside to: No. 1, improve state licensing, investigating, and disciplining of medical professionals; and, No. 2, reduce medical malpractice expenses for physicians who volunteer to provide care in medically under served areas.

Finally, the scope of this amendment applies to all federal and state medical malpractice cases, except in those states that already have stronger medical malpractice reforms.

Mr. President, it is clear that we need to do something to deal with this crisis, and I believe the McConnell amendment is a step in the right direction. What is important is that we take steps to benefit both the patient and the health care provider, not the trial lawyers—otherwise we are in danger of losing access to necessary healthcare. I urge my colleagues to support this amendment.

Mr. MCCONNELL. I yield 3 minutes to the Senator from Tennessee.

Mr. FRIST. First, I want to go back to the theme that I introduced last Friday: This is not about insurance companies or injured patients but about patients broadly. The debate boils down to patients broadly; to the American people versus a broken system of runaway, skyrocketing premiums secondary to the trial lawyers.

As I paint the picture, look at the skyrocketing medical premiums which we know are out there. They have an impact that is directly translated to access of health care. This is important to everyone listening to me today because they want access to health care, and affordable access to health care.

What is happening is that the skyrocketing costs, coupled with these runaway jury awards, have an impact on physicians in the following way. As the Senator from Mississippi said a few minutes ago, physicians are leaving parts of the country. They are relocating. They are stopping certain riskier procedures, such as delivering babies. Because of these skyrocketing premiums, obstetricians are having to stop delivering babies and neurosurgeons are beginning to limit their practices. We will hear shortly about trauma centers closing in Nevada and elsewhere. Trauma centers provide highly specialized care, and they are actually closing because of these skyrocketing premiums.

We also talked a little yesterday about defensive medicine. It increases costs the system overall, but these costs also translate down to how much you pay every time you go see a doctor or pay an insurance premium.

Ask your physician about defensive medicine. Eighty percent of physicians practice defensive medicine to the tune of billions of dollars. Patients are hurt in terms of poor access to health care and in terms of greater costs to them.

Let me just close, by asking the following: Who do you believe? Is it the insurance companies? Is it the trial lawyers? I will simply say, go back and ask somebody you trust for your health care. Ask your doctor who is telling the truth about the impact of skyrocketing medical malpractice costs; ask your doctors why physicians are leaving States to practice in other States where there is some sort of control on these runaway costs. Ask your doctor why physicians are retiring early or refusing to see certain patients. Ask your doctor why obstetricians are refusing to take new patients, or adjusting their practice just to practice gynecology and not obstetrics. Ask your doctor why trauma centers are closing today because of these skyrocketing premiums. Ask your doctor whether legal reform in the area of medical malpractice is good for patients.

I do not care about the insurance companies. They can come or go; they can deny business. The people I care about are the patients, who need access to better care. To better understand this debate ask your doctor, somebody you trust. Call them on the phone today, and I guarantee the answer they will give you is that the judicial system today is out of control and must be reformed. That is what the McConnell amendment does.

To summarize, States across the country are experiencing a health care liability crisis. Medical liability insurance premiums are skyrocketing as medical liability claims and damage awards are exploding. This problem is not limited to just a few States or a few areas of the country. It is nationwide, and it is getting worse.

The end result of this national crisis is simple: patients suffer. Patients suffer because in many areas because their access to care is in grave danger due to rising medical liability insurance premiums. Doctors are being forced to leave their practices, to stop performing high risks procedures and to drop vital services. Specialists are leaving certain areas or simply retiring. Women suffer the most. One out of 10 OB/GYNs no longer delivers babies because of the high cost of liability insurance. In addition, emergency departments are losing staff and scaling back certain services. This can literally be a life or death problem.

The problem is so sever that, according to the AMA, there is a crisis in 12 States where patient access to care is now seriously threatened And there are 30 more States that are near crisis, including my home State of Tennessee.

Patients also suffer because of the large costs of defensive medicine. To avoid situations in which a contingency fee attorney can claim injury occurred because certain tests were not performed, doctors engage in ''defensive medicine'' by performing testes and prescribing medicines that are not necessary for health reasons. This costs our economy billions.

As a doctor I know this problem is real. I don't need to know all the facts and figures because I have heard from many of my colleagues from across the country who are concerned about their liability insurance. I have heard from many who are seriously considering leaving an area or dropping a service because of the liability problem. They don't want to leave or change their practice, but the are being forced to do so.

My colleagues are demanding action by Congress to address this crisis in order to help their patients and to continue to provide quality health care.

So we are we in this crisis? Why are malpractice premiums skyrocketing? Why is patient access in jeopardy? Why are trauma centers closing? Why are OB/GYNs refusing to deliver babies? Why are maternity wards shutting down?

The answer is simple—medial malpractice suits are out of control. Between 1995 and 2000 the average jury award jumped more than 70 percent to $3.5 million, and more than half of all jury awards today top $1 million. However, payouts aren't the only problem. Simply Defending a malpractice claim costs on average over $20,000, whether or not a doctor or hospital is at fault.

Of course, this litigation is having a major impact on medical liability premiums. In 2001, physicians in many states saw rates raised by 30 percent or more and in some areas in some specialities, malpractice insurance is rising by as much as 300 percent per year. In New York and Florida obstetricians, gynecologists and surgeons pay more than $100,000 for $1 million in coverage. Soon, the annual premium which these doctors pay could reach $200,000. In my home State of Tennessee—a State that is not considered in crisis by th AMA—premiums rose 17.3 percent last year and are rising 15–17 percent this year.

It should be no surprise that these premium increases are causing this serious health care access problems across the country.

We know what must be done—intelligent and reasonable tort reform. Such reform will help solve this problem and, most importantly, help patients. Sensible reform will provide for fair and equitable compensation for those negligently injured and stabilize the insurance marketplace which will help maintain patients' access to quality health care.

Experience at the state level clearly shows the dramatic benefit of tort reform. California tort reform, the Medical Injury and Compensation Refom Act, or MICRA, which became law in the mid 1970s, is the most obvious example of what works. California doctors and patients have been spared the medical liability crisis that other States are facing. In fact, California currently has some of the lowest medical malpractice insurance premiums in the country.

This is why I strongly support this amendment offered by Senator MCCONNELL. Though this amendment does not include all the measures that I think are necessary to address this problem,

it is a good step in the right direction. We know that sensible tort reform works. It holds down rising health care costs and helps maintain access to quality health care. We must act now to protect patients and their accessibility to quality health care before the problem gets worse.

I encourage my colleagues to vote for this important amendment.

I reserve the balance of my time.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, I yield 4 minutes to the Senator from Massachusetts.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KERRY. Mr. President, I thank my colleague for the time.

I listened to the Senator from Tennessee, who is also a physician, speaking a moment ago. All of us have heard the complaints of doctors, of individuals, with respect to premiums. One wishes we were fashioning a remedy to some of the problems within the medical system that fits. This is not a remedy that fits. This is, in fact, an excuse for people who have always tried to liberate malefactors of one kind or another from responsibility to the legal system through the normal court process that is part of our Constitution.

People don't like being sued—of course not—so they try to find a way, statutorily, to limit their liability for things that they do wrong. The fact is, this particular remedy is not going to deal with the problem, No. 1, and, No. 2, it unfairly double victimizes American citizens who are the victims of some kind of incident of malpractice or of medical error from being able to seek the appropriate redress for that and being able to keep the level of accountability in our system which only, today, is provided by that capacity to be able to bring suit.

In fact, in our Patients' Bill of Rights, we directly passed the right to sue nursing homes and HMOs, which Americans want, when they are unfairly treated. This amendment even reaches to undo that right which the Senate granted but which we have not yet, obviously, put into law.

The fact is, this is not a serious approach to the problem that our physician, Senator, fellow Member, has articulated. Yes, there are some high premiums, but the president of the American Tort Reform Association has been quoted as saying:

> We wouldn't tell you that the reason to pass tort reform would be to reduce insurance rates.

So the McConnell amendment will not result in lower premiums, which is what they are screaming about. In fact, California, which enacted medical malpractice tort reform in 1974, has malpractice premiums 19 percent higher than the national average. So why are medical malpractice insurance premiums rising? Let's look to what the Wall Street Journal tells us—not known for its liberal stance on tort reform. In a June article, they stated:

> Even doctors are beginning to acknowledge that the conventional focus on jury awards deflects attention from the insurance industry's behavior.

According to the International Risk Management Institute, the reason premiums are rising is because throughout the 1990s insurance companies cross-subsidized low premiums with profits from investments. This enabled them to lower the premiums to attract more policyholders. Now the economy has slowed and investment profits have dried up, and investing decisions, not tort claims, bear the responsibility for rising premiums.

Moreover, medical malpractice insurance costs, as a proportion of national health insurance care spending, amounts to less than 60 cents per $100 spent.

We should ask any American whether they are prepared to pay 60 cents of the cost of medical care of all the hundred dollars that are spent in order to know that, if something is done wrong to them, they have the right of redress.

Moreover, it is false to state that claims have ''exploded'' in the last decade. Closed claims, which include claims where no payout has been made, have remained constant, while paid claims have averaged just over $110,000. Meanwhile, this is the most important point——

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. KENNEDY. I yield an additional minute.

Mr. KERRY. Mr. President, incidents of medical errors are growing. Countless Americans risk serious injury because of mistakes made in hospitals and in other places. Medical errors occur all over the system. In hospitals alone, the Institute of Medicine has reported that between 44,000 and 98,000 Americans are killed by medical errors annually. Using the 44,000 figure, medical errors are the eighth leading cause of death in the United States, more than breast cancer and more than AIDS. So I think to take away from Americans the single available tool they have to try to make the system be accountable, in the absence of any other responsible effort, is wrong.

Using the 98,000 figure, medical errors would be the fifth-leading cause of death in this country.

As the IOM report puts it,

> These stunningly high rates of medical errors—resulting in deaths, permanent disability and unnecessary suffering are unacceptable in a medical system that promises first to do no harm.

Now, clearly, some medical errors are the direct result of physician negligence and many are not. But it is clear that we ought to think long and hard before placing an arbitrary cap on the financial value of human life.

Knowing that the McConnell amendment would have virtually no impact on insurance premiums, let's look at the merits of the legislation: The amendment before us is not simply about preventing excessive malpractice actions.

When the Senate flipped to Democratic control a little more than a year ago, the Senate finally passed a real Patients Bill of Rights. For the first time, the Senate sought to hold HMOs truly accountable for their actions. But this amendment would severely limit suits not only against standard medical malpractice actions, but also actions against HMOs and nursing homes. This amendment is extremely broad in scope and is directly opposite of the Senate's position on the Patients' Bill of Rights.

The amendment's restrictive statute of limitations are similarly misguided. The amendment reduces the amount of time a patient has to file a lawsuit to 2 years from the date the injury was discovered. So if someone contracts HIV through a negligent transfusion but learned of the disease 5 years after the transfusion, he or she would be barred from filing a claim. This statute of limitations would cut off claims for diseases with long incubation periods. Even shareholders, investors and others have 5 years under the just-enacted accounting reform bill.

This amendment would also punish injured patients who have prudently purchased insurance policies to protect themselves and their families. Senator MCCONNELL would require a judge to reduce the amount of damage award by all collateral sources, such as life or disability insurance payments. So if you are thoughtful enough to purchase health care—a growing difficulty for too many Americans—you will be less likely to be compensated for someone else's negligence. This just does not make sense.

I know how difficult is for hospitals to find specialized doctors and nurses today. The Nation's shortage of nurses has reached crisis stage, and we do need to keep experienced health care professionals on the job. But this amendment will not help control malpractice premiums.

I am prepared to talk about reasonable ways to do this. In Massachusetts years ago we put in a screening system. There are many ways to approach this, but this is an arbitrary limit, which will be unfair to the average American and will not result in lowering premiums.

The PRESIDING OFFICER. The time of the Senator has expired. Who yields time?

The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, the pending amendment should be called a clients' bill of rights because it is designed not to in any way handicap the recovery of the victim, but to rearrange the relationship between the lawyer and the victim so the victim can get more of the money he or she justly deserves and to deal with the problem of runaway punitive damages—which are not for the purpose of rewarding the plaintiff anyway; they are for the purpose of punishing the defendant.

I was in Henderson, KY, which is right on the Ohio River, Friday night.

There were four doctors at the meeting I attended. Every single one of them was on the verge of moving over to Indiana—it is very easy for them; they just go across the Ohio River—in order to escape this malpractice crisis which has afflicted, of course, my State of Kentucky. It hasn't afflicted Indiana because they have reasonable caps on recovery and have had for years.

The next day, on Saturday, I was in Morganfield, KY, and there were some people there who have a son who lives in Mississippi. The distinguished Republican leader was talking about the crisis in Mississippi. The son of one of the people in Morganfield is an obstetrician in Mississippi, getting ready to pack his bags and move to a State where they have dealt this issue.

Speaking of a State that has a crisis, there is no State that has a greater crisis than the State of Nevada, and our colleague from Nevada is here to discuss the crisis in Nevada. It is my understanding that there is a special session going on this very week.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. Seventeen and one-half minutes.

Mr. MCCONNELL. I yield 10 minutes to the Senator from Nevada.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, I thank the senior Senator from Kentucky for yielding time.

There is a serious crisis going on in the State of Nevada. We have heard here today that insurance rates are not going up. Let me tell you that they are dramatically going up in Nevada, and it is because jury awards are out of control.

About one-half of the doctors in southern Nevada have their homes up for sale because they cannot afford increased medical liability premiums. Whether these are OB/GYNs or neurosurgeons or orthopedic surgeons, many of the specialists are taking their practices and moving them to States that have enacted tort reform and/or medical liability reform measures that are similar to the McConnell amendment we are considering here today.

In my State right now, obstetricians are telling pregnant mothers in late stages of pregnancy they will not deliver their babies. We are the fastest growing county—Clark County—in America. Yet these obstetricians are saying they are not taking any new patients. OBs are saying they will not take any new patients because they cannot afford to, and those are the ones who are staying in town. Unfortunately, many of them are leaving.

Let me give you an example. There is a couple who are both OB/GYNs who practice together. In fact, they delivered my wife's and my three children. They have already been in several meetings to move their practice to either northern or southern California where their medical liability insurance rates would be about one-fifth of what they would pay in the State of Nevada.

On July 3, our only level 1 trauma center closed for 10 days. This trauma center services four States. If someone has a serious accident and has severe trauma, this is where they would get the kind of care necessary for saving their life. The reason it is closed was, once again, was because doctors were afraid they would not be able to get the kind of insurance coverage they needed and they would lose everything they worked for their whole life if they were sued. The only reason it was reopened was because they were afforded insurance coverage that included a $50,000 cap on damages. They were told—If you practice here, and there happens to be some kind of a malpractice, we will cap the jury award at $50,000.

Now, there are no such caps in the McConnell amendment we are discussing. However, I believe very strongly in caps on non-economic damages. I wish they were part of this amendment.

As a matter of fact, yesterday Nevada's Governor proposed and laid out a compromise with Republican and Democrat legislators in which there would be a $350,000 cap on jury awards for non-economic damages. You would be able to recover, through economic damages, everything you would have ever earned and expenses you incurred for medical bills. But on non-economic damages there would be a $350,000 cap, except in cases where treatment was received at the trauma center—that would be kept it at a $50,000 cap. They did this because they know that it is the only way they can keep the trauma center open.

In any case, there are several other provisions in the McConnell amendment that are very important. This idea of joint and several liability was mentioned. The Senator from Massachusetts talked about this; that it is important to keep joint liability so the patient would be able to get the whole award.

Now let me tell you what this really means. If you are practicing in a trauma center, and if you are responsible for 1 percent of the medical malpractice that happened in a particular case, you can be held responsible for 100 percent of the jury award.

Is that fair? That isn't fair.

That is also one of the reasons rates continue to go up across the country.

Neurosurgeons are leaving our State. This isn't about trial lawyers versus doctors. This is about availability of doctors. This is about whether we are going to have people such as Senator BILL FRIST—a very talented heart surgeon—continue to go into the practice of medicine and who want to save lives. We have people who are not only leaving our State, but who are just retiring their practices early because of this crisis.

One of the best surgeons in Las Vegas—a gastrointestinal surgeon—was planning on retiring in 1 year. He actually retired this year because had he stayed in the practice an additional year, he would not have only had to pay $200,000 for insurance this year, but he would have faced what is called ''tail coverage''. Tail coverage is what a doctor pays when they quit practicing or change insurance companies in order to cover any claims which might arise from when they were covered under the previous company or while they were still practicing. He would have had to pay another $400,000 just for tail insurance. He makes about $200,000 a year. So, it would have cost him $600,000 to practice while he would have only earned $200,000 for the year. It was obviously ridiculous to stay in business, so he quit practicing.

Las Vegas and southern Nevada lost one of their best surgeons because of early retirement, leaving even more patients without the services of a highly-trained, highly respected physician. That kind of situation is indicative of how badly broken the system is.

Let me briefly mention just one of the abuses in our civil justice system and how that contributes to the overall problem we are having in runaway jury verdicts. If you are accused of medical malpractice you are brought into the courtroom, at which time the case is laid out. At some point during the case, ''expert'' witnesses are called to testify. I put ''expert'' in quotations because many physicians can be brought in as an expert. Unfortunately, there are physicians who are now working in concert with trial lawyers, and it is really their business to become expert witnesses even though they are not experts. Not to impugn their motives, but certainly this happens, and many times the abuse is blatantly outrageous. Yet the jury hears from the supposed ''experts,'' and in main part of that testimony, medical malpractice is found by the jury.

This illustrates what is happening in States and cities all across the United States. It is a system that is prejudiced toward finding malpractice. While the McConnell amendment does not specifically address this issue, it does help bring some accountability and feasibility back to our civil justice system.

I am a veterinarian, and I have worked in the health care profession for some time. Anybody who has worked in health care understands human error. Do you know why? It is because we are humans who practice. And anytime you have human beings practicing a profession, you are going to have errors—sometimes errors that can't be helped. There are some very sad cases, and we want to ensure those people continue to be able to have a remedy. But, outside of providing appropriate compensation, our system of secondary recovery it is out of control. The system needs to be brought back into balance.

The bottom line is when you have human beings, there are errors. However, we must remember that often times those errors are not malpractice. The physician did not intend to hurt his or her patient. But more often than

not, it can appear as malpractice to a jury. We need to make sure that we have a system in place that most justly adjudicates each and every case on its merits, and fairly places culpability where it should be placed.

Under the current system, juries are out of control with awards that we are all paying for. Medicare costs and private insurance premiums are higher, and they keep going up every year. There are several factors that contribute to this rise in costs, but none more than the excessive, unfounded awards given out by juries on a seemingly regular basis.

Mr. KENNEDY. Mr. President, will the Senator yield for a question?

Mr. ENSIGN. Mr. President, let me finish my statement, and then I would be happy to yield.

In the State of Nevada last year, the average OB/GYN made about $200,000. Now, taking into consideration that figure, their insurance rates went from about $35,000 a year to about $130,000 a year. We can't pass that cost on anymore. That means basically every OB/GYN in southern Nevada is going to have to either see double the number of patients they are seeing now or just quit practicing altogether.

There is a huge incentive for these doctors to go to California where their rates will not only not go up, but they will actually go down from what they were the previous year.

I keep mentioning California because California enacted the Medical Injury Compensation Recovery Act (MICRA). MICRA has all the reforms that are in Senator MCCONNELL's amendment—plus they have the $250,000 cap on non-economic damages.

MICRA has been challenged in the courts four times. It has been upheld four times. It is not that people in the State of California do not receive injury awards. It isn't that the people in California are disadvantaged in some way so the patients don't get what they need.

There was a situation in 1975 that California recognized as a crisis. Because of court challenges, the bill didn't actually take effect until 1985. But since that time, they have had a stable situation where insurance companies know approximately what is going to happen and know how much their costs are going to be. Consequently, their rates have stabilized.

There are about 12 States right now, according to the American Medical Association, that are in crisis, Nevada being the worst of all.

Because of this crisis, Nevada's Governor had to call a special legislative session. Now, we only meet every 2 years in our legislature. Therefore, he had to call a special session just to deal with this severe crisis that is going on right now.

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

Mr. ENSIGN. Let's enact this amendment to bring about some reasonable reforms to our medical liability system in the United States.

There is a crisis happening right now in my home State of Nevada. Obstetricians are telling pregnant mothers in late stages of their pregnancy that they can't deliver their babies.

On July 3, our only Level One trauma center closed for ten days, leaving victims of car accidents and gun shot wounds without appropriate care. Officials are saying it will probably have to close again.

Neurosurgeons are canceling operations with patients who have spinal cord injuries that adversely affect every second of their daily lives.

In fact, as I talk to you right now, the Nevada Legislature has been forced to meet in a special session with Governor Kenny Guinn to address this crisis.

What is the common thread between these events? It lies in the fact that all of these health care providers are unable to afford the skyrocketing cost of their medical malpractice insurance.

So, if this is a Nevada problem, then why would I bring this issue to the floor of the United States Senate?

Because it is no longer just a Nevada problem; it is now a nationwide problem. President Bush recognized this fact last week when he called our medical liability system ''badly broken,'' and emphasized the immediate need for Federal medical liability reform.

In order to illustrate this urgent need, let me give you some examples of what I am talking about:

In Bisbee, AZ, the only maternity ward has closed. Expectant mothers must now drive more than a half hour to the nearest town to deliver;

In Broward County, FL, 14 of the 16 practicing neurosurgeons are uninsured;

In Mississippi, 324 doctors have stopped delivering babies in the last decade. Today, only 10 percent of family doctors will deliver babies;

In Wheeling, WV, all of the neurosurgeons have stopped practicing. I could go on and on about a number of different States.

We have to examine why this current crisis is happening. What it boils down to is two factors: affordability and availability.

On affordability, let me give you a statistic from the American Medical Association. In 2000, medical liability insurance rates increased by at least 30 percent in 8 States, and by at least 25 percent in more than 12 States. I don't know too many physicians that can afford such rates. These rates are forcing more physicians, hospitals, and other health care providers to limit their practices or leave the profession altogether.

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

Now, why are insurers raising rates and/or leaving the market? Because there is no stability in the marketplace for providing medical liability insurance.

Why is there no stability in the marketplace? Because our healthcare system is being overrun by frivolous lawsuits and outrageous jury awards.

Let me give you some statistics to illustrate these points. This information is according to the Physician Insurers Association of America's Data Sharing Project:

Since 1998, the average claim payment value has risen from approximately $130,000 in 1988 to $330,000 in 2001. Likewise, since 1988, the median claim payment values have risen from approximately $50,000 in 1988 to $175,000 in 2001.

In 1985, less than 1 percent of the claims that were paid were equal or greater than $1 million. Contrast that to 2001 when 7.9 percent of the claims paid were equal or greater than $1 million.

This excessive litigation is leading to higher health care costs for every American and an unstable piece of mind for our health care providers. To fend off litigation, healthcare professionals are forced to practice defensive medicine by ordering unnecessary tests just so that they will not be sued for ''under-diagnosing'' their patients.

A recent study by the Department of Health and Human Services found defensive medicine is costing the Federal Government an estimated $28 billion to $47 billion in unnecessary healthcare costs.

And who else pays for those unnecessary costs? Every American with health insurance, in the form of higher premiums. Gone are the days when our civil justice system was used to help protect patients. Now we are left with a system that is used to primarily fatten the wallets of personal injury attorneys.

More often than not, medical liability claims are more financially beneficial to the lawyers than they are to the injured and sick patients.

According to the Physician Insurers Association of America's Data Sharing Project, only fifty cents of every dollar paid in medical liability awards go to the patients. Only 50 cents.

Additionally, nearly 70 percent of all medical liability claims result in no payment to the plaintiff.

So what does all this mean? It means that we need to bring some accountability back to the civil justice system by way of medical liability reform.

Not only would this allow physicians to continue to concentrate fully on providing superior care to their patients, it would help tremendously in curbing the skyrocketing costs of healthcare for consumers.

In addition, and probably even more staggering, is the success rate of most medical liability claims. Consider this information:

In 2001, only 1.3 percent of all claims filed ended in a verdict for the plaintiff. In contrast, 61.1 percent were dropped or dismissed for various reasons.

These numbers highlight the significant amount of frivolous lawsuits that

are filed, costing healthcare professionals valuable patient time, and ultimately costing every insured American millions in increased health care costs.

Medical liability reform is not something that is new to the Senate. During debate on the 1995 Product Liability Bill, the Senate considered and voted on medical liability reform proposals. In fact, one of those proposals is the exact amendment that we are considering here today.

This amendment takes a sincere and aggressive approach toward helping reign in our out of control civil justice system. It does so in the following ways: sensible limits on punitive damages; elimination of joint liability on most damages, making sure that defendants are only liable for their fair share; modest limits on attorney's fees in medical malpractice cases to maximize patient recovery; collateral source reform to prevent plaintiffs and attorneys from ''double dipping'' for compensation; alternative dispute resolution to encourage states to develop mechanisms to help resolve disputes before they go to court; and periodic payments for large awards.

Although I am strongly in favor of this proposal, I must mention that the one significant provision it is missing is a cap on non-economic damages. I believe this cap could only strengthen the proposal we are considering today. However, every other reform in this amendment has proven to be effective in bringing accountability back to the civil justice system.

This amendment was passed in 1995 on a vote of 53–47. Therefore, with the number of Senators who supported this proposal before, coupled with the number of senators whose States are facing a medical liability crisis, I think we have an excellent chance to pass this amendment. Just to highlight that point, a recent study conducted by Wirthlin Worldwide found that 78 percent of Americans express concern that skyrocketing medical liability costs resulting from the current system could limit their access to care. Clearly, the American public sees the crisis we care facing and are calling for nationwide reform. Americans are afraid they will not have anyone to deliver their babies or perform life-saving procedures on their loved ones in emergencies, and they should not have to be. If there are senators here today that are still not convinced about the need and overall effectiveness of medical liability reform, let me briefly explain how to put your doubts to rest.

Let's take a look at the wildly successful Medical Injury Compensation Reform Act (MICRA) of 1975 that California has in place. Now, I will concede that the amendment before us is not identical to MICRA, but it does incorporate all but one of the major provisions that MICRA contains.

To further explore the impact of MICRA, just look at the difference between how medical liability premiums have risen in California versus the rest of the United States. According to the National Association of Insurance Commissioners, from 1976 through 1999, California's insurance premiums has risen 167 percent, while the other 49 States' premiums have risen 505 percent.

Obviously, MICRA has brought about real reform in California's professional liability system, while still protecting the rights of injured patients. Studies have shown the following. The number of frivolous lawsuits going to trial has declined dramatically; injured patients receive a larger share of their awards; the number of disciplinary actions against incompetent health care providers has increased.

The bottom line is that California's medical liability system works. Shouldn't these types of outcomes be shared by every state, and ultimately every patient, in America?

Again, the amendment before us contains all but one of the major provisions that MICRA entails, so each senator has something to substantiate their vote. And let us remember one important point we are NOT limiting the amount of economic and non-economic damages that can be recovered by the patient.

All we are doing is bringing some accountability and reasonability back to our civil justice system in the form of common-sense reforms which I know will lead to lower health care costs for every American.

I know it is possible to pass these types of reform measures through the Houses of Congress, because while I was a member of the House of Representatives we passed some type of medical liability reform measure six times. Unfortunately, each time it was stalled in the Senate and real reform was never enacted.

But the next time around I am hopeful that it will be different. And there is no better time than now for the Senate to make a strong statement on behalf of American patients.

Let's make sure there are no more expectant mothers turned away at the door and refused pre-natal care.

Let's make sure trauma patients receive immediate and appropriate medical services.

And, let's make sure that we continue to provide patients everywhere the opportunity to receive affordable, accessible, and quality health care for years to come.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. I yield 6 minutes to the Senator from Tennessee.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. THOMPSON. Mr. President, let me address what I consider to be the real issue, really the only issue, as far as I am concerned. It is not who the bad guys are and who the good guys are. I have seen excesses on both sides of this issue. It is not a matter of what is best for the trial lawyers or best for the insurance companies or even what is best for the patients. It is a question of whether we have a limited form of government, whether we have a Federal Government with enumerated powers. That is the underlying issue. It is amazing to me that we can have a debate on something such as this without it even being brought up.

What we have is an amendment which will take things that have been under the purview of the State governments for 200 years and federalize them. This is getting to be such a common occurrence that nobody pays much attention to it anymore. I pay attention to it. I think it is a bad trend. I think it goes against the system of government that our Founding Fathers set up and has worked in our favor for 200 years.

Mr. REID. Will the Senator yield for a brief question?

Mr. THOMPSON. Yes.

Mr. REID. Is the Senator aware that the State of Nevada is in a special session to work out malpractice problems, and does the Senator believe that is the way we should go?

Mr. THOMPSON. The answer to that question is yes. I am amazed to hear that we have a problem in a particular State and that the solution is for the citizens of the small town in that State maybe to drive past the courthouse and drive through the capital, past the statehouse, and get on an airplane and fly to Washington, DC, to talk about a Federal solution against their own State.

Tennessee just had a discussion about a State income tax and a State sales tax. One of the points made against a higher State sales tax was that the State of Kentucky and the State of Mississippi and the State of Arkansas, all these other surrounding States, had a lower sales tax and people would go to those States to buy their goods, just as apparently people are going from one State to another to take advantage of a better medical malpractice case.

The answer to that is, that is the way it is supposed to work. That is our system of government. That is the reason we have States, to have competition among States. If we extend the commerce clause to this, after having been told by the Supreme Court in the Lopez case that the commerce clause does not extend to guns in the local school, after having been told in the Morrison case by the Supreme Court that the commerce clause does not extend to a sex-based crime at a local level—if we extend the commerce clause to the delivery of a baby in Lawrenceburg, TN, there is nothing to which we cannot extend the commerce clause. I regret to say, it is some of us who talk about limited government and enumerated powers who are doing this. I do not think it is sound policy.

It does not matter whether or not there are excesses on one side or another. States are supposed to address these matters. I would not come here

and say the State of Tennessee is inadequate in this regard unless I was willing to go back to the State of Tennessee and fight for a change in the laws. Senator KENNEDY and I, are we supposed to write the laws for the State of Tennessee with regard to something that has been under their purview for 200 years? I don't think so.

We can disagree on what those laws should be, but we cannot disagree, surely, on the principle that underlies this debate. The proposed amendment goes so far as to require that each State require 50 percent of all punitive damage awards be used for licensing, investigating, disciplining, and certifying health care professionals and the reduction of malpractice costs for the health care professional volunteers.

This requirement would get us into the management of the licensing and regulation of health care professionals in every State in this country. This is just one step away from national standards and national regulation, not just in the health care area but potentially in any other area.

Regardless of whether you think medical malpractice premiums are too high or lawyers are terrible people, or whatever, if we walk away at this time from this principle, when we want to assert this principle, we are not going to have any principles to stand on because we will have ignored them so often for the particular causes we want at the moment that they will be totally eroded. I submit to the Chamber that is too high a price to pay.

I yield back whatever time remains.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, I listened carefully to the Senator from Tennessee. I commend him for being very consistent in his concern about federalism and States rights. He has raised that issue not just on the occasion of today's amendment but across the board. He has certainly been consistent. I do find it somewhat amusing to hear it invoked from time to time by those on the other side of the aisle for whom States rights are rarely a concern.

Let me say to my good friend from Tennessee, he raises exactly the point I wanted to address in my remaining time this morning. This is a national crisis, a national crisis in the delivery of medical services. This is a national problem, and it demands a national solution. States all across the country—in the West, the South, the Midwest, and the East—are in crisis. Many more States are experiencing serious problems, including my own State of Kentucky. Because it is a national problem, it demands a national solution. Furthermore, it is necessary and appropriate for the Federal Government to be involved in fixing this problem.

Let me give you my first reason. As the single largest purchaser of health care, the Federal Government has a compelling interest in health care liability reform. In 2002, the Federal Government will spend $223 billion on Medicare, $145 billion more on Medicaid, and $11.3 billion more on Federal employee health benefits. That is a total of $400 billion by the Federal Government on health care.

Furthermore, a 1996 study by Stanford economists projected that commonsense medical malpractice reforms, many of which are included in my amendment, could reduce health care costs by 5 to 9 percent without jeopardizing the quality of care. Using this study, the Department of Health and Human Services projects that reducing the practice of defensive medicine could save the Federal taxpayers between $23 and $42 billion.

Finally, Federal legislation is necessary because of the increasingly interstate character of health care. I just mentioned, a few moments ago, the four physicians I saw Friday night in Henderson, KY, on the verge of moving to Indiana. That is fine for them. It doesn't do much for their patients who are left without care on the Kentucky side. Patients in the Washington, DC, area receive care not only here but in Maryland and Virginia. Many of the Nation's finest health care facilities—the Mayo Clinic and M.D. Anderson—treat patients from across the country.

While a Federal solution is necessary and appropriate, my amendment does not wholly preempt State medical malpractice reforms. The amendment would not preempt those States that have already developed strong medical malpractice laws.

This crisis has been created by the failure of the National Government to act. That has caused a problem. This crisis is due to the failure to impose accountability and responsibility—the same things we have been talking about around here the last few weeks with regard to corporate America—on big, powerful trial lawyers who are running roughshod over doctors and in many instances taking advantage of their own clients.

As a result of our failure to act, there has been an explosion in medical malpractice awards. Let us take a look at this chart which shows the explosion in medical malpractice awards from roughly $500,000 in 1995, up to $1 million in 2000.

Now, I gather my friends on the other side apparently think doctors have become twice as incompetent in the last few years or that medical schools are now turning out graduates who are inept. But I am inclined to believe that the medical professionals at the AMA and other health care organizations don't agree with that. The standard of care of physicians has not radically deteriorated in just the last few years. Rather, from looking at the problem, I believe the AMA and other health groups when they say it is our medical malpractice liability system, not our delivery system, that is badly broken.

The amendment I offer is a modest one. As I have said repeatedly, it doesn't in any way cap compensatory damages to the victim. It simply seeks to cap lawyer's fees so more money will go to the injured victim, and caps punitive damages, which are not designed to compensate the injured party in any event but to punish the defendant—cap that at twice the balance of the compensatory damages. So this doesn't take any funds that are needed to put the injured victim back on his or her feet. It simply addresses the issue of lawyer abuse and of excessive punitive damages, which are not designed to enrich the injured party in any event.

It is a very modest amendment. The AMA supports this amendment. They would have liked it to be much stronger, but I crafted this amendment in a very modest way in order to make it more palatable to more Senators. We have had a vote on this amendment before, back in 1995. At that point, it got 53 votes, including Senators FEINSTEIN, LIEBERMAN, and JEFFORDS, who are still in the Senate.

As I said, this is a pro-victim amendment. There is no cap on noneconomic pain and suffering damages, no cap on compensatory damages. There is simply a reasonable cap on lawyer's fees and a cap on punitive damages at twice the balance of the other damages.

So I think this is clearly a national problem requiring a national solution. I hope the amendment will be approved.

Mr. KENNEDY. Mr. President, I yield 1 minute to the Senator from Tennessee.

Mr. THOMPSON. Mr. President, just a very brief response. I think the logical extension of this amendment would mean if we could pass any large Federal program—as we have—such as Medicare, Social Security, and I guess our defense appropriations bills, and so forth, then we could take any activity, even noncommercial activity in the smallest hamlet of the smallest town in America, anything they would do that might arguably impact on the cost of those programs would be fair game under the spending clause.

If that is the case, that is not a direction in which we need to go. I would contrast what we are doing here with regard to delivery of a baby, let's say, in Lawrenceburg, TN, and the rules the State of Tennessee imposed upon that we would abrogate—I contrast that with a product liability debate we had. I voted for that bill. That is an inherently interstate commerce, commercial activity. I have concluded that there was a legitimate reason to have some national standards with regard to that. I think our Founding Fathers would have approved of that. I think it is a far cry from where we are with regard to this.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, how much time do I have?

The PRESIDING OFFICER. The Senator has 1 minute 50 seconds.

Mr. KENNEDY. Mr. President, as I understand it, we will have a very brief

time after the break. I point out that the National Association of Insurance Commissioners study shows that in 2000—the latest year for which data is available—the total insurance industry profits, as a per average premium for medical malpractice insurance, were twice as high as overall casualty and property insurance profits. In fact, malpractice insurance was a very lucrative area for the industry, averaging a 12 percent profit. Over a 10-year period, their premiums went up 1.9 percent, and they are making 12 percent on that.

This is about the insurance industry; it is not about the doctors. We will have more to say about this. This is a lucrative aspect of the insurance industry—everyone knows it—and they just want to cash in on this opportunity at the present time.

Mr. President, I see our leader on his feet at this time in anticipation of a consent agreement, so I withhold further comments.

Mr. REID. Mr. President, I ask unanimous consent that the time from 2:15 p.m. this afternoon until 2:45 p.m. be equally divided between Senators KENNEDY and MCCONNELL or their designees and that at 2:45 p.m. Senator REID of Nevada or his designee be recognized to move to table Senator MCCONNELL's amendment.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

RECESS

The PRESIDING OFFICER. The hour of 12:55 p.m. having arrived, the Senate stands in recess until the hour of 2:15 p.m. today.

Thereupon, the Senate, at 12:55 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mrs. CARNAHAN).

GREATER ACCESS TO AFFORDABLE PHARMACEUTICALS ACT OF 2001—Continued

AMENDMENT NO. 4326

The PRESIDING OFFICER. Who yields time?

The Senator from Kentucky.

Mr. MCCONNELL. Madam President, it is my understanding that I have 15 minutes remaining.

The PRESIDING OFFICER. The Senator is correct.

Mr. MCCONNELL. Madam President, I yield 5 minutes to the Senator from Tennessee who, as we all know, is the only physician in the Senate.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. I thank the Chair.

Madam President, I rise in support of the McConnell amendment on medical malpractice to the Greater Access to Affordable Pharmaceuticals Act. It goes to the heart, I believe, of an issue that has reached crisis proportions in the United States.

Much of the argument and debate on Friday and a little bit yesterday and today centered on how best to frame this debate. Our opponents to the McConnell amendment have tried to frame this as a debate focused on corrupt insurance companies and HMOs.

What is absolutely critical for my colleagues and the American people to understand is that this debate is not about insurance companies. This debate is about patients, patients who are suffering today and, even more important, unless we act on this crisis, will be hurt in the future.

It is about patients versus skyrocketing medical liability insurance premiums that, in large part, are driven by the current medical liability system. This amendment strikes right at the heart of that problem.

Why is this debate important? I go back to patients. How do patients suffer because of these skyrocketing insurance premiums? They suffer in two ways: No. 1, lack of access to health care. If in the future you are a patient, you will see a decrease in access when you want to go to a physician, such as an obstetrician or a neurosurgeon or an orthopedic surgeon. They have all seen these skyrocketing premiums, and these doctors are not going to be there. Why? Because they happen to live in Mississippi where their premiums are $50,000 or $100,000 or in Florida where an obstetrician premium might be $150,000 or $200,000. They might decide, A, to pack it up and leave and go to another State or, B, to stop practicing or, C—and this is what we see happening all over the country—to stop delivering babies. If your doctor delivered your first baby and you want him to deliver your second baby, you had better call far in advance. Because of these skyrocketing premiums, many physicians are leaving that specialty.

In addition we saw what happened in Nevada where the trauma surgeons basically said, we cannot stay in business, we cannot keep delivering these services, because malpractice premiums are too high. They were actually forced to close down shop for a period of time. Thank goodness it was just for a few days.

I mention the impact on doctors because this is important. For example, if one is an obstetrician and he pays $200,000 a year for his insurance premiums, as in Florida, and he delivers 100 babies, which is the average for an obstetrician in Florida delivers, that means for every baby the doctor delivers there is a $2,000 tax or premium.

Now, one might say that this is the worry of the doctor. Well, the doctor can leave. He can switch specialities. He can relocate or retire, early retirement, none of which is very satisfactory. But if a doctor is going to stay in practice, ultimately the doctor is going to pass the cost on to the patient. Who else will pay it? It has to be passed on to the patient.

Americans are watching this debate and they hear the ranting and raving against the bad insurance companies. Let's go back to the effect of the problem, which is on that individual patient. Then let's look at the root cause, which is this runaway tort liability system, which this amendment takes the first step at fixing.

Patients are hurting in two ways. First, they suffer from a lack of access to care. Specialist are leaving areas, and doctors are refusing to deliver babies.

The second way patients suffer is the overall cost of defensive medicine. Ask your physician right now: Do you practice defensive medicine? According to a recent Harris poll, 76 percent, or three-fourths, of physicians believe concern for medical liability litigation has hurt their ability to provide quality care in recent years. Eighty percent of physicians say they ordered more tests than they thought were medically necessary because they worried about malpractice liability. It is called defensive medicine. It is something the consumer does not see, the patient does not see, but America pays for it. How much? Fifteen, 20, 30, 40, 50—about $50 billion.

I close by stating my strong support for the McConnell amendment and look forward to continued debate during the course of this afternoon.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I yield 7 minutes to the Senator from Illinois.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. I thank the Senator from Massachusetts for yielding the time.

I readily acknowledge the expertise of Senator FRIST. He is a widely respected heart surgeon. He certainly is a man who understands the practice of medicine, unlike anyone else in the Senate. I do not come as an expert on the practice of medicine. If I have any expertise, it is in trial practice because before I was elected to Congress, I was a trial attorney. I made my living defending doctors and hospitals, and suing doctors and hospitals. I understood medical malpractice then, but as I read this amendment I am troubled.

Let me acknowledge first, yes, there is a national problem with medical malpractice insurance across America. It costs too much in many areas, and we are finding that in many parts of the country doctors cannot afford to continue to practice because of the cost of premiums. But the answer from Senator MCCONNELL on the Republican side is to suggest that the reason the premiums are so high is because of jury verdicts.

They overlook the obvious. Let me point to a source of information not considered liberal in nature, the Wall Street Journal, which on June 24 of this year published an article. I ask unanimous consent that this article be printed in the RECORD.

There being no objection, the article was ordered to be printed in the Record, as follows:

[From the Wall Street Journal, June 24, 2002]

DELIVERING MS. KLINE'S BABY

(By Rachel Zimmerman and Christopher Oster)

As medical-malpractice premiums skyrocket in about a dozen states across the country, obstetricians and doctors in other risky specialties, such as neurosurgery, are moving, quitting or retiring. Insurers and many doctors blame the problem on rising jury awards in liability lawsuits.

''The real sickness is people sue at the drop of a hat, judgments are going up and up and up, and the people getting rich out of this are the plaintiffs' attorneys,'' says David Golden of the National Association of Independent Insurers, a trade group. The American Medical Association says Florida, Nevada, New York, Pennsylvania and eight other states face a ''crisis'' because ''the legal system produces multimillion-dollar jury awards on a regular basis.''

But while malpractice litigation has a big effect on premiums, insurers' pricing and accounting practices have played an equally important role. Following a cycle that recurs in many parts of the business, a price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims.

Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year.

''I don't like to hear insurance-company executives say it's the tort [injury-law] system—it's self inflicted,'' says Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California.

What's more, the litigation statistics most insurers trumpet are incomplete. The statistics come from Jury Verdict Research, a Horsham, Pa., information service, which reports that since 1994, jury awards for medical-malpractice cases have jumped 175 percent, to a median of $1 million in 2000. During that seven-year period, the median award for negligence in childbirth was $2,050,000—the highest for all types of medical-malpractice cases, Jury Verdict Research says. (In any group of figures, half fall above the median, and half fall below.)

But Jury Verdict Research says its 2,951-case malpractice database has large gaps. It collects award information unsystematically, and it can't say how many cases it misses. It says it can't calculate the percentage change in the median for childbirth-negligence cases. More important, the database excludes trial victories by doctors and hospitals—verdicts that are worth zero dollars. That's a lot to ignore. Doctors and hospitals win about 62 percent of the time, Jury Verdict Research says. A separate database on settlements is less comprehensive.

A spokesman for Jury Verdict Research, Gary Bagin, confirms these and other holes in its statistics. He says the numbers nevertheless accurately reflect trends. The company, which sells its data to all comers, has reported jury information this way since 1961. ''If we changed now, people looking back historically couldn't compare apples to apples,'' Mr. Bagin says.

Some doctors are beginning to acknowledge that the conventional focus on jury awards deflects attention from the insurance industry's behavior. The American College of Obstetricians and Gynecologists for the first time is conceding that carrier's business practice have contributed to the current problem, says Alice Kirkman, a spokeswoman for the professional group. ''We are admitting it's a much more complex problem that we have previously talked about,'' she says.

The upshot is beyond dispute: Pregnant women across the country are scrambling for medical attention. Kimberly Maugaotega of Las Vegas is 13 weeks pregnant and hasn't seen an obstetrician. When she learned she was expecting, the 33-year-old mother of two called the doctor who delivered her second child but was told he wasn't taking any new pregnant patients. Dr. Shelby Wilbourn plans to leave Nevada because of soring medical-malpractice insurance rates there. Ms. Maugaotega says she called 28 obstetricians but couldn't find one who would take her.

Frustrated, she called the office of Nevada Gov. Kenny Guinn. A staff member gave her yet another name. She made an appointment to see that doctor today but says she is skeptical about the quality of care she will receive.

In the Las Vegas area, doctors say some 90 obstetricians have stopped accepting new patients since St. Paul Cos., formerly the country's leading provider of malpractice coverage, quit the business in December. St. Paul had insured more than half of Nevada's 240 obstetricians. Carriers still offering coverage in the state have raised rates by 100 percent to 400 percent, physicians say.

Dr. Wilbourn says his annual malpractice premium was due to jump to $108,000 next month, from $33,000. The 41-year-old solo practitioner says the increase would come straight out of his take-home pay of between $150,000 and $200,000 a year. In response, he is moving to Maine this summer.

Dr. Wilbourn mourns having ''to pick up and leave the patients I cared for and the practice I built up over 12 years.'' But in Maine, he has found a $200,000-a-year position with an insurance premium of only $9,800 for the first year, although the rate rises significantly after that. Premiums in Maine are relatively low because a dominant doctor-owned insurance cooperative there hasn't pushed to maximize rates, the heavily rural population isn't notably litigious and its court system employs an expert panel to screen out some suits, says Insurance Commissioner Alessandro Iuppa.

Until the 1970s, few doctors faced big-dollar suits. Malpractice coverage was a small specialty. As courts expanded liability rules, malpractice suits became more common. Dozens of doctor-owned insurance cooperatives, or ''bedpan mutuals,'' formed in response. Most stuck to their home states.

St. Paul, a mid-sized national carrier named for its base in Minnesota, saw an opportunity. An insurer of Main Street businesses, St. Paul became the leader in the malpractice field. By 1985, it had a 20 percent share of the national market. Overall, the company had revenue of $8.9 billion last year, with about 10 percent of its premium dollars coming from malpractice coverage.

The frequency and size of doctors' malpractice claims rose steadily in the early 1980s, industry officials say. St. Paul and its competitors raised rates sharply during the 1980s.

Expecting malpractice awards to continue rising rapidly, St. Paul increased its reserves. But the company miscalculated, says Kevin Rehnberg, a senior vice president. Claim frequency and size leveled off in the late 1980s, as more than 30 states enacted curbs on malpractice awards, Mr. Rehnberg says. The industry's rate increases turned malpractice insurance into a very lucrative specialty.

A standard industry accounting device used by St. Paul and, on a smaller scale, by its rivals, made the field look even more attractive. Realizing that it had set aside too much money for malpractice claims, St. Paul ''released'' $1.1 billion in reserves between 1992 and 1997. The money flowed through its income statement and boosted its bottom line.

St. Paul stated clearly in its annual reports that excess reserves had enlarged its net income. But that part of the message didn't get through to some insurers—especially bedpan mutuals—dazzled by St. Paul's bottom line, according to industry officials.

In the 1990s, some bedpan mutuals began competing for business beyond their original territories. New Jersey's Medical Inter-Insurance Exchange, California's Southern California Physicians Insurance Exchange (now known as Scpie Holdings), and Pennsylvania Hospital Insurance Co., or Phico, fanned out across the country. Some publicly traded insurers also jumped into the business.

With St. Paul seeming to offer a model for big, quick profits, ''no one wanted to sit still in their own backyard,'' says Scpie's Mr. Zuk. ''The boards of directors said, 'We've got go grow.''' Scpie expanded into Connecticut, Florida and Texas, among other states, starting in 1997.

As they entered new areas, smaller carriers often tried to attract customers by undercutting St. Paul. The price slashing became contagious, and premiums fell in many states. The mutuals ''went in and aggravated the situation by saying, 'Look at all the money St. Paul is making,'' says Tom Gose, President of MAG Mutual Insurance Co., which operates mainly in Georgia. ''They came in late to the dance and undercut everyone.''

The newer competitors soon discovered, however, that ''the so-called profitability of the '90s was the result of those years in the mid-80s when the actuaries were predicting the terrible trends,'' says Donald J. Fager, president of Medical Liability Mutual Insurance Co., a bedpan mutual started in 1975 in New York. Except for two mergers in the past two years, his company mostly has held to its original single-state focus.

The competition intensified, even though some insurers ''knew rates were inadequate from 1995 to 2000'' to cover malpractice claims says Bob Sanders, an actuary with Milliman USA, a Seattle consultancy serving insurance companies.

In at least one case, aggressive pricing allegedly crossed the line into fraud. Pennsylvania regulators last year filed a civil suit in state court in Harrisburg against certain executives and board members of Phico. The state alleges the defendants misled the company's board on the adequacy of Phico's premium rates and funds set aside to pay claims. On the way to becoming the nation's seventh-largest malpractice insurer, the company had suffered mounting losses on policies for medical offices and nursing homes as far away as Miami.

Pennsylvania regulators took over Phico last August. The company filed for bankruptcy-court protection from its creditors in December. A trial date hasn't been set for the state fraud suit. Phico executives and directors have denied wrongdoing.

In the late 1990s, the size of payouts for malpractice awards increased, carriers say. By 2000, many companies were losing money on malpractice coverage. Industrywide, carriers paid out $1.36 in claims and expenses for every premium dollar they collected, says Mr. Golden, the trade-group official.

The losses were exacerbated by carriers' declining investment returns. Some insurers had come to expect that big gains in the 1990s from their bond and stock portfolios would continue, industry officials say. When the bull market stalled in 2000, investment gains that had patched over inadequate premium rates disappeared.

Some bedpan mutuals went home. Scpie stopped writing coverage in any state over

than California. ''We lost money, and we retreated,'' says the company's Mr. Zuk.

New Jersey's Medical Inter-Insurance Exchange, now known as MIIX, had expanded into 24 states by the time it had a loss of $164 million in the fourth quarter of 2001. The company says it is now refusing to renew policies for 7.000 physicians outside of New Jersey. It plans to reformulate as a new company operating only in that state.

St. Paul's malpractice business sank into the red. Last December, newly hired Chief Executive Jay Fishman, a former Citigroup Inc. executive, announced the company would drop the coverage line. St. Paul reported a $980 million loss on the business for 2001.

As carriers retrench, competition has slumped and prices in some states have shot up. Lauren Kline, 6½ months pregnant, changed obstetricians when her long-time Philadelphia doctor moved out of state because of rate increases. Now, her new doctor, Robert Friedman, may have to give up delivering babies at his suburban Philadelphia practice. His insurance expires at the end of the month, and he says he is having difficulty finding a carrier that will sell him a policy at any price.

Last year, Dr. Friedman says he paid $50,000 for coverage. If he gets a policy for next year, it will cost $90,000, he predicts, based on his broker's estimate. ''I can't pass a single bit of that off to my patients,'' because managed-care companies don't allow it, he says.

Dr. Friedman says he is considering dropping the obstetrics part of his practice. Generally, delivering babies is seen as posing greater risks than most gynecological treatment. As a result, insurers offer less-expensive policies to doctors who don't do deliveries.

Mr. Golden of the insurers' association argues that whatever role industry practices may play, the current turmoil stems from lawsuits. The association says that from 1995 through 2000, total industry payouts to cover losses and legal expenses jumped 52 percent, to $6.9 billion. ''That says there are more really huge verdicts.'' Mr. Golden says. Even in the majority of cases in which doctors and hospitals win—the zero-dollar verdicts—there are still legal expenses that insurers have to pick up, he adds.

Industry critics point to different sets for statistics. Bob Hunter, director for insurance at Consumer Federation of America, an advocacy group in Washington, prefers numbers generated by A.M. Best Co. The insurance-rating agency estimates that once all malpractice claims from 1991 through 2000 are resolved—which will take until about 2010—the average payout per claim will have risen 47 percent, to $42,473. That projection includes legal expenses and suits in which doctors or hospitals prevail.

While the statistical debate rages, pregnant women adjust to new limits and inconveniences. Kelly Biesecker, 35, spent many extra hours on the highway this spring, driving from her home in Villanova, Pa., to Delran, N.J., so she could continue to use her obstetrician. Dr. Richard Krauss says he moved the obstetrics part of his practice from Philadelphia because malpractice rates had skyrocketed in Pennsylvania. Ms. Biesecter, who gave birth to a healthy boy on June 5, says Dr. Krauss was the doctor she trusted to guard her health and the health of her baby: ''You stick with that guy no matter what the distance.''

Dr. Krauss, 53, left Philadelphia last year only after his malpractice premium rose to $54,000, from $38,000, and then was cancelled by a carrier getting out of the business, he says. After getting quotes of about $80,000 on a new policy, he moved. New Jersey hasn't been a panacea, however. His policy there expires July 1, and the carrier refuses to renew it. The doctor says he hopes to go to work for a hospital that will pay for his coverage.

Mr. DURBIN. The article points out the reason the premiums are rising so high is because the insurance companies miscalculated. They went into the business without adequate reserves. They have seen their investments plummet, as everyone else has on Wall Street, and they are trying to make it up with new malpractice insurance premiums at the highest possible levels. So, instead of blaming the juries that find a doctor or hospital at fault, let us also take into account the insurance companies' economic and accounting problems which have led to this crisis today.

Let's look specifically at this amendment. Senator MCCONNELL is consistent. When we brought up the bill about corporate corruption, he offered an amendment relating to trial lawyers. He believes that trial lawyers are the root of all evil. That amendment did not pass.

Now we come to a bill involving the cost of prescription drugs. Senator MCCONNELL returns with another amendment related to trial lawyers.

It is said that if the only tool you own is a hammer, every problem looks like a nail. It appears that when it comes to the issues in the Senate, for some Senators the answer to every problem is to go after the trial lawyers.

I suggest that when we take a look at the McConnell amendment, there are at least four areas that should be troubling to everyone following this debate. First, Senator MCCONNELL limits the period of time when someone can discover an injury or act of malpractice and bring a lawsuit. If they wait too long, they lose their chance to go to court. That is something we ought to think about long and hard.

Secondly, Senator MCCONNELL says that once someone has discovered that they have an injury caused by a doctor or a hospital and go to find an attorney, he limits in this amendment the amount of money that an attorney can receive for a contingency fee. A contingency fee is the poor man's ticket to the courthouse. If injured victim is not a millionaire, the only way that an attorney will take a complicated medical malpractice case is for a percentage of what they ultimately recover. If they recover zero, they are paid zero. But if they recover a substantial amount, they receive a percentage. Senator MCCONNELL wants to limit the contingency fee to limit the number of attorneys who will take these cases to court.

The third issue is this: Senator MCCONNELL creates a new tax on punitive damages. What he says is, if someone has done something so outrageous or deliberate, with conscious malice and disregard, that a jury would impose punitive damages on that doctor or hospital—and I can give a litany of possibilities—Senator MCCONNELL says, sorry, the Government is going to take away half of the punitive damages verdict; albeit, for good reasons. But nevertheless, this is a new tax created by Senator MCCONNELL on a jury verdict.

Finally, what the Senator says in this bill is, if one had the foresight to buy medical or life insurance, for example, to cover their health or life, and they are injured or killed because of medical malpractice, any jury verdict will be reduced by the amount of the insurance payment that one happens to receive from the policy they took out on their own life. These people invest in insurance and pay for it over a lifetime. But the amendment would take away part of that amount from a jury award. Those four things are fundamentally unfair.

We have talked in the corporate corruption debate about accountability. We have said corporate officials should be held accountable for their conduct. The same is true of people in the practice of medicine. They should be held accountable, too. If they are guilty of wrongdoing, injuring innocent people, then they should be held accountable.

Unfortunately, the McConnell amendment goes too far and takes away accountability. It is certainly the type of an amendment which insurance companies are happy to see. It reduces their ultimate exposure, but what it does is close and limit the courthouse doors for ordinary people who have become victims.

To give one illustration from my State: A young woman in April of 1989 went into a hospital for treatment for breast cancer. The doctor inserted a 16 centimeter-long catheter in her vein in her upper chest. After her chemotherapy was completed, the catheter was supposed to be removed. In July of the following year, the doctor removed the catheter, but he did not take it all. In December 1991, over 2 years after her initial treatment, she went in for an X-ray and discovered that 9 centimeters of this catheter was lodged in her heart, causing pain, causing her discomfort all of the time.

Ultimately, the doctors decided it was too risky to engage in surgery to remove the fragment, and so they decided to let the catheter piece remain lodged inside her heart. She will live with that foreign object inside her for as long as she lives. The doctor's mistake will be a pain that she feels every moment for the rest of her life.

Under Senator MCCONNELL's amendment, there is a serious question as to whether or not she could have ever brought the lawsuit. Did she wait too long? It took more than 2 years to discover this situation. She would have to fight, under the McConnell amendment, to prove that this was a reasonable amount of time, that the pain should not have alerted her sooner.

Secondly, the amendment limits the attorney's fees. If this woman goes to consult an attorney and says, ''I am in pain; the doctor did something wrong; I

have the X-ray,'' Senator MCCONNELL would say her attorney cannot be paid more than a limited amount on contingency fees to go to the courthouse. Is that reasonable?

Fortunately, those provisions in the McConnell amendment did not apply and this lady went to court. She ultimately was awarded $1.5 million for pain and suffering, and an additional $500,000 for the increased risk of future injury.

Sadly, there are cases such as this that happen every day in America. The vast majority of doctors in our Nation are conscientious, hard-working, wonderful people, but mistakes are made. Sometimes they are tragic, sometimes they show gross negligence, and sometimes they are intentional, such as the removal of the wrong kidney when they leave a cancerous kidney in a person and remove the wrong one. What Senator MCCONNELL is saying is that person who has been aggrieved and injured would be limited in their opportunity to recover.

I urge my colleagues to oppose this amendment.

Mr. LIEBERMAN. Mr. President, I rise to address the pending McConnell medical malpractice amendment. I have long agreed with my colleague from Kentucky that our legal system needs reforming, and I have joined him in supporting a bill in many ways similar to this amendment in the past. But I cannot support him today, because I do not believe that this prescription drug debate is either the right time or the right place to address the medical malpractice issue.

The Senate has been debating the critical and urgent issue of how to provide seniors with prescription drug coverage for 2 weeks. As my colleagues know, we are having a very hard time finding common ground on the issue. The last thing we need now is to inject into this debate a highly controversial issue which we all know for a certainty will prevent us from ever fulfilling our goal of giving seniors the prescription drug benefits they need. We should be focused on debating and passing a prescription drug bill, not other issues. For that reason, I will vote to table this amendment.

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

Who yields time?

The Senator from Kentucky.

Mr. MCCONNELL. Madam President, I will address several of the myths that have been stated during the course of this debate. Myth No. 1 is that average medical malpractice premiums in California are higher than they are in States that have not enacted medical malpractice reform.

Obviously, that statement is absurd on its face. The fact is, the opponents of my amendment cited numbers from the Medical Liability Monitor arrived at by some playing of games with the numbers to prove a predetermined result. The editor of that publication, the Medical Liability Monitor, takes issue with the manner in which the other side has fudged the numbers. She states unequivocally that: We do not believe an average premium exists, nor do we attempt to produce such a spurious number. She concludes in her letter to Senator FRIST: I find it particularly offensive, especially when I have spent my entire career pursuing objectivity, honesty, and balance in everything I produce.

She also noted in a recent National Journal article that insurers in California hold the lines fairly well because they have tort reform in place.

Myth No. 2: Medical malpractice premiums are not a burden on health care costs. It has been said on the other side, they account for only .6 percent of all health care costs—so it is said.

First, the studies cited by my Democratic friends do not take into account large segments of the medical malpractice community. Moreover, a 1996 study by two Stanford economists found that commonsense medical malpractice reforms, many of which are included in my amendment, could reduce health care costs by 5 to 9 percent without jeopardizing quality of care. Using this study, the Department of Health and Human Services projected that reducing the practice of defensive medicine would save Federal taxpayers between $23 and $42 billion.

Myth No. 3: It has been stated that companies have to raise premiums because they lost money on bad investments such as Enron. The fact is, the American Academy of Actuaries states insurers typically invest the vast majority of premiums in fixed income investments, not stocks. They also state that insurers do not set rates to recoup investment losses.

It has been suggested that somehow the door to the courthouse will be closed because there is a reasonable cap on attorneys' fees, which of course would guarantee that the victim got more of the money and the lawyer a little bit less—but certainly not enough to make them unwilling to take cases.

My friend from Illinois says contingency fees are the poor man's ticket to the courthouse. Apparently our trial lawyer friends will only punch the ticket if they can get more than a third of their clients' awards. My amendment limits the lawyer's fee to 33 percent of the award up to $150,000 and 25 percent above $150,000. So the suggestion is being made that if the lawyers do not get more than a third of the money involved, they somehow will not represent the injured victim.

One of our colleagues on the other side in a previous life got an award of $27 million, as the Washington Post reported. Under my formula, he would have gotten only $6.75 million, plus costs. I don't think that is much of a disincentive to represent an injured victim.

Mr. KYL. Will the Senator yield for a request?

Mr. MCCONNELL. I yield.

Mr. KYL. Directly on this point, I learned in law school sometimes it is hard for people to get a lawyer to take their case if they do not have a very good case. Lawyers charge a higher and higher and higher contingency case. But if the case was a pretty good case, back when I was in law school, contingency fees were pretty low.

As I understand your amendment, limiting the contingency fee to one-third of what is recovered is a pretty high contingency fee. Under the Federal Tort Claims Act, since the late 1940s, the limit has been 25 percent, and there has been no dearth of cases. It is actually higher than we already have under the Federal Tort Claims Act.

Continuing this line of thought, if you have a good case, then the contingency fee tends to be lower. The worse the case is—the less likelihood of succeeding—generally, the higher the contingency fees.

What would you say to the argument that we have to have no limit on the contingency fees or cases will not be taken?

Mr. MCCONNELL. I say to my friend from Arizona there is no evidence that there are not lawyers willing to take the cases. What this underlying amendment is about is protecting the victim and giving the victim more of the money and giving the lawyer a little bit less without taking away any incentive.

Statistics indicate the poor victims, on the whole, get about 48 percent of the money; 52 percent goes to the lawyers and the costs and the courts. This is a pro-victim amendment that benefits these injured parties over whom many have expressed so much concern.

Mr. KYL. One final question: Your amendment in no way limits the amount that the individual can recover in economic damages, or pain and suffering damages, at all, but it would put at least an upper limit of one-third on a contingency fee that the lawyers could charge for that plaintiff or victim?

Mr. MCCONNELL. My amendment would cap attorneys' fees at 33 percent of the first $150,000 awarded and 25 percent of the award above $150,000.

Mr. KYL. I think the amendment is an excellent amendment in support of victims, and therefore I am very pleased to support it.

Mr. MCCONNELL. I thank my friend from Arizona very much.

This is a national problem that affects States all across the country. It has been caused by the failure of the National Government to act. The Federal Government is the single biggest purchaser of medical services. It buys $400 billion in medical services each year. The purchase and delivery of medical services substantially affects interstate commerce. Patients and doctors routinely cross State lines. Parties buy medical services from doctors and hospitals in other jurisdictions. And doctors and hospitals sell medical services to citizens from different

States. Indeed, our most famous hospitals, such as the Mayo Clinic, are known for this.

Does anyone deny this is a substantial commercial activity? Thus, there is a commerce clause and a spending clause basis for the Federal Government to act.

Regardless of the problem caused by our civil justice system, some of our colleagues will point the finger at anyone but big personal injury lawyers. No matter what the trial lawyers do, no matter what abuses they may commit, some colleagues absolutely refuse to admit that there are any abuses or excesses in our civil justice system. Some of our colleagues say they are for accountability and responsibility in helping average Americans. They say that is what the debate is all about on corporate governance and prescription drugs. But when it comes down to it, some of our colleagues are for accountability and responsibility and helping average people only when it does not affect the interests of big, wealthy, powerful trial lawyers. In short, they are about accountability for everyone but the personal injury bar.

Our friends who share that view will do anything that will impede big personal injury lawyers being able to run rampant through our legal system. We have seen them over the last few weeks. They will protect big, powerful trial lawyers over American victims of terrorism when it comes to punitive damages. We have seen that those colleagues will shield big, powerful trial lawyers from having to disclose basic information about their fees and costs to their clients. We have seen that some will not restrict big, powerful trial lawyers from ambulance chasing victims by reserving a respectful period of bereavement before soliciting business. And now we have seen those same folks urging the Senate not to help medical professionals by adopting the most modest of pro-victim reforms to our medical malpractice liability system. The AMA would like to go further than this amendment goes.

And now we've seen that my Democrat friends urging the Senate not to help medical professionals by adopting the most modest of pro-victim reforms to our medical malpractice liability system. Again, my amendment is provictim because it: doesn't limit pain and suffering one penny; ensure that the victims, not their lawyers, get most of the compensation; allows them to get punitive damages; and improves overall patient care by providing that half of a punitive damages award goes to improving medical standards and practices.

My colleagues: this is a chance to do something to help doctors, to help patients, to help our medical delivery system without capping by one nickel a patient's pain and suffering damages. The question, then, is whether you are going to vote with the trial lawyers or are you going to vote with the doctors and their patients.

If my Democrat friends are serious about doing something to improve the delivery of medical services, they'll break with the trial lawyers for a change and listen to the medical community and adopt my amendment—an amendment that has already passed the Senate once.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. KENNEDY. Madam President, we have 6½?

The PRESIDING OFFICER. Yes.

Mr. KENNEDY. I yield a minute and a half to the Senator from Delaware.

Mr. CARPER. I thank the Senator for yielding.

Mr. MCCONNELL. I ask that Senator ENZI be added as a cosponsor to the amendment.

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

Mr. CARPER. The Senator from Kentucky and I agree on a variety of issues that relate to what we are talking about. Tomorrow, the Senate Judiciary Committee holds hearings on class action reform. I think it is a situation that calls for a national or a Federal solution.

Many of us heard from our constituents around the country that we as a Congress need to do something to address asbestos reform legislation because there are a lot of folks who are being hurt from asbestosis and they are not getting anything out of it. Their damages are not being covered. Meanwhile a lot of people who are not sick, will never be sick, are diluting the money that should be going to people who really have asbestosis or diseases related to asbestos. Those are issues that I think cry out for a national solution.

The one we are talking about here today, medical malpractice, is a problem in a number of States—I will acknowledge that—but it is a problem that can be fixed in a number of States. Delaware is one of those States in which legislation is pending today to address this issue and where it is most appropriately addressed.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I yield myself the remaining time.

At a time when the American people are calling for greater corporate accountability, it is unbelievable that our Republican colleagues would bring to the floor an amendment which would do just the opposite. The McConnell amendment would allow the entire health care industry to avoid accountability for the care they provide.

The Amendment would deprive seriously injured patients of fair compensation. At virtually every stage of the legal process, the amendment systematically rewrites the rules of civil law to tip the balance in favor of defendants. It would arbitrarily shield health care providers and their insurance companies from basic responsibility for the harm they cause.

While those across the aisle like to talk about doctors, the real beneficiaries will be insurance companies. This amendment would enrich the insurance industry at the expense of the most seriously injured patients; men, women, and children whose entire lives have been devastated by medical neglect and corporate abuse.

This proposal would also shield HMOs that fail to provide needed care, nursing homes that neglect elderly patients, drug companies whose medicine has toxic side effects, and manufacturers of defective medical equipment.

It would drastically limit the financial responsibility of the entire health care industry to compensate injured patients for the harm they have suffered. When will the Republican Party start worrying about injured patients and stop trying to shield big business from the consequences of its wrongdoing? Less accountability will never lead to better health care.

Substandard medical care is a growing problem. The Agency for Healthcare Research and Quality at HHS found that the number of adverse effects from medical treatment has more than doubled in recent years, rising from 302,000 in 1993 to 710,000 in 2000. A Healthcare Research and Quality study also found that adverse effects of medical drugs have increased by more than 44 percent in recent years, rising from 657,000 in 1993 to 992,000 in 2000. A 1999 study, by the Institute of Medicine at the National Academy of Sciences determined that at least 44,000 patients, and perhaps as many as 98,000 patients, die in hospitals each year as a result of medical errors. That is more than die from auto accidents, breast cancer, or AIDS each year. Despite these alarming numbers, less than one-half of 1 percent of the nation's doctors face any serious sanctions from Medical Review Boards each year.

These statistics make clear that we need more accountability in the health care system, not less. In this era of managed care and cost controls, it is ludicrous to suggest that the major problem facing American health care is ''defensive medicine.'' The problem is *not* ''too much health care,'' it is ''too little'' quality health care.

The restrictions on compensation for seriously injured patients which the McConnell Amendment seeks to impose would 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. Malpractice premiums are not the cause of the high rate of medical inflation. Over the decade from 1988 to 1998, the cost of medical care rose 13 times faster than the cost of malpractice insurance. Did you get that? The cost of medical care rose 13 times faster than the cost of malpractice insurance.

The restrictions in this amendment are not only unfair to patients, they are also an ineffective way to control medical malpractice premiums. There

is scant evidence to support the claim that enacting malpractice limits will lower insurance rates. There is substantial evidence to the contrary. Malpractice premiums are no higher on average in the 27 States that do not place limitation on malpractice damages, than in the 23 States that do have such limits.

Do we understand that? The premiums are no higher where you do not have these kinds of limitations than in the States that do. And you know what that means. The doctors are paying the higher premiums. Who do you think is keeping the difference? The insurance companies. The insurance companies. They are the ones that are making out.

The evidence clearly demonstrates that placing arbitrary limitations on the malpractice damages does not benefit the doctors it purports to help. Their rates remain virtually the same. It only helps the insurance companies earn even larger profits.

The malpractice premiums are not affected by the imposition of the limits on recovery, so it stands to reason the availability of physicians does not differ between the States that have limits and the States that do not.

I will use the chart that shows the difference between the States that do have limits and those that do not.

Physicians In Patient Care: States without caps on damages, with 233 per 100,000 residents; the States with caps on damages, 223—virtually identical.

The point here, in summation, is accountability and responsibility in the whole area of the health care industry and the profits that are going to result if this amendment is successful. It will not mean better health care. It will mean, less attention to protecting patients all the way through the health care system.

It will mean larger profits. It will mean larger profits for an industry. It will mean less corporate responsibility. I hope this amendment will not be successful.

Since malpractice premiums are not effected by the imposition of limits on recovery, it stands to reason that the availability of physicians does not differ between states that have limits and states that do not. AMA data shows that there are 233 physicians per 100,000 residents in states that do not have medical malpractice limits and 223 physicians per 100,000 residents in states with limits. Looking at the particularly high cost specialty of obstetrics and gynecology, states without limits on damages have 29 OB/GYNs per 100,000 women while states with limits have 27.4 OB/GYNs per 100,000 women. Clearly there is no correlation.

If this amendment were to pass it, it would sacrifice fair compensation for injured patients in a vain attempt to reduce medical malpractice premiums. Doctors will not get the relief they are seeking. Only the insurance companies, which created the recent market instability, will benefit.

Even supporters of the industry acknowledge that enacting tort reform will not produce lower insurance premiums:

Victor Schwartz, the American Tort Reform Association's General Counsel, told Business Insurance,

. . . many tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'

Debra Ballen, Executive Vice-President of the American Insurance Association even released a statement earlier this year (March 13, 2002) acknowledging,

[T]he insurance industry never promised that tort reform would achieve specific premium savings . . ..

A National Association of Insurance Commissioners study shows that in 2000, the latest year for which data is available, total insurance industry profits as a percentage of premiums for medical malpractice insurance was nearly twice as high 13.6 percent as overall casualty and property insurance profits 7.9 percent. In fact, malpractice was a very lucrative line of insurance for the industry throughout the 1990s, averaging profits of 12 percent per year. Recent premium increases have been an attempt to maintain high profit margins despite sharply declining investment earnings.

Insurance industry practices are responsible for the sudden dramatic premium increases which have occurred in some states in recent months. The explanation for these premium spikes can be found not in legislative halls or in courtrooms, but in the boardrooms of the insurance companies themselves.

There have been substantial increases in recent months in a number of insurance lines, not just medical malpractice. In 2001, rates for small commercial accounts have gone up 21 percent, rates for mid-size commercial accounts have gone up 32 percent, and rates for large commercial accounts have gone up 36 percent. According to industry sources, auto insurance rates are projected to climb by 23 percent between 2000 and 2003, and homeowners insurance is projected to climb by 21 percent over the same period. These increases are attributable to general economic factors and industry practices, certainly not medical liability tort law.

Insurers make much of their money form investment income. During times when investments offer high profit, companies compete fiercely with one another for market share. They often do so by underpricing their plans and insuring poor risks. When investment income dries up because interest rates fall and the stock market declines, the insurance industry then attempts to increase its premiums and reduce its coverage. This is a familiar cycle which produces a manufactured crisis each time their investments turn downward.

One of the leading insurance industry analysts, Carol Brierly Golin, editor of Medical Liability Monitor, concluded:

As the economy enjoyed a magic carpet ride in the 1990s, insurers kept rates artificially low because they earned more money investing than by writing policies . . . The insurance companies wouldn't be in this position if they hadn't been so hungry for investment profits . . . (Dec. 19, 2001).

This analysis of why we are seeing a sudden spike in premiums was confirmed by a June 24, 2002 Wall Street Journal article describing what happened to the malpractice insurance industry during the 1990s.

Some of these carriers rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of shortsighted price slashing led to industry losses of nearly $3 billion last year.

I don't like to hear insurance-company executives say it's the tort [injury-law] system—it's self-inflicted, says Donald J. Zuk, chief executive of Scpie Holdings, Inc., a leading malpractice insurer in California . . .

The losses were exacerbated by carriers' declining investment returns. Some insurers had come to expect that big gains in the 1990s from their bond and stock portfolios would continue, industry officials say. When the bull market stalled in 2000, investment gains that had patched over inadequate premium rates disappeared.

Proponents of the McConnell amendment justify the extreme restrictions they would place on the rights of injured patients as necessary to control medical malpractice premiums. The real beneficiaries of the amendment would be the insurance industry, which would pocket the money it saved on claims. The insurance premiums which doctors pay would not significantly change. The real losers, of course, would be the most seriously injured patients, who were denied fair compensation for their life-altering injuries. I strongly urge my colleagues to reject this amendment.

The PRESIDING OFFICER. All time has expired.

The Senator from Nevada.

Mr. REID. Madam President, I move to table the McConnell amendment. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. NICKLES, I announce that the Senator from North Carolina (Mr. HELMS) is necessarily absent.

I further announce that if present and voting the Senator from North Carolina (Mr. HELMS) would vote ''no.''

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

The result was announced—yeas 57, nays 42, as follows:

The result was announced—yeas 57, nays 42, as follows:

[Rollcall Vote No. 197 Leg.]

YEAS—57

Akaka	Baucus	Biden
Allen	Bayh	Bingaman

Boxer	Feingold	Miller
Breaux	Feinstein	Murray
Byrd	Graham	Nelson (FL)
Cantwell	Harkin	Nelson (NE)
Carnahan	Hollings	Reed
Carper	Inouye	Reid
Cleland	Jeffords	Rockefeller
Clinton	Johnson	Sarbanes
Conrad	Kennedy	Schumer
Corzine	Kerry	Shelby
Crapo	Kohl	Smith (OR)
Daschle	Landrieu	Specter
Dayton	Leahy	Stabenow
Dodd	Levin	Thompson
Dorgan	Lieberman	Torricelli
Durbin	Lincoln	Wellstone
Edwards	Mikulski	Wyden

NAYS—42

Allard	Fitzgerald	Murkowski
Bennett	Frist	Nickles
Bond	Gramm	Roberts
Brownback	Grassley	Santorum
Bunning	Gregg	Sessions
Burns	Hagel	Smith (NH)
Campbell	Hatch	Snowe
Chafee	Hutchinson	Stevens
Cochran	Hutchison	Thomas
Collins	Inhofe	Thurmond
Craig	Kyl	Voinovich
DeWine	Lott	Warner
Domenici	Lugar	
Ensign	McCain	
Enzi	McConnell	

NOT VOTING—1

Helms

The motion was agreed to.

Mr. REID. Mr. President, I move to reconsider the vote.

Mr. DASCHLE. I move to lay that motion on the table.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. REID. 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. REID. Mr. President, the amendment that is going to be the subject of discussion this afternoon is being copied, and it takes a few minutes always to do that.

I ask unanimous consent that during that period of time, the Senator from California, Mrs. FEINSTEIN, be recognized to speak as in morning business for up to 15 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. GREGG. Reserving the right to object, is it my understanding the piece of legislation which increases spending by $400 billion over the next potentially 8 or 10 years is not available for us to read?

Mr. REID. I say to my friend, the amendment which is a step in the direction of helping senior citizens who need prescription drugs is available. It is just being copied. The Senator's floor staff asked for a copy of it, and Senator GRAHAM did not have an extra copy. It is hot off the press right here.

Mr. GREGG. It is good to know we are going to have a chance to take a look at this piece of legislation.

Do we expect to vote on this piece of legislation that is just hot off the press today that is a $400 billion expansion of the expenditure of the Federal Government over the next 10 years?

Mr. REID. I say to my friend, it is our purpose to allow the Senate to vote on a good prescription drug benefit for senior citizens, something that is long overdue and, as the Senator knows, in 1965 when we passed Medicare, there was not a prescription drug benefit. This will be a downpayment for that. Yes, we would like to vote on it today.

Mr. GREGG. I thank the Senator.

The PRESIDING OFFICER. Is there objection?

Mr. GREGG. I have no objection.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from California is recognized for 15 minutes.

The PRESIDING OFFICER. The Senator from California.

Mrs. FEINSTEIN. I thank the Chair.

(The remarks of Mrs. FEINSTEIN pertaining to the submission of S. Con. Res. 133 are located in today's RECORD under ''Statements on Submitted Resolutions.'')

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. REID. 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. REID. Mr. President, the next amendment to be offered is from the Senator from Nevada, Mr. REID. I have an amendment that we have worked on for a couple of years dealing with prescription drugs and allowing those people who have health insurance plans to have prescription drug benefits for contraceptives. I am not going to be able to do that because this legislation is, of course, winding down one way or the other. Everyone seems to have focused on a prescription drug benefit for Medicare. That does not take away from how important I believe my amendment is.

I am terribly disappointed, and I suggest there are advocacy groups all over America that are disappointed as they hear me say this. Members of my own staff are terribly disappointed because they have worked on this sometimes days at a time. We have been able to get little bits and pieces of it over the years.

Federal employees, for example, have a benefit that other people in the country do not have; that is, in their prescription drug plans, their health care, they can have contraceptives under the benefits of their plan. That should apply to everyone in America. We are not going to be able to do that today, and I am disappointed.

I am happy, though, to designate Senator GRAHAM to offer the amendment on which he has spent such an inordinate amount of time. Senator GRAHAM and I came to the Senate together. He was a very successful and popular Governor. It is said that he is probably the most popularly elected official to ever come from the State of Florida. Whether that is true or not, I do not know. I do know he is a great legislator. The work he has done on this amendment has been exemplary. There is not anyone who understands Medicare and the tax aspects of it better than the Senator from Florida. He has spent not hours, days, or weeks; he has spent months on this legislation. Always available to anyone who has a question, he explains it in detail so it is understandable.

I would only say that the people of Florida are well served by the work he has done, and I hope this amendment that he is going to offer would pass the Senate. It is something that not only the people of Florida need but the people of Nevada, Delaware, and our entire country need. It is not everything that I want, but it is certainly a giant step forward. So I, under the unanimous consent order that is now in effect, designate my spot to the Senator from Florida.

The PRESIDING OFFICER. The Senator from Florida.

AMENDMENT NO. 4345 TO AMENDMENT NO. 4299, AS AMENDED

Mr. GRAHAM. I wish to express my appreciation for the graciousness of our colleague from Nevada for his very kind remarks. I share his sense of the importance of the debate we are about to begin. It is a debate which has been waiting for 37 years.

As history would have it, it was exactly 37 years ago today, July 30, 1965, President Lyndon B. Johnson signed the law that created the Medicare Program. President Johnson did not sign the legislation in Washington, but he went to Independence, MO, the home of an American who had spent much of his political career attempting to secure a health care benefit for older and poorer Americans, President Harry S Truman, and his wife Bess. He wanted them not only to be able to witness the signing of the Medicare legislation, but President Johnson then went the next step and gave to President Truman and his wife the first two Medicare cards.

President Truman had been fighting for decades for help for insurance for America's senior citizens, most of whom had been denied private insurance coverage because of preexisting conditions. In his remarks at the signing of the Medicare legislation, President Johnson declared: No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings they have so carefully put away over a lifetime, so they might enjoy dignity in their later years. No longer will young families see their own incomes, their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents and to their uncles and to their aunts. And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country.

There was one thing left out of the law President Johnson signed on that day 37 years ago. That was prescription drug coverage. Today, because prescription medications are so much more vital to health care in the 21st century and, frankly, because they are so expensive, we have the opportunity and the challenge to finish the job. Today we are poised to give this, the greatest generation, what they deserve. Today we can add a meaningful prescription drug benefit to the Medicare Program so that nearly 40 million older and disabled Americans who rely on Medicare are not choosing between medicines and the necessities of life.

In 1965, the average older American spent on prescriptions $65. That was not $65 a week or $65 a month but $65 for an entire year. What is happening today, July 30, 2002?

Today the average senior American spends $2,149 on prescription drugs each year. The average senior today has to worry about what will happen to his or her health and financial security if, like about 20 percent of Medicare beneficiaries today, his or her prescription drug needs escalate, grow to a level of $3,300 or greater.

The average senior today has to work because the options for prescription drug coverage are few and those that are available are withering.

Medigap coverage is expensive and generally is capped. Medicare+Choice coverage is available only to some, and it is almost totally unavailable in rural areas of America. Employer-funded retiree coverage has been shrinking dramatically over the last decade.

The Senate has been debating a Medicare prescription drug benefit for the past 2 weeks. It has been actively considering such a benefit for the past 6 years. In 2000, I was proud to vote for a comprehensive prescription drug benefit for all Medicare beneficiaries. It lost. In 2001, I introduced another version of a comprehensive, universal bill. It lost. With my friends and colleagues, Senators MILLER and KENNEDY, I introduced an amendment a week ago today in hopes of again providing a comprehensive, affordable prescription drug benefit for all seniors. This proposal gained 52 votes, a majority of the Senate, but we did not have the 60 votes necessary to prevail against the point of order.

What now? One thing we know, time is not our friend. It is certainly not America's seniors' friend. In another year, if we put this off from 2002 to 2003, the average senior will be spending $2,439 on drugs. If we wait 2 years, the average senior will be spending $3,059 on prescription drugs. In another year, the percentage of seniors spending more than $3,300 on drugs will not be the 20 percent today but will exceed 24 percent. By 2005, the number will have grown to about 35 percent of our seniors. In another year, Medigap coverage will be more expensive, fewer seniors will have access to Medicare+Choice, and fewer seniors will be covered by a previous employer's retiree program.

There is no basis for delay. Whatever we do, the time to act is now. I am offering a proposal, and I am joined by Senators GORDON SMITH—and I thank Senator SMITH for the great contribution he has made to the development of this proposal—ZELL MILLER, who has been a stalwart for months in this effort, and Senators LINCOLN, BINGAMAN, KENNEDY, and STABENOW. Together, we are offering this amendment which will make a significant difference in the lives, the health, and the financial security of our grandparents, our parents, our aunts and uncles, our neighbors, the people we love the most, who will be affected the most by this legislation.

The bipartisan Medicare Prescription Drug Costs Protection Act is estimated by the CBO to cost $390 billion over 10 years. It offers all seniors protection against catastrophic drug bills, and it provides special assistance for seniors with the lowest income.

What will this plan do? First, for a low annual fee of $25, this legislation will offer all seniors who decide to voluntarily enroll up to 30 percent discounts and Federal supplements on the drugs they purchase—a very substantial benefit. This will also bring to all seniors the peace of mind in knowing, if I should have that heart attack, if I should be diagnosed with cancer or diabetes or any of the perils of old age, I will have, once I have paid $3,300 out of my pocket, or in conjunction with a stated prescription drug benefit, beyond that, I will have my prescription drugs paid, with only a $10 copayment per prescription. That will give enormous peace of mind to our seniors who are fearful of that catastrophic health event that will drive them into economic poverty.

Moreover, this legislation will offer to those seniors who are the neediest, coverage for all of their costs. It will cover all seniors who are 200 percent, or lower, of poverty in their income. That means for an individual who earns less than $17,720, or a couple with an income of less than $23,880, all of their costs will be covered except for a copayment of $2 for each prescription which is generic, $5 for a brand name prescription.

According to some recent information submitted by the Urban Institute, in the year 2002, a 200 percent of poverty standard would represent 47 percent of the almost 40 million Medicare beneficiaries in the United States.

There is also an important consideration of the effect of this legislation on employers. Today, the largest segment of seniors who get some assistance with their prescription drugs, do so because a previous employer is providing that assistance. More people get assistance through that means than through a Medicare+Choice, HMO, or through a Medigap policy they have purchased. So it is very important that employers have a continuing commitment to participate in the health care costs of their retirees.

I am pleased, therefore, to State that the Congressional Budget Office predicts that no employer will drop existing coverage because of the benefit that is in this legislation. This is a very important assurance for seniors who are receiving assistance today.

I might say that competing plans have been evaluated by the Congressional Budget Office as causing up to one-third of the seniors who are currently receiving employer retiree benefits with their drug costs to lose those benefits.

Is this proposal the perfect Medicare prescription drug benefit? I must admit it is not. I had hoped we could provide a more comprehensive and more affordable drug benefit which would be universally applicable to all seniors. This proposal is a responsible step towards providing what seniors want and need. While providing assistance for all seniors, it targets the seniors who need help the most—the sickest and those with the lowest income.

There are always, here, voices for delay: Why do we need to do this on July 30? Why can't we wait? Why can't we wait until September? Or why can't we wait until next January? Why can't we put off the hard decisions?

If we wait until January of 2003, and if we start this process again in the next Congress, and if we go to the Congressional Budget Office and say, then: Here is the same plan that was introduced on July 30, 2002; please tell us what it is going to cost over the next 10 years—we have been told as of today it will cost $390 billion—the estimate is that same bill in January of 2003 will be given a 10-year cost of $470 billion.

Why? Why in the world would the same plan just 6 months later cost approximately $80 billion more over 10 years? The answer is, the perfect storm of economic circumstances. It is the convergence of, first, the fact that the cost of prescription drugs, including both inflationary cost of the drugs, plus increased utilization has been going up at a rate of approximately 18 percent every year. You just ask the people who buy substantial amounts of prescription drugs what their costs are today in comparison to what their costs were just 12 months ago. And the number of seniors who will be participating is increasing dramatically.

I was born in 1936. The year 1936 was the second lowest birth rate year in the 20th century in the United States. The reason? We were in the middle of a depression. Not very many families were adding to their size in 1936. So last November, when I reached 65, had I not been employed here in the Senate, I would have become a Medicare beneficiary. But you know what? I would not have had to have stood in a very long line to sign up because there are not a lot of people who became 65 in November of last year because there weren't very many people born in November of that year 65 years ago. But if

we wait another 10 years, we are going to be on the leading edge of one of the most significant bubbles of population in the history of the United States of America.

Today, we have 40 million Americans eligible for Medicare. Do you know how many Americans we are going to have eligible for Medicare in the year 2013? Fifty-one million. That is what is driving these costs. Every year that we delay, it becomes that much more expensive to initiate the program, to look at a 10-year window of how much this is going to cost. The time for the Senate to act is now.

If we act now, in July, we will have the full month of August to work with our colleagues in the House where a bill has already been passed, a bill that is substantially different than the one we will be considering in this amendment but one which I think is the basis of reasonable compromise.

Just a few hours ago the President signed corporate governance legislation. I know my good friend, Senator SMITH, was at the signing of that legislation. I commend him for his role in the creation and passage of that legislation. Many people thought that it was going to be impossible to reach agreement between a different House bill and a Senate bill. But, in fact, it was only a matter of a few days when serious, conscientious people came to such an understanding. I believe we can do the same thing with our conference with the House on this legislation, but we need to use the month of August as the time to begin to build that consensus towards a common piece of legislation.

There is no benefit in the cry for delay, delay, delay. We need every day that we can have to see that we arrive at a consensus that will lead the Congress to develop legislation which it can pass and the President can sign into law. We need to avoid adding yet another year of inflation and millions of additional seniors coming into the Medicare population, so we can pass this at today's price of $390 billion and not wait until next year when the same program is going to cost $470 billion.

This is the type of good-faith compromise that I hope will bring all parties together. It has the best chance of becoming the law of the land and providing to our grandparents and parents and all of our loved ones who depend upon Medicare this critical additional benefit.

In closing, I would like to remind all of you of something else that President Johnson said 37 years ago today when he signed the Medicare bill into law:

> Many men can make many proposals. Many men can draft many laws. But few have the piercing and humane eye which can see beyond the words to the people [those words] touch. Few can see past the speeches and the political battles to the doctor over there . . . trying to tend to the infirm; to the hospital that is receiving those in anguish, or feel in their heart the painful wrath at the injustice which denies the miracle of healing to the old and to the poor.

This debate is not about specific concepts. It is not about economics. It is not about public administration. This debate is about real people, people, as President Johnson said 37 years ago, who served this Nation with honor and dignity. The lives of almost 40 million of our fellow citizens are going to be impacted by the vote we are going to cast today. They are America.

On our behalf, I ask all our colleagues to support this legislation. On behalf of the cosponsors, I send to the desk the amendment and ask it be immediately considered. The sponsor's names are Senator SMITH of Oregon, Senator MILLER, Senator LINCOLN, Senator BINGAMAN, Senator KENNEDY, and Senator STABENOW.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Florida (Mr. GRAHAM), for himself, Mr. SMITH of Oregon, Mr. MILLER, Mrs. LINCOLN, Mr. BINGAMAN, Mr. KENNEDY, and Ms. STABENOW, proposes an amendment numbered 4345 to amendment No. 4299 as amended.

Mr. GRAHAM. I ask unanimous consent the reading of the amendment be dispensed with.

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

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. GRAHAM. Mr. President, I ask unanimous consent to have printed in the RECORD the preliminary Congressional Budget Office estimate of the proposal to establish an outpatient prescription drug benefit in Medicare.

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

PRELIMINARY CBO ESTIMATE OF GRAHAM-SMITH PROPOSAL TO ESTABLISH AN OUTPATIENT PRESCRIPTION DRUG BENEFIT IN MEDICARE

[In billions of dollars]

	2003–2012
As a stand-alone bill:	
Medicare	306.9
Refinancing	−126.8
Low-Income Subsidy	187.6
Other	22.0
Total	386.6
Prescription drug benefit after interaction with Edwards' generic-drug proposal:	
Medicare	302.3
Refinancing	−126.8
Low-Income Subsidy	184.7
Other	22.0
Total	382.1
Budgetary Effect of Combination of Graham-Smith and Edwards	
Direct Spending:	
Edwards' Generic Drugs	−5.9
Graham-Smith Medicare Drug Benefit	382.1
Total	376.2
Revenue, on-budget	1.5
Revenue, off-budget	0.7
Revenue, combined	2.2
Effect on Surplus:	
On-budget	374.7
Combined	374.0

CBO staff have not reviewed the legislative language of the Graham-Smith proposal. This preliminary estimate is subject to revision upon such review.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. SMITH of Oregon. Mr. President, I rise today to urge my colleagues on both sides of the aisle to support the Graham-Smith amendment. This is our best and perhaps our last opportunity to come together and actually pass a meaningful prescription drug benefit in the Senate this year. I admit that this is a difficult issue. It is a privilege to work on it, though, because I hear of no single issue more on the minds of the American people—particularly our senior citizens—than this issue. It is critical that we give them more than a war of words for yet another year—we must give them some results that work toward wellness rather than just rhetoric.

I know I have colleagues on the left who don't believe we are spending enough. I know I have colleagues on the right who do not like the delivery system that is provided in this bill. But I believe it is critical we clear the 60-vote hurdle because if we don't, the seniors will get nothing for yet another year. That I think is unacceptable.

We are running out of time. Seniors are running out of money to pay for their prescription drugs. They can't afford to wait another year for us to reach a compromise. We simply have to act now on a proposal Senator GRAHAM and I bring to the floor that is affordable for them and affordable for the Government.

I believe this is a focused plan that we all ought to support so we can at least keep this process going to get something to conference, so then we can get something to vote on in September, and so that our seniors can get the medicine they need.

To review this bill: First and foremost, it is voluntary and it is comprehensive. Our bill focuses on providing a comprehensive benefit to our neediest low-income seniors—people who are least able to pay for their prescription drugs. Those who are below 200 percent of the Federal poverty level will never have to choose between food and lifesaving drugs again.

I think that is a remarkable and significant proposal in itself. We voted on different iterations of that before. We are bringing it together again in this amendment.

The latest figures from the Urban Institute say 47 percent of our Nation's seniors live with incomes below 200 percent of poverty, which translates into $17,720 for individuals and $23,880 for couples. We don't have the money for us to do everything in the world, to enact a prescription drug benefit that covers every cost for everybody. But under our plan, low-income seniors receive the most help because they need the most help, and they need it today. But even they have a copay. Some will say it is too small. But it is, I believe, enough to at least get the attention of low-income seniors when you ask them to pay $2 for a generic drug prescription or $5 to get a branded product. I think that promotes good consumerism among our seniors.

Second, our proposal addresses the fear that millions of seniors feel every day—the fear that the loss of their

health will result in the loss of their home. Our bill will ensure that no senior, no matter what their income, will ever have to pay more than $3,300 per year in prescription drug costs. I think that is significant. Some will describe it as a doughnut; others will say it is a cliff.

But I will tell you that I believe seniors in this country appreciate that in this bill they will get a discounted price, a discount card, and those in combination may equal up to 30 percent of the cost of a prescription. Moreover, they get an insurance policy that says you don't have to lose your home if you lose your health because, as to your prescription drug costs, the Government will be there to make sure that doesn't happen. The Graham-Smith amendment will ensure that they don't have to spend themselves into poverty, but it does ask them to pay something in addition to the copay. Each American who voluntarily signs up for this bill will pay $25 per year. In terms of discounted prices, a discount card, and an insurance policy against catastrophic illness, $25 is a well priced policy.

Finally, with this, every senior can expect, as I indicated before, somewhere between 20 percent to 35 percent of the cost of each of their drugs to flow to them in a discount. That is because we are using the delivery system—as all Republicans, or nearly all the Republicans, already voted on—in the Hagel-Ensign bill.

The Graham-Smith amendment would allow all employer-sponsored plans, the Medicare supplemental plan, the Medicare+Choice plan, pharmaceutical benefit managers, PBMs, pharmacies, and even States working with private companies to compete to deliver the benefits. This market-based competition, which so many of my Republican colleagues have already supported, will generate lower prices for all of our seniors.

Another provision we took from the Hagel-Ensign bill—a provision that was critical if this was to win my support—which all of my colleagues on this side of the aisle have already supported, was the Hagel-Ensign formulary language.

When I first talked to Senator GRAHAM about this, I told him my reluctance to vote for his bill in the first instance was, in large measure, over the formulary issue because, as set out in the bill previously before us, it essentially took 90 percent of current prescription drugs available to seniors and said they are not available under this plan. So 10 percent of available drugs, in my view, is too restrictive.

While under the Hagel-Ensign language there is a formulary which is a part of this bill, we make no such restriction, but leave to the experts the ability to make a more liberal formulary plan that will serve the health needs of our seniors. We did not want to limit drug choices for seniors. I think this is an important part of this bill that ought to attract the support of many of my colleagues.

Americans across the country are asking for our help. There are Americans who cannot afford to wait one more year because we have been unwilling to compromise on a prescription drug plan. This is our last chance to keep this process moving forward. I need 60 votes, America needs 60 votes on this bill, because seniors deserve more than lip service from the Senate. They deserve a prescription drug benefit from the U.S. Government—and a process and a plan that build on what we already have at a cost we can afford, at a cost that allows seniors to be included, and in a way that seniors themselves can afford this plan as well.

It is critical that we do this now, so that during the August recess we stop the haggling over whether we have a bill in the Senate, but get something to conference so that we can work out with the House and the White House the kind of bill that ultimately will win the support and the hearts and the minds of the American people.

I say to all of my friends in this body—whether you are a Republican or Democrat, whether you like this bill or not—it is the last train leaving the station, in my view. It has enough in it that ought to attract your support because it keeps the train moving instead of derailing it, to the great disadvantage and harm of the senior citizens of this country.

I plead with you for your support. If we can get it up and get past 60 votes, we can make amendments. We can make improvements. Then we will get to the House of Representatives and a conference, and to the kind of product that ultimately can pass muster for the White House, the House, and all of us.

I thank you for the time. I plead with my colleagues: Don't lose this opportunity.

I ask for their votes and yield the floor.

The PRESIDING OFFICER (Mr. CORZINE). Who yields time?

Mr. GRAHAM. Mr. President, 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. DASCHLE. 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. DASCHLE. Mr. President, 37 years ago today President Lyndon Johnson traveled to Independence, MO, to the home of Harry Truman to sign Medicare into law. In signing the bill, LBJ said:

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they may enjoy dignity in their later years. . . .

No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, to their uncles, and their aunts.

Medicare, he stated, would provide light and hope to older Americans ''fearing the terrible darkness of despair and poverty.''

To a remarkable degree, Medicare has fulfilled that promise.

But today the high cost of prescription drugs, combined with seniors' increasing need for such drugs, is once again destroying the life savings and threatening dignity and security of millions of older Americans.

We have debated many important questions over the last 2 weeks, but the fundamental question facing us is, Are we willing to work together constructively to renew the promise of Medicare? Or will we refuse to help even the most hard-pressed seniors with prescription drugs?

We have considered three very different plans so far. The bill I supported, the Graham-Miller-Kennedy bill, was the only true Medicare prescription drug benefit among the three plans. It would have created a guaranteed Medicare prescription benefit for all seniors. It included reasonable premiums of $25 a month. It included affordable copays of $10 for generic prescriptions and $40 for brand name ones.

Our Senate Republican colleagues offered a very different plan, not a guaranteed Medicare benefit. It would have forced seniors into HMOs to get prescription drug coverage and given HMOs billions of dollars in taxpayer subsidies and seniors' premiums to entice them to offer seniors a prescription drug plan.

There were no guarantees. HMOs and insurance companies would decide who gets prescription drug coverage, what coverage is included, and how much it costs. The plan used accounting gimmicks to hide huge costs to seniors. A coverage gap meant millions of seniors would have no coverage at all over a period beyond a few hundred dollars, even if they continued paying premiums. A new $10 copay for home health visits was also required. But basically and fundamentally their premise was that HMOs could deliver prescription drug benefits and all health care better than Medicare.

Well, HMOs don't even exist for the most part in South Dakota and rural States. In areas where they do exist, HMOs have proven to be a poor fit with health needs of seniors. More and more HMOs are pulling out of Medicare+Choice. Many that are not leaving the program have dramatically cut benefits or increased premiums or both.

Two fundamentally different plans, one fundamental similarity: Neither plan got 60 votes. Our proposal, the Medicare benefit, got 52 votes, a majority of the Senate. Their plan to create pharmaceutical HMOs received 49 votes.

But still, we didn't give up. The Hagel-Ensign bill was offered, and for the first time Medicare would have linked seniors' benefits to their incomes, which was a major concession. The Hagel-Ensign bill did not get 60 votes either.

Now we are considering a fourth proposal, the Graham-Smith amendment. It is not the comprehensive coverage that Democrats all voted for, but it is an important first step. The Graham-Smith proposal offers real protection for every senior for just $25 a year. Let me emphasize, $25 a year. Seniors get up to a 30-percent discount on all prescriptions, coverage against catastrophic expenses over $3,300 a year. Low- and moderate-income seniors would receive extra help. The program would pay for all of their benefits for just a small copay on prescriptions of $2 for generic drugs and $5 for brand name drugs.

CBO predicts that the Graham-Smith proposal would result in few or no employers dropping retirees prescription coverage, versus an estimated one-third of seniors who would have lost benefits under the Republican plan.

I have to say that the two Senators responsible for this plan deserve a great deal of credit for their persistence, for their effort to come up, yet again, with another approach, with a recognition that perhaps there are those unwilling to spend more than about $400 billion in resources on a drug plan. They have come up with a way to address health benefits for all seniors, yet recognizing the limited resources we have to do so. I don't know that you could come up with a better framework than the one they have proposed.

I will say this: I met a woman in Mitchell, SD, a few weeks ago when I was home in Mitchell. Her name is Margaret McBrayer. She is 75 years old. She and her husband raised 11 children. Since 1956, she has had 21 surgeries, 3 aneurisms, and 1 stroke. She takes 11 prescriptions a day. Her average prescription costs are $814 a month, if she takes all brand names. If she uses generic brands, she can still spend $625 a month, two-thirds of her total monthly income.

Medicaid used to pay all but $2 per month per prescription. But this past February, Mrs. McBrayer lost her husband to bone cancer. She also lost her Medicaid coverage. As a widow, rather than half of a couple, her income is now too high for Medicaid—less than $12,000 a year, but too high for help.

So Margaret McBrayer is left to figure out how to pay for her own prescriptions. Her children help, but she is worried that they will end up spending all of their retirement savings on her prescription drugs, too.

Some doctors who know Margaret McBrayer call her ''the Miracle Woman'' because of all the health difficulties she has overcome, and the courage and dignity with which she has done it.

Fortunately, it doesn't require a miracle for us to help her—and Medicare's 40 million other beneficiaries—with the high cost of prescription drugs.

The reason LBJ traveled to Independence 37 years ago today to sign the Medicare bill was to honor Harry Truman—the man who had begun the fight for medical insurance for seniors 20 years earlier.

In his remarks that day, LBJ said Americans loved Harry Truman not because he gave 'em hell, but because he gave people hope.

We can walk away from this effort and give each other hell—blame each other for failure—or we can accept good-faith compromise and give the American people hope, and continue working to provide an affordable, reliable prescription benefit for all seniors. the choice is in our hands this afternoon.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, I rise to join my colleagues on both sides of the aisle in support of this very important downpayment on a comprehensive Medicare prescription drug benefit.

First, I commend my friend, the senior Senator from Florida, for his tremendous leadership on the comprehensive proposal that received 52 votes, as well as this proposal to move it forward in the right direction. He has been a stalwart. I commend Senator GRAHAM and his staff, who have worked very hard in pulling all this together. Also, I thank Senator SMITH of Oregon for his willingness to step forward in a bipartisan way and work with us to do what can be done.

As has been indicated, we had two competing proposals put forward last week, with very different philosophies—one with a private sector insurance company, HMO model; the other with a model to expand Medicare as we know it today. One, the Medicare expansion effort, received 52 votes. The other, private insurance, received 48 votes. Neither one had the 60 votes that are necessary to make this law and move it forward.

So we went back to the drawing board and, as is true in this great democracy of ours when you are not able to get exactly what you would like to see happen, you listen to people and you find a way to move forward, to take a step forward in the right direction.

That is what this amendment is. This is a downpayment on comprehensive coverage. It is a step in the right direction. It will lower prices for all of our seniors. Every person who is on Medicare will see the prices, the costs, of their prescription drugs going down. That is important.

I also mention that the underlying bill, and the efforts we have been using to add more competition, will lower prices for everyone, whether you are in business, a farmer, a worker, or part of a family struggling with prices. The goal is to bring down prices for everyone.

This amendment addresses specifically those on Medicare. It has been said that the promise was made 37 years ago today that we would provide for older Americans and the disabled universal health coverage; they would know that health insurance, health coverage, was there for them. Unfortunately, because the way we provide health care has changed, that promise has been eroded; so we are trying to fix that, trying to modernize Medicare so it covers the way health insurance is covered today.

This amendment begins that process. It says to those in the category of up to 200 percent of poverty—and in my home State of Michigan, that involves 46 percent of Michigan's beneficiaries who are on Medicare—46 percent of Michiganians on Medicare will find that, without a monthly premium, without a deductible, with a very small copay of $2, or up to $5, they can receive the prescription they need, the medicine they need. No longer will they have to choose between food and medicine and paying the rent or paying the electric bill.

So we have accomplished one goal in this amendment right off the bat, which is making sure that those with the greatest need are not having to choose between the daily necessities of life and getting their critical medicine.

We then said that for everybody else, we want to make sure we start this downpayment with a discount. That discount will fall somewhere between 20 and 30 percent of the cost of a prescription. That is a good discount to begin the process of lowering prices and creating the kinds of prescription drug coverage that people need and deserve.

Then we have said that, for a simple $25 annual fee—I might say, this is not per month, per week, it is just once a year for $25—you can become part of an insurance policy that says once your out-of-pocket costs equal $3,300 for your prescriptions, you will then be able to get your costs covered. There will be, I believe, a small copay involved. But we are talking about the ability for people to—with a minimum of $10—be able to get coverage for any prescription drugs above $3,300 out of pocket a year.

This is a major insurance policy. There are many seniors who are paying $400 or $500, and some are paying more. I have read stories from constituents paying $700 or $800 a month, who are literally selling their homes, losing their retirement, and are not able to get the medications they need for cancer, for heart conditions, for diabetes, for a variety of other serious ailments. For them, we are saying that you are not going to have to go through that. We will put in place a maximum amount that someone has to spend out of pocket, and, beyond that, they are going to have their prescription drugs

covered. That is very important for those who are the sickest in the country.

So we have addressed both of those aspects—those who are struggling to meet the daily needs of life, those who are the sickest and have the highest bills and are finding themselves in extremely difficult situations. We are also making sure that everyone is getting their prices lowered through substantial discounts.

We have also guaranteed there are no new State costs, and we have addressed a number of other issues raised by colleagues on both sides of the aisle. I simply say again that this is a critical day to get something done.

You know, there are those who have accused folks on both sides of the aisle of playing politics, of just wanting to have an issue, of not wanting to get things done. Well, if that were the case, the votes were taken last week, the issues have been laid out. If that were all this were about, we would have ended it. But we know that people expect more from us. They are tired of talk, tired of another election coming around, with everybody talking about the high prices of prescription drugs and the need to modernize Medicare and still nothing getting done.

So this is an effort on both sides of the aisle to bring people together and do what we can do, to do the achievable, make the downpayment, to take the first step.

I hope we do not lose this opportunity. I believe this is a very important day—in fact, a historic day—for all of us, and hopefully we are going to see colleagues wanting to come together and showing leadership on both sides of the aisle to make an important step forward to begin to modernize what has been a great American success story called Medicare.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, I am going to be very brief because Senator MIKULSKI and others wish to speak as well. I actually did not come with prepared remarks, but I do have a bit to say about my State of Minnesota. I will make one or two points and then thank some of my colleagues for their fine work.

There are 644,000 Minnesotans enrolled in Medicare. By the way, one of the reasons I am glad of what we are doing as part of the Medicare framework is that Medicare was an enormous step forward, not just for senior citizens but for our country. Senior citizens means we are talking about our parents or grandparents.

For my mother and father, who never made a lot of money, Medicare made an enormous difference. Both of them have passed away. Both had Parkinson's disease. My father had advanced Parkinson's disease. Medicare was a huge step forward.

A second factor, if you will, is the median income of senior citizens and the disabled enrolled in Medicare is $15,173 in Minnesota.

There is this stereotype about how you have all of these high-income senior citizens who are playing all the swank golf courses around the country. The fact of the matter is, the income profile of senior citizens is not that high. It certainly is not in my State. It certainly is not for the Medicare enrollees.

The impact of this amendment is 644,000 beneficiaries and 258,000 Minnesotans—that is 40 percent of the population—with incomes below 200 percent of poverty are going to be eligible and will receive all the needed drugs for nominal copayments. I do not have such intellectual distance from this issue that I think this is insignificant. That is important. That is very important.

Mr. President, 386,000 Medicare beneficiaries will be receiving the discount which could go from 20 to 30 percent. That is the estimate. Then finally, 119,000 senior citizens and disabled Medicare beneficiaries will benefit from the catastrophic coverage, and that is the catastrophic stop-loss protection.

Of course, it is an insurance policy that means a lot to people who worry: My God, we are going to go under because of catastrophic expenses.

I have two or three points to make. The first one is—and I hope Senator GRAHAM, Senator SMITH, and Senator LINCOLN, who have done so much work on this legislation, believe me—I would far prefer to have a broader, more inclusive piece of legislation. Senator STABENOW, who is leaving the Chamber, has also done tremendous work. I say to Senator STABENOW, I am sorry I did not mention her name from the go.

I would rather this legislation be much broader in scope of coverage, no question about it. We had a bill before us earlier, the Graham-Miller bill, on which we received 52 votes, but we did not get 60 votes. By the budget rules, we were not able to pass it.

We are trying to get 60 votes to pass legislation that will be a first installment. We have to do more. We have to have coverage of all recipients. It has to be broader coverage, and we know that. We are trying to make sure we get something done that is concrete and makes a positive difference in the lives of people. That is why we are here as legislators. That is what this effort is about. That is why it deserves 60 votes. That is my first point.

My second point is, if I have my way—I guess I get to say it once because I am not going to have my way with this proposal, and this would get not 60 votes, I say to Senator GRAHAM, but far fewer—I would have more cost containment so we could cover more people. I still believe—and I want to do a careful examination of how CBO makes some of its analyses—Health and Human Services ought to say to the pharmaceutical industry that has been making these huge what I call Viagra-like profits over the years: We represent 40 million Medicare recipients; we want a discount; we want the best price; we want what you give in Canada; we want the price you give to veterans.

We can get the prices down and cover a lot more people. Someday we are going to get to this whole question of cost containment because that is where this is heading ultimately.

My last point is, if you take this Graham-Smith initiative—and I thank all colleagues. I have been in some of the meetings. I cannot imagine the zillions of hours they have been in meetings. I have been in plenty of discussions.

If we add this to drug reimportation, albeit a little weakened on the floor of the Senate, and we add access to generic drugs, then we have this amendment and the Stabenow amendment that enables States to do better by way of Medicaid and by way of providing a discount for people who do not have any health insurance coverage at all for prescription drugs—if we put that package together, I would call this a significant first step. It is a first step only, but it is an important one. It makes a difference for people. Then we are going to have to build on it and do better in the future.

Last point—I promised that four points ago—I hope this gets 60 votes. I think it should. I think it is obviously an effort to stay under this $400 billion. That is another issue that drives me nuts. I am so glad I did not vote for these Robin-Hood-in-reverse tax cuts. They have eroded the revenue base and have made it impossible for us to make investments in education and health care. We are stuck now with this arbitrary number to keep it under $400 billion. We have done that.

We have tried to bring people together. We have tried to have a bipartisan initiative. We need 60 votes. I hope colleagues will vote for this so we can move forward. As for the naysaying—I am opposed; I do not like it; I do not want it—enough. Let's pass this and then improve it and then leave with legislation of which we can be proud as an important first step.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maryland.

Ms. MIKULSKI. I thank the Chair.

Mr. President, today I thought very long and hard making up my mind with respect to the legislation we are presently debating. I tell my colleagues that I am going to support the Graham-Stabenow plan.

The reason I am going to support this benefit is that it provides catastrophic coverage for those who have drug bills over $3,300 a year. For a $25 annual fee, it will provide catastrophic coverage for those who have prescription drug bills over $3,300 a year. This is absolutely essential to those seniors who have illnesses that cause them to pay this tremendous amount of money and who fear they could lose their life savings just to stay alive.

This benefit also provides a comprehensive benefit for seniors with meager incomes. For the middle class, it provides a discount, ranging from 20 to 30 percent, plus a 5-percent subsidy.

This bill has three parts to it: Catastrophic coverage, which I really like; help for those with meager incomes, which I think is a national necessity; and discounts for those in the middle class.

For those who worked very hard on this bill, I salute them. It is a beginning. It is the first step. It is a downpayment on a comprehensive drug coverage. But it cannot be the only step.

Today we are giving the middle-class seniors a discount card, but we cannot discount the middle class.

They are the ones who are going to get squeezed between shrinking savings and rising prescription costs, and they are the ones I will fight to help.

I think about ordinary Americans, those in manufacturing whose jobs are either on a fast track to Mexico or a slow boat to China, where they are afraid their companies, like my steelworkers, are going to go into bankruptcy and they are going to lose their pension, they are going to lose their health care. Then I think about the retail clerks who work in little shops, many of whom are in Baltimore, and in my little rural communities. Many of them work for 25 or 30 years, barely making the minimum wage, and though they had some savings, they are now just over the line in terms of qualifying for the benefit. Yet at the same time, we are going to give them a discount. I could go through example after example.

My preference was expressed last week when we voted for a universal Medicare coverage bill, one that was under Medicare, covered all seniors, no means testing, no deductibles, and modest copays. I supported that plan without reservation. We got 52 votes, a majority of the Senate, but we have a new Senate now, and the majority is not good enough. We now need to have a supermajority, or 60 votes, to waive the Budget Act. We did not get those last eight votes because some of my colleagues thought the benefit was too expensive to provide a universal prescription drug benefit.

Last year, many of those same colleagues who now say we do not have the wallet, were the first in line to pass excessive tax cuts. Those tax cuts went to the top 1 percent. Those who got it did not need it, and it certainly did not help the economy. When we were deliberating those tax bills last year, I knew this year would come. I knew we would come to the point where we would not have enough revenue to pass a prescription drug benefit.

I am really agitated about this because for many years, particularly working with President Bill Clinton, we exercised fiscal discipline. I personally worked for balanced budgets. I worked very hard to create a surplus, the first surpluses since the Johnson administration. Why did I work so hard? I mended old ways and old habits. Well, I worked because I knew it was going to be good for the economy and that also one day we would need it for a prescription drug coverage.

Instead, Congress gave the tax cut to the wealthiest, those who live off of expense accounts, while I worry about the middle class who have to live off a budget.

So we cannot afford it? I am not so sure about it because when we have the will, we often find the wallet. Today is not the day where we are going to be able to find that wallet. I believe with the catastrophic coverage for those with the situation over $3,300, we do take a very important step. I think the sensitivity to those meager incomes is what we in America should be all about.

For the middle class, we get them started, but we need to let them know we have to be able to do more.

The limited coverage bill that I am supporting today is not everything I wanted, but it does give seniors peace of mind that an illness with huge drug bills will not push them into financial ruin. For that $25 annual fee, there will be catastrophic coverage.

For some time, the whole issue of the consequences of health care has been an obsession of mine. I know the costs of long-term care. I know that when I came to this Senate the cost of nursing home care was enormously expensive, but to qualify for Government help under Medicaid families often had to push themselves into family bankruptcy, couples made out better if they divorced, or seniors were forced to spend down their savings to get help for nursing home care. Widows were impoverishing themselves so their husbands could qualify for Medicaid and nursing home care. I said then, as I say now, I believe in family and personal responsibility but not family bankruptcy because of the cruel rules of Government. The cruel rules of Government should not force people into family impoverishment.

When it came to long-term care, I wrote something called the Spousal Anti-Impoverishment Act. I made sure the senior could keep the home or the family farm and some savings to get help when a spouse was in a nursing home. That was a very important step. I hope we can do more.

Today, seniors are worried about going broke for their prescriptions. This limited coverage will help lift that fear and ease the burden of many seniors. For that catastrophic coverage alone, this bill is worth voting for.

In closing, later on this week the Senate will be voting on legislation to defend the homeland. It is called homeland security. But I ask, What does the ''homeland'' stand for and what are we trying to make secure?

I absolutely salute our military, law enforcement, and intelligence agencies that are working against terrorism, but I have senior citizens living in terror of whether they can afford their prescription drugs.

I believe not only in universal freedom, I believe in universal public education, and universal health care for seniors. If we want Americans to live free from fear, we need to take the fear away of losing their savings and not keeping up with the cost of prescription drugs. Today is a downpayment. We must do more. I intend to vote for this bill today and return to find other alternatives later.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arkansas.

Mrs. LINCOLN. Mr. President, I rise in support of this amendment, which I have been proud to promote over the last couple of weeks. I want to especially thank Senator BOB GRAHAM of Florida and Senator GORDON SMITH for their leadership in drafting this amendment. The hours and the patience that they have put into this is forthcoming in what we have been able to produce.

I also want to express my appreciation to Senator BINGAMAN for his guiding vision and the eloquence with which he first offered this proposal to our colleagues in meetings last week, and to Senator DEBBIE STABENOW. If we could harness the kind of energy, dedication, and commitment that Senator STABENOW has for our seniors in providing them a quality prescription drug benefit, we would certainly be doing our job for the benefit of the seniors in this country.

I also thank Senator FEINSTEIN who has been very instrumental in making sure that we do not adjourn without helping low-income seniors and those with the highest drug costs. This amendment is the product of many long hours of discussions among many of these Senators and so many others who bridge the spectrum of political philosophies in this body, and I believe that it represents the deliberative process envisioned by our forefathers for what the Senate was intended to do.

Through this debate, I have been firm in my conviction that we must help as many seniors as possible this year—not next year, not the year after, but this year. This amendment allows us to help everyone while providing the most help to the neediest and the sickest.

We have had two opportunities to vote on more expansive prescription drug packages, and I was pleased to support an amendment offered by Senators GRAHAM and MILLER that would have done far more for our seniors. Regrettably, that package did not garner the 60 votes needed to overcome a Senate procedural rule. So we stand today with a new opportunity that I believe offers the best hope for Arkansas seniors.

I have said all along we must help the neediest and the sickest of our seniors and provide drugs at a reduced cost for those in between. I am not willing to tell seniors, who spend more than $3,300 a year on drugs, that we

cannot help them this year. I am not willing to tell the seniors who struggle to live on less than $1,500 a month for their rent, groceries, utility, and health care costs that we cannot help them this year. So I am proud to support this amendment, which will ensure that seniors who are at or below 200 percent of the Federal poverty level will get prescription drugs through Medicare.

For all seniors who spend more than $3,300 a year on drugs, I want to be able to say to those seniors: Stop worrying. The Government will cover the rest of your prescription drug costs with a minimal copay.

What does this mean for the seniors of Arkansas? It means a great deal. Under this plan, one of every two seniors in Arkansas will have all of their prescription drug costs covered under Medicare with a minimal copayment. There will not be any additional paperwork as part of this program, and there will not be fees to enter the program. If you are on Medicare, you can be automatically enrolled in the prescription drug program. That should be welcome news for the 56 percent of Arkansas seniors whose annual income is below the 200 percent of poverty level.

For those individuals who have annual incomes above $17,720 and those couples whose income is over $23,880, there is also a benefit. In addition to the peace of mind that will come from knowing the Government will cover drug costs that exceed $3,300 a year, these seniors will also benefit from drug discounts negotiated by the Government and a 5-percent subsidy. Drug costs could be reduced by as much as 30 percent.

I wish we could do more for this group of seniors, and I publicly pledge to keep pushing until we have done so. Is it an ideal benefit? No, but it is a start. I have always said in this body that legislation is not a work of art; it is a work in progress. That is what this body was intended to do, to deliberate and work through these issues to come up with a solution.

Last week's votes were like a flashing neon sign declaring it is not possible to get a more generous drug benefit this year. A 5-percent subsidy negotiated drug discount and a catastrophic benefit for middle- and high-income seniors is better than no benefit at all, especially considering the ever increasing costs of prescription drugs, an issue we will have to address. We will have to continue to address the ever increasing costs of prescription drugs in the years to come and the cost of what it is going to mean to us and the seniors of this Nation.

We must also remember and never underestimate, with the out-of-pocket limit for all seniors in this proposal, we will be providing for the initiative to bring down the costs of employer-sponsored plans, as well as any supplemental plans, such as Medigap or others. That is a real savings and a benefit to all of these individuals who need prescription drug coverage.

I thank John and Betty Scroggins of Monticello, AR, who took the time over a series of phone calls with my staff to share their health care struggles. The Scroggins are now retired. They worked all of their lives driving trucks. After they pay their drug bill each month, they have less than $1,000 to cover utilities, groceries, and other living expenses. For John and Betty, under this plan, the Government will pay for all of their prescription drugs with a minimal copay.

I also thank Lila Lee Moore, a volunteer social worker at a health care clinic in Little Rock, who told me about a couple whose Social Security income is $1,100 a month but their drug costs exceed $800 a month.

I also send a very special thank you to 18-year-old Jessica Mann of Jonesboro, AR, who wrote asking me to help her grandparents who struggle just to make ends meet due to the high cost of medical care and prescription drug medicines.

Jessica said: I believe that when people such as my grandparents have worked hard their whole lives, they deserve a better and less worrisome time in their retirement years. They have given so much to make it better for my generation, please help us to make it better for theirs.

Each of these people have helped me form the template against which I have measured these prescription drug proposals. The amendment before the Senate helps meet these needs. We are talking about moving forward on behalf of the seniors of this Nation, not saying, once again, that we are going to put it off for another year or another day, but that we are bound and determined to do what we can to make each and every one of their lives a little bit better.

I urge my colleagues to support this amendment and help the Senate move forward in the efforts on behalf of the seniors of this Nation.

I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM. I thank my colleague and friend for his courtesy.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON of Florida. Mr. President, I am here to support my colleague from Florida and to thank him for his leadership, which has been bipartisan in nature. It reflects the bipartisan yearning and desire of the people of this country, and particularly of our State.

Most people understand that Florida has a higher percentage of those over age 65 than the rest of the country. That is true. But wherever you are, age 65 and older, there are seniors who are facing choices in the year 2002 that seniors should not have to face. The choice that many seniors have to face is: Do I buy groceries or do I buy medicine?

It is unimaginable to me that in this land of plenty, in this time of abundance, in this land of beneficence, in this land of great generosity, that we have among us, the generation that we owe so much to, our seniors, the generation that has built the strong economy upon which all now enjoy, the generation that has reestablished and secured the freedoms with which each of us participate in each day and sometimes takes for granted, it is unimaginable to me in the year 2002 that of that great generation there are those who would have to make a choice—because they cannot afford it—between buying groceries to eat and the medicine they need on a daily basis.

Why are we trying to do what we are trying to do? It is because Medicare was set up 37 years ago when health care was centered around acute care in hospitals. If Medicare had not been set up in 1965, but instead, if we were designing a system which would take care of senior citizens by designing a health insurance plan funded by the Federal Government for senior citizens, would we include prescription drugs? The answer is, obviously, yes, because prescription drugs are so much a part of our health care today, so much a part of our quality of life, so much a part of the miracles of modern medicine that give us a greater quality of life. So if that is how we would design it, and yet it was designed 37 years ago, should we not modernize that system? The answer to that is, obviously, yes.

Then it comes to a question of cost. And if the cost is such that we cannot get through this Senate because we have to operate with 60 out of 100 votes in order to pass anything, and we got to 52 votes with Senator GRAHAM's and Senator MILLER's amendment—that was a much more comprehensive plan than trying to find a plan that we can fashion, that we can get 60 votes to get it through this Chamber, this is what we have come up with. Some would say it has two prongs, but it really has three. There is the one that would take care of the most poor; i.e., it would take care of those up to 200 percent of the poverty level. They would have a fully funded Medicare prescription drug benefit. It would also take care of those the most sick. It would take care of the most poor and the most sick, the most sick being those stricken by a catastrophe, who have to spend a lot of money out of pocket. When they get to a certain level, a level in excess of $3,000 out of pocket, the Federal Government is going to take care of that, and, indeed, you are going to be able to buy that protection for $25 a year. That is called catastrophic coverage, and that is a pretty good deal.

There is a third element, or prong, to this amendment. Those who would detract from this amendment would say it doesn't take care of the middle class. It certainly doesn't take care of the middle class as much as the original amendment offered by Senators GRAHAM and MILLER, but of course that costs a lot of money. What does this do

for the middle class besides the catastrophic coverage for $25? It has a system in place that will have discounts up to 30 percent of the cost of those drugs, through a system designed to use bulk buying, plus an additional 5-percent reduction by virtue of a Federal subsidy.

So it takes care of the most needy—that is, the poorest—by taking care of those with incomes up to 200 percent of the poverty level. It takes care of the most sick—when we have a catastrophic illness—for $25 a year, for anything out of pocket over something just in excess of $3,000 per year it takes care of that. And for everybody else it clearly reduces the price, up to 30 percent plus another 5-percent subsidy.

That is not everything we want. That is not a total across-the-board prescription drug benefit under Medicare. But it is clearly a step in the right direction so we go about doing what we need to be doing: Modernizing Medicare that was set up 37 years ago.

That is why I rise to add my voice to the support for this amendment and encourage its adoption.

I yield the floor.

The PRESIDING OFFICER (Mr. MILLER). The Senator from Louisiana is recognized.

Mr. BREAUX. Mr. President, I rise to make a couple of comments—I will not be that long—on the pending business, prescription drugs. It was said before that this is sort of a unique day in the sense that this is the 37th anniversary of the signing of the Medicare Act back in 1965. What we did in 1965 was unique. It was very important. It was very special. What we did in 1965, with Medicare, was to say: We are going to establish a Medicare Program for our Nation's seniors that is going to be comprehensive. It is going to cover all seniors. It is going to be universal, in the sense that all seniors will be eligible for the same benefits under the Medicare Program. So we had a program that said to every senior: We are going to cover you. Regardless of where you live, regardless of your status in life, you are going to be covered for hospital care and other related conditions as well.

We should have, at that time, added prescription drugs. Congress did not. Prescription drugs were not as important in 1965 as a hospital bed was in 1965. So Congress, in its wisdom, at that time said we are going to provide comprehensive coverage for hospitals, and later on it became also coverage for doctors and physicians as well.

The unique feature about that bill is that it covered everybody and it treated everybody equally. I think when you look at a proposal we have before us today that says this program is going to be fundamentally changed. In the sense that it is no longer universal, it is no longer comprehensive, we are going to pick and choose who gets what, and different people who are eligible for Medicare will get different things—I think that is fundamentally breaking faith with the American people who, when they look at Medicare, think of it as being universal and comprehensive. That is the first mistake.

Many people who talked about the tripartisan bill—some of our colleagues on the floor, some in the private sector—said we don't like the tripartisan bill because it has a gap. They called it a doughnut. The gap in the tripartisan bill was between $3,450 worth of drug expenses and $3,700 of prescription drug expenses. If you were poor, you still got your drugs taken care of through that gap, but if you were not under 150 percent of poverty, you did not get coverage in that relatively small gap between $3,150 and $3,700. Why? Because of the extreme cost associated with covering even that small gap.

The point I made is that many people who were critical of the tripartisan bill said: You have a gap, so we can't support it. If we had a gap, this plan has a canyon, because it says to the Nation's seniors: If you are under 200 percent of poverty, we will cover your drugs, but if you make one dollar more, you are in a different category.

I think the figures I have seen indicate it is approximately $17,720 of income as an individual. I think is the number. But if you make one dollar more than 200 percent of poverty, you are in a totally different category, you are in a category that says you have to pay about 95 percent of the drug costs. Ninety-five percent of the drug costs? What kind of help are we giving to someone who makes one dollar above 200 percent of poverty?

One of the charts I saw said 70 percent of seniors are over 200 percent of poverty. Are we going to say to that group of seniors: Somehow you are going to be treated differently than anyone else the Government treats under Medicare because you make one dollar more than 200 percent of poverty? You are going to be required to pay 95 percent, and the Federal Government will pick up 5 percent of your drug costs? Is that fair? That is not what we did in 1965 when we said everybody would have comprehensive, universal coverage and access to a health care plan.

That is not an insignificant number of people you are talking about. I looked at some of the statistics with regard to how many people you are talking about. In my State—and my State is a poor State—it is about 230,000 people making over 200 percent of poverty. What am I going to tell the seniors in Louisiana: If you are poor, you are going to get all this help, but if you make one dollar more, excuse me, you are out of luck?

What are they going to say? They are going to say: I paid taxes all my life, I worked hard all my life, but now, for the first time under Medicare, you are going to treat me differently than anybody else? My State is a poor State, and 230,000 people would fit into that category of being outside of 200 percent of poverty.

Now I have the numbers. In the United States, nationwide—these are the numbers from the Kaiser Family Foundation—there are about 18,450,000 seniors who are eligible for Medicare who are outside the 200 percent of poverty—18 million people plus. We are telling those 18 million-plus seniors they are going to be treated quite differently when they are called upon to pay 95 percent coinsurance on their prescription drugs. Are we telling them that we are giving them something? We are not giving them what we are giving other parts of our society who are seniors. These are working people who have paid taxes and in their retirement think, if you are going to have a National Government program, they should be treated like everybody else.

The 200 percent of poverty is nice to talk about—how many people we are helping. But a substantial portion of the 200 percent under poverty are already covered with prescription drugs under the Medicaid Program. At about 75 percent of poverty, you have coverage under Medicare for prescription drugs already. They already have prescription drugs under the State Medicaid Program. If you are about 75 percent of poverty, in my State, you are covered for prescription drugs—the poorest of the poor.

So we are really saying: Between 75 percent of poverty and 200 percent of poverty, we are really going to give you a great deal of help. But if you are over 200 percent of poverty, you are out of luck.

They say we have a catastrophic plan. I am all for catastrophic coverage. It should be there. But let's be honest about how many people it covers.

If you look at $3,300 of catastrophic coverage where the Government picks up the lion's share of 90 percent—I take it, in their plan—of the cost of drugs after you reach the $3,300 out-of-pocket costs, how many people is that? I am told approximately 10 percent of the seniors are going to have actual out-of-pocket costs of $3,300 and above on an annual basis, not including insurance, not including a union package, not including a former employer's package, and not including any Medigap coverage they have.

If it has to be out of pocket $3,300, you are talking about approximately 10 percent of the remaining number of seniors. What do we have? We are spending almost $400 billion, and we are selectively saying some are going to get it, some are not going to get it, and some are going to get a little bit more.

The tripartisan bill had about $370 billion of Medicare reform, plus prescription drugs—$340 billion on prescription drugs. That was universal and comprehensive and at a $24-a-month premium. It had a $250 deductible and 50 percent coinsurance. Everybody was treated alike. Everybody would know what they were going to get and how they were going to get it.

Some say: We want a Government-run program. We want private insurance companies delivering prescription drugs.

What are we coming to? It is the exact same system that I have as a Member of the Senate and that 9 million other Federal employees have. Do you think we do not have a Government-run health program? Of course it is a Government-run program. It is run by the Office of Personnel Management—a Federal agency that goes out and solicits bids from private companies, such as Blue Cross and Aetna, to provide 9 million Federal workers with comprehensive, universal health coverage which includes doctors, hospitals, and, yes, it includes prescription drugs.

We are talking about saying that these providers who are big, healthy insurance companies ought to assume some risk. Why do we say that? Because if they are doing the providing and they make a bad deal, they should have to pick up the cost of making a bad deal. That is the risk. That is what makes them negotiate with pharmaceutical companies, to get the best possible deal from pharmaceuticals for prescription drugs at the best possible price.

If I am a pharmacy benefit manager—so-called PBM—and I have no risk other than my contract, why am I worried about what type of price I get for prescription drugs if I know the Government is going to eat the cost of anything over what I bid? There is no risk. If there is no risk, there is not going to be any incentive to go out and get the best possible deal on prescription drugs.

But to get back to the program that we have, some of my colleagues say we have to have a Government-run program. The Government-run program we have as Federal employees is exactly the same program we have recommended under the tripartisan approach. The Office of Health and Human Services' Medicare office would contract. They would do the approvals. They would supervise it. They would make sure it was being run properly. They would make sure no one was trying to scam it. And they would make sure that every part of the country had a competitive model to deliver drugs in their area.

Some have said: I am from a rural area. We are not going to have a lot of private companies coming to the most rural part of the country. We said: All right, we understand your concern. We will modify our bill. We will say that if there is a rural part of the country or any part of the country where you do not have private providers competing to bring prescription drugs to individuals at the best possible price—if that doesn't happen in your area—the Federal Government will do it just as under the Graham model. The Federal Government will contract with the PBM. They will have only the management fee at risk when they have that provision for those drugs. And in the most rural areas, you would be guaranteed a Government-run program just like in the Graham model, if you did not have the private system to be available because they just did not want to go to any part of the country.

As to the concerns that have been expressed about wanting a Government-run program, ours is a Government program that utilizes the best of what Government can do combined with the best of what the private sector can do.

Some on their side of the aisle may say we only need a private sector program. Some on my side of the aisle may say we need a Government-run program. The answer truly is somewhere in between. You need the best of what Government can do merged with the best of what the private sector can do in order to get a delivery system that would have Government oversight, Government supervision, and Government guarantees when the private sector does not participate to make sure the beneficiaries get the product. That is what the tripartisan bill attempted to do.

The final point I will make is that this fight is not over. This proposal, our tripartisan proposal, and the previous Graham proposal—none will have had 60 votes. The fact is that we are not going to be able to do anything unless we find a way to get 60 votes to provide prescription drugs. For the past several years, we have been giving seniors excuses. I daresay this time we are going to give them one more excuse.

The Republicans will say: It is the Democrats' fault that we didn't get this done. The Democrats will say: No. It is the Republicans' fault that we didn't get this done. What we will have given seniors once again is a bucket of excuses. They can't take those excuses to a drugstore and buy one prescription.

It is time that we as Members of Congress try to recognize we have to combine the best of ideas from both sides of the aisle and come up with an agreement that can get the job done. We are dedicated, and we will continue to work in that direction.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Mr. President, before the Senator from Louisiana leaves the floor, let me just say we have people on both sides of the aisle—especially on this side of the aisle—who look to him for guidance. He knows these numbers, having been a member of the Finance Committee as long as he has, and having served in Congress for as long as he has—both in the House and in the Senate. He does commendable work. His work on this legislation is no different.

Mr. President, the Republican leader is going to be here shortly, I am told.

How long does the Senator from New Mexico wish to speak?

Mr. BINGAMAN. About 6 minutes.

Mr. REID. When the Republican leader shows up, we certainly will——

Mr. GRASSLEY. Can't we go back and forth?

Mr. REID. I don't know. I guess whoever gets recognized. How much time is the Senator talking about?

Mr. GRASSLEY. About 7 minutes.

Mr. REID. Mr. President, I ask unanimous consent that the Senator from Iowa, the ranking member of the Finance Committee, be recognized for 7 minutes; following that, the Senator from New Mexico be recognized for 6 minutes; and following that, the Senator from Texas be recognized forever.

(Laughter.)

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

Mr. REID. I see my colleague from Nevada. I ask unanimous consent that he follow Senator GRAMM.

I ask for the courtesy of both Senator GRASSLEY and Senator BINGAMAN—that when the Republican leader appears, they allow us to move forward with an important unanimous consent agreement.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I rise to oppose the amendment before us. For the third time in as many weeks, a mostly partisan Democrat prescription drug bill is about to fail on this floor. And beyond failing here, today's amendment, from what I've heard of it, fails seniors and taxpayers as well. I still haven't seen the bill language itself. But from what I've heard, it fails seniors because it fails to cover most of them. From what we know of the proposal—and we are only this afternoon getting the details—most middle income seniors will get next to nothing when it comes to prescription drug coverage.

My friends on the other side of the aisle have accomplished quite a feat—they have managed to write a Medicare prescription drug proposal that does less with more money. Their proposal provides generous coverage to beneficiaries below 200 percent of poverty. There is nothing wrong with that. I agree that scarce resources should be used wisely by Congress to target money where it is needed the most.

However, their proposal provides almost no assistance to Medicare beneficiaries whose incomes exceed $18,952 a year. A senior at 201 percent of poverty will receive no meaningful coverage under the Graham proposal until she has spent 17 percent of her income on drugs. A married couple at 201 percent of poverty will spend 25 percent of their annual income on drugs before both gain catastrophic coverage protection. To make matters worse. Three-quarters of seniors above 200 percent of poverty have other prescription drug coverage. Since these plans cover some drug expenses, and because the Graham plan does not have a basic benefit, these folks will receive no help even if they have total drug expenses over $3,300. A typical senior above 200 percent of poverty will receive approximately $6 of assistance every month

toward their prescription drug expenses.

The Congressional Budget Office has given Graham a preliminary cost estimate of $389.5 billion. Keep in mind, though, that CBO did not have legislative language to review at the time they completed their cost estimate. So, depending on what legislative language is included in the Graham proposal—it could cost more than $400 billion.

The tripartisan bill with an official CBO cost estimate of $370 billion provides a solid benefit for all Medicare beneficiaries. Lower-income enrollees are provided with additional protections, which, as I said before, is appropriate.

What the tripartisan bill has that Graham does not is a significant drug benefit for every single Medicare enrollee. Under our 21st Century Medicare Act, enrollees will save on average 50 percent off their drug bills. And, lower-income enrollees will see a 95 percent savings in their drug bills.

The Graham bill fails these people. It fails them badly. Indeed, these failures amount to a massive failure for this body. Under Senator DASCHLE's leadership, Democrats and Democrats alone have tried to write partisan legislation on the Senate floor time and time again this summer.

That has gotten us nowhere. It has led to chaos, to partisanship and, as I said just a minute ago, to failure.

So, where are we now? It looks like we are ready for another mostly partisan vote on a pretty much partisan bill—another vote that will fail to get 60 votes, and will fail to give seniors the help they need.

We could have been somewhere far different from this. The House passed a bill. We could have been in conference with the House at this point. The President wants a bill. We could have been in the Rose Garden. Senator DASCHLE says he wants a bill, but what has taken place here over the last 3 weeks means he really wants something else: an issue.

Had regular order been followed, had the Finance Committee been given the right to work its bipartisan will, we could have had far more than just an issue. We could be far closer to providing real, affordable and universal prescription drug benefits than we are today. The sponsors of the Tripartisan bill, the only bipartisan bill in all of Washington to provide comprehensive, universal coverage on at a cost that is far lower than that in the amendment before us now, were ready and willing to talk to anyone about compromises. We still are.

But we were denied the right to a markup in the Finance Committee. I believe that if it had been given the chance to work its will, the Finance Committee would have reported out a bipartisan proposal, based on the tripartisan 21st century Medicare Act we introduced earlier this month.

I've said it before, everyone in this chamber knows that for anything of this magnitude to pass—and adding a prescription drug benefit to Medicare is the single greatest entitlement expansion in history—it needs to get 60 votes.

And everyone in this chamber knows that the only way to get 60 votes is to have bipartisan support. The proper place to find bipartisan support is in the Finance Committee, not on the Senate floor.

By bypassing the Finance Committee entirely and doing drafting on the floor—literally on the backs of envelopes—the Democrat leadership has led us to where we are today: In shambles.

Mr. President, I urge my colleagues to sweep up the shambles on the Senate floor and start over. We can and should do better.

I ask unanimous consent that a statement by several organizations be printed in the RECORD.

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

JULY 29, 2002.

THE GRAHAM-SMITH PROPOSAL: CHANGING THE NATURE OF MEDICARE IS NO WAY TO CELEBRATE THE 37TH ANNIVERSARY OF MEDICARE

To: Members of the United States Senate:

On June 14, 2002, our organizations sent a letter to Chairmen Tauzin and Thomas in support of their Medicare legislation. We were very clear when we gave our support that our goal was to ensure a voluntary prescription drug benefit which would be available to all Medicare beneficiaries.

The Graham-Smith low-income/catastrophic amendment provides complete drug benefits for only the very poor. The Washington Post reports that ''millions of seniors 'in the middle' would not qualify for any prescription drug benefits at all under the Graham-Smith legislation.'' In short, the middle class would, in fact, receive no meaningful coverage under the Graham-Smith amendment. This means test violates the fundamental principle of Medicare social insurance that it is a universal program, not an anti-poverty program. It is ironic that on the same day that America's senior celebrate the 37th anniversary of the enactment of Medicare (July 30, 1965), the United States Senate will be considering a proposal that takes us a very significant step away from the general entitlement that Medicare has always been.

The passage of such legislation would change the nature and intent of America's 37-year-old Medicare program. We respectfully ask you to oppose this amendment and enact meaningful prescription drug coverage which would give all Medicare beneficiaries access, coverage and choice.

American Osteopathic Association, Kidney Cancer Association, Cancer Research Institute, Pancreatic Cancer Action Network, Pulmonary Hypertension Association, Center for Patient Advocacy, Endocrinology Associates, National Coalition for Women with Heart Disease.

UNANIMOUS CONSENT AGREEMENT—S. 812

Mr. DASCHLE. Mr. President, I ask unanimous consent that notwithstanding the provisions of rule XXII, the Senate at 9:30 a.m. tomorrow resume consideration of S. 812; that there be 90 minutes for debate on the motion to waive the Budget Act with respect to Senator GRAHAM's amendment equally divided between Senator GRAHAM and Senator GRASSLEY; that if the motion to waive fails and the amendment falls, then the underlying Dorgan amendment be agreed to and the Senate vote immediately on cloture on the generic drug bill, S. 812; further that if cloture is invoked, the bill be read a third time and the Senate then vote immediately on final passage of the bill, with the preceding all occurring without any intervening action or debate.

The PRESIDING OFFICER. Is there objection?

Mr. GRAMM. Reserving the right to object, I suggest the absence of a quorum.

The PRESIDING OFFICER. The Senator does not have the floor.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DASCHLE. 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. DASCHLE. Mr. President, I again propound the request.

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

UNANIMOUS CONSENT AGREEMENT—EXECUTIVE CALENDAR

Mr. DASCHLE. Mr. President, as in executive session, I ask unanimous consent that later today when the Senate considers the nomination of D. Brooks Smith to be a U.S. circuit court judge, there be a time limitation for debate of 4 hours equally divided between the chairman and ranking member of the Judiciary Committee; that at the conclusion or yielding back of the time, the Senate return to legislative session; that following the vote on final passage of S. 812, the Senate return to executive session and vote on confirmation of the nomination; that the motion to reconsider be laid on the table; the President be immediately notified of the Senate's action; and the Senate return to legislative session; and that the preceding all occur without any intervening action or debate.

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

Mr. DASCHLE. Mr. President, it is also then my intention to invoke the authority given Senator LOTT and I last week with regard to DOD. It would be my intention to move immediately to the DOD appropriations bill, and we will seek a time agreement on that, perhaps sometime tomorrow morning. Let me thank all of our colleagues for their cooperation and I certainly thank the distinguished Republican leader.

Again, let me outline the schedule, as a result of these unanimous consent agreements, tonight and tomorrow.

We are now in a position to move shortly to the nomination of D. Brooks Smith. There is a 4-hour time agreement that has been allocated to that debate. We will then resume consideration of the Graham amendment tomorrow morning at 9:30. The debate will last an hour and a half. It is equally divided. There will be a vote on the Graham amendment, a vote on the Dorgan amendment, as amended, and a vote on final passage, to be followed by a vote then on the judicial nomination.

I would then move to the DOD appropriations bill, in consultation with the distinguished Republican leader. I should also note that it is my intention to call up the fast-track conference report, and we will, if necessary, file cloture on that motion as well.

Senators should be prepared, if necessary, to be on the floor to accommodate that desire as well.

I yield the floor.

The PRESIDING OFFICER. The Republican leader.

Mr. LOTT. Mr. President, for a couple of clarifications, first of all, with regard to the trade promotion authority, from what I believe the majority leader was saying, it would be his intent to call it up tonight and, if there is objection, you would file cloture on the trade promotion authority bill; is that correct?

Mr. DASCHLE. Mr. President, that is correct. I have been informed that there are those who will object, so it is unlikely that we would be able to complete our work on the trade promotion authority conference report tonight. Expecting that, I would intend then to file cloture on the conference report itself.

Mr. LOTT. Mr. President, continuing, I would like to get a clarification because I believe the Senator indicated that after the Dorgan amendment was agreed to, then the Senate would vote immediately on cloture on the underlying generic drug bill, and only if cloture is invoked would you then go to final passage. If cloture is defeated, of course, then that issue would still be pending.

Mr. DASCHLE. The Senator is correct. I anticipate that we would get cloture. If we don't, of course, we will stay on the bill for whatever length of time it takes and be unable to complete our schedule as it has been announced.

Obviously, cloture on the motion to proceed to a conference report is not necessary. This would actually be cloture on the conference report itself with regard to the trade promotion authority.

Mr. LOTT. Mr. President, for those who are following this, I emphasize that nobody has given up any position here or lost any rights. We are trying to set up a process so Senators would know what is going to be the business for the rest of the evening and what would be the sequence of votes tomorrow.

Tonight, we will have the debate on the nomination of D. Brooks Smith for the Sixth Circuit. I thank Senator DASCHLE for going forward with it. Time is required for the debate, and that can occur tonight. The vote will be tomorrow in the stacked sequence along with votes on the Graham-Smith alternative and then on cloture on the underlying bill.

Depending what happens, we would go to the Department of Defense appropriations bill, which we have made a commitment to complete this week. We will try to get a reasonable time agreement on that. We would have the trade bill following, too. This is a large agenda to accomplish. This agreement is to try to put into place when the votes will occur.

Mr. DASCHLE. Mr. President, again, the distinguished Republican leader is correct. Because the motion to proceed to the conference report on trade promotion authority is subject to a vote, I announce that that vote will take place at 6:15 this evening. That will be the last vote of the day.

We will accommodate Senators who have already expected to speak on the pending legislation, and the 6:15 vote will accommodate all Senators who have come to the floor with an expectation of being recognized.

I yield to the assistant Democratic leader.

Mr. REID. Is it the intention of the majority leader, when we complete that vote, that we would go to the judicial nomination at that time, and then the 4 hours will start on or about that time?

Mr. DASCHLE. The Senator is correct. We would start debate at approximately 6:45 on Mr. SMITH. Senators should be here. The debate will be completed tonight. It is a 4-hour debate. So Senators will have ample opportunity to come to the floor and express themselves. It must be done tonight. There will be no time tomorrow.

Mr. President, I ask unanimous consent that, within that 45-minute time block that has now been designated for debate prior to the vote at 6:15, Senator KENNEDY be accorded 10 minutes of that time.

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

The Senator from New Mexico is recognized.

Mr. BINGAMAN. Mr. President, we are well past the time when the 39 million older Americans and disabled citizens should be receiving affordable, comprehensive, and reliable prescription drug coverage. More tan 225,000 of these citizens live in New Mexico.

Medicare must be brought into the 21st century and that includes adding a prescription drug benefit. We must pay special attention to the needs of the most vulnerable—low-income seniors and people with disabilities. This is particularly important to New Mexico, where the median income of our senior citizens is just $11,370, or 15 percent below the national average.

Under the current system, an unconscionable number of these people are forced to choose every day between filling a doctor's prescription with limited incomes or paying for some other basic need.

As we consider the drug proposal before us, there are some important principles that I believe we should adopt.

The first principle should be that we ensure that the most vulnerable are protected. That includes the neediest, or poorest, the sickest, or those with the greatest health care needs. With the Federal Government now running significant deficits, we clearly have a limited amount of money and cannot ensure all senior Americans and disabled citizens will get everything they need, but we should be sure the most vulnerable are protected.

The second principle should be that we must use a delivery mechanism that is stable and that seniors can rely on. It must be a system that is accessible and not an untried or untested system. It must be a system that is reliable and stable and not one that potentially leaves seniors without prescription drug coverage or is in transition from year to year, as is often the case with the Medicare+Choice program now.

Before us is the Graham-Smith-Lincoln-Bingaman amendment that meets these principles. It has been a pleasure to work with all three of them on this compromise and others with a similar desire to provide the most help to the neediest and the sickest, including Senators CHAFEE, FEINSTEIN, and NELSON. This compromise offers the best hope for a prescription drug benefit this year and also compares well to the Grassley-Breaux amendment that received 48 votes in the Senate last week.

In comparing these plans to ensure that the principles of protecting the most vulnerable and to ensure that the proposal is stable and reliable, the Graham-Smith amendment is the only one that meets the two basics, but critical, principles I have outlined.

With regard to protecting the most vulnerable, the Graham-Smith amendment ensures that Medicare beneficiaries below 200 percent of poverty receive drug program assistance. This provides the 12.3 million low-income seniors, or over one-third of elderly beneficiaries, with some protections from rapidly increasing drug costs. In New Mexico, this protects over 100,000 low-income seniors, or 47 percent of elderly beneficiaries.

For these financial vulnerable seniors, they will receive a comprehensive benefit under the Graham-Smith amendment that would be questionable under Grassley-Breaux. Briefly, the Graham-Smith amendment provides coverage up to 200 percent of poverty; limits low-income out-of-pocket expenses to just $2 and $5 per prescription compared to up to $3700 for beneficiaries below 200 percent of poverty in the alternative plan; and, provides coverage for low-income elderly that is as comprehensive as state pharmacy assistance programs and without a drop in employer coverage, which again, is

in sharp contrast to Grassley-Breaux. That amendment provides more limited coverage than some elderly get through employer coverage or state pharmacy assistance programs.

It makes little sense to spend almost $400 billion and have a consequence that some elderly will receive drug coverage worse than they currently receive, but that would be the consequence of Grassley-Breaux. I appreciate all the hard work Senators GRASSLEY, BREAUX, JEFFORDS, SNOWE, and HATCH have put into their bill and I understand this aspect of their proposal is certainly an unintended consequence, but it is a consequence that CBO estimates will cause one-third of employer to drop retiree health coverage.

Of great significance, the Graham-Smith amendment eliminates the assets test in Grassley-Breaux, which bars low-income beneficiaries from having total assets of more than $4,000 a year. Own a car under that proposal and you will likely be denied financial protections otherwise.

According to the Kaiser Family Foundation, it is estimated that up to 40 percent of low-income elderly would not pass the assets test even if they are willing to undergo it. In New Mexico, coverage of low-income elderly in Graham-Smith is twice that of Grassley-Breaux—102,000 elderly covered to just 50,000.

In comparing the two proposals for those that are the sickest in society and have the most health care needs, Graham-Smith has a catastrophic limit of $3,300 out-of-pocket or 12 percent less than the $3,700 in the competing proposal.

How do the plans fare with respect to providing health and financial security for the elderly and disabled? Again, Graham-Smith is a stronger proposal.

The comparisons are stark. Graham-Smith requires a $25 annual fee compared to $288 per year or more under Grassley-Breaux.

Graham-Smith builds on the current employer and state-based systems and does not supplant employer coverage in stark contrast to the unintended drop of one-third of retirees from employer-sponsored plans in the alternative proposal.

Furthermore, the Grassley-Breaux amendment relies upon a virtually untried and untested system. For the full 37 years of the Medicare program, private insurance companies have had every opportunity to offer the elderly drug-only insurance plans. None have done so. This, my friends, is the definition of ''market failure'' and the very reason we have a Medicare program.

We have evidence of only one instance in which we have a drug-only, private insurance model and that was attempted by the State of Nevada. It is estimated that their current effort cost taxpayers almost 60 percent more through private insurance than if the State had run the program itself. Yet, this is the model the Grassley plan would require all 39 million Medicare beneficiaries to participate in.

This is clearly a risky proposition. Moreover, the proposal allows insurance companies to bid on an annual basis. Even if we can spend the billions of dollars necessary to induce private insurance companies to participate, we are not buying stability or reliability for the elderly. Bids would come in every year with plans coming and going, just as they do in the Medicare+Choice program.

A prescription drug benefit should provide the elderly some security and not place them in some kind of grand experiment. We should not experiment with the health of our Nation's seniors and disabled.

Furthermore, the Grassley-Breaux model allows insurance companies to charge whatever the market will bear. Beneficiary premium costs could be very high and vary by geographic area and vary by year-to-year.

To deal with the similarity with Medicare+Choice, whereby health plans often pull out and leave seniors without their health plan, the Grassley bill requires the Secretary to provide the plans with whatever inducement or incentives necessary to ensure that people have a choice of at least two plans.

The language reads:

> [T]he Administrator may provide financial incentives (including partial underwriting of risk) for an eligible entity to offer a Medicare Prescription Drug plan in that area. . . .

This could cost billions and billions of dollars without giving the elderly any assurance that the plans will be affordable.

For these reasons, I support the Graham-Miller amendment. It meets the principles of providing protections and security to our Nation's most vulnerable citizens through a system that is both reliable and stable. It is for these reasons that AARP and the National Council on Aging support Graham-Miller as well.

This amendment appears to offer us the final opportunity to pass prescription drug coverage for our Nation's elderly this year. To those that criticize it because it does not do enough for the middle class, I agree and point out this should be seen as a first step and down-payment on more comprehensive coverage for the Nations elderly and disabled.

However, if we do not take this first step, we are giving our Nation's seniors absolutely nothing. For those that voted for the Hagel-Ensign bill, I note that this proposal is very much like Hagel-Ensign in design, with a low-income benefit. Why is protecting the most financially vulnerable among our elderly objectionable?

I think this is a terrific compromise that takes aspects from both the Democratic and Republican proposals.

Mr. President, I believe the amendment Senators GRAHAM and SMITH have offered is a very good-faith effort to provide a genuine benefit to Medicare recipients. I am glad to support it. It is a product of a lot of discussion. Senator LINCOLN deserves substantial credit, as do Senator STABENOW, Senator FEINSTEIN, Senator CHAFEE, and Senator MILLER. A great many Senators have worked on this issue, in addition to Senators GRAHAM and SMITH, and I particularly appreciate their leadership.

Let me say that the need is enormous. I see it in my home State. Many of the most vulnerable in our society do have very difficult choices to make about whether to fill the prescriptions they are given by their doctors or to meet their other needs—pay their rent, pay their utilities, buy food for the family, whatever.

We need to solve that problem, and we need to do so in a way that makes sense for all the people who benefit from the Medicare Program.

There are some important principles that I think we need to keep in mind as we craft a Medicare prescription drug benefit.

The first principle: We need to ensure the most vulnerable are protected.

The second principle: We need to have a benefit for all Medicare beneficiaries, and I believe we are meeting both of those principles with this proposal.

The third obvious principle: We need to have a delivery mechanism that is stable and upon which seniors can rely. It needs to be an accessible system. It should not be something that is untried and untested so that we do not get into the same kind of mess we had with Medicare+Choice in my State, and I think in many States around the country. I believe this amendment meets those principles. I believe it is a great benefit to us.

Let me say briefly what the amendment does. I have a chart, which may be difficult for some to read, but let me go through it very briefly.

The estimated cost of the Graham-Smith compromise is in the range of $390 billion. I think that is a reasonable price for this kind of a very major benefit.

There is a benefit for all seniors. All seniors under the Medicare Program have a negotiated drug discount of something in the range of 30 percent, with a 5-percent Medicare payment and an additional discount added on to whatever discount can be negotiated through this program.

In addition to that, the seniors have catastrophic insurance coverage above $3,300. So if any Medicare beneficiary pays $3,300 out of pocket, after that, with a small copayment of not more than $10, they will have the Government cover the cost of any additional drugs needed that year.

There is a substantial benefit for low-income seniors. We are saying people with incomes of 200 percent of poverty or less are covered for all of their prescription drug needs, with a very small nominal $2 or $5 copayment, depending upon whether they purchase generic drugs or brand name drugs.

This proposal is designed so that no employer will drop coverage for those who are presently covered. That is a very important provision. This amendment is also designed so there are no additional costs added to the States. Many of our States are faced with real financial difficulties because of the economic downturn, and this is not a time to be adding additional cost to the States. We have guaranteed in this proposal that they not be given additional costs.

That is a summary of the amendment as it is drafted.

What does it mean for my State? It means that all the Medicare beneficiaries in my State, everyone over 65, does get this very substantial catastrophic benefit, as well as the discounts.

It also means that 47 percent of the senior Medicare beneficiaries in my State will fall into the category of 200 percent or less of poverty and will have all of their drug costs paid.

Obviously, the choice we have to make is a difficult choice. We can do what is possible. Politics is the art of the possible, and I think all of us who have served in public office know that politics is the art of the possible. Maybe the possible plus 10 percent, but it is not a whole lot more than that. We need to get 60 votes. We need to get a prescription drug benefit that is understandable, that is straightforward, that is an add-on to the Medicare Program, and that is what we have proposed.

We can do what is possible and adopt this amendment or we can take the approach that the perfect is the enemy of the good and that we are basically not going to go home with anything. We will continue to tell the senior citizens of our States that we were not able to come up with anything and give them excuses.

I hope very much the Senate will not take that latter course. I hope the Senate will embrace this amendment and move ahead so that we can, in fact, deliver a prescription drug benefit. The time is well passed for us to do this. I believe it is very important work that we need to get accomplish.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. GRAMM. I thank the Chair for the recognition. Mr. President, I hope people who are following this debate realize that we are having a debate about politics; that this is a debate about the next election; that this is hardly a debate about Medicare.

How extraordinary it is that we are here talking about an entitlement program that represents the largest single commitment of Federal spending in 37 years, one program that will cost in and of itself more than defending the national security of the United States. Yet no bill has ever been reported out of committee.

This was a process from beginning until end—and I hope we are approaching the end—that was designed to fail. It was designed to fail because we did not follow the normal procedure; we did not report a bill out of committee. We violated the budget. So, therefore, by not reporting a bill out of committee and by violating our own budget, it means that each of these proposals that are made have to get 60 votes.

We have already had one proposal that had we followed the regular order, the normal procedure of the Senate, would have already been adopted.

I have to note that basically what is going on is a political debate. One of the issues I find alarming about this debate is that it is obvious that some people believe the way to win the political debate is to spend money. I wish to remind my colleagues of a little history.

In 1999, we had a report of the Bipartisan Commission on the Future of Medicare. Senator BREAUX from Louisiana was the chairman. We had a clear majority of Members who were in favor of the recommendations for reform, but we had to have a supermajority of 11 Members to make a recommendation to the Congress and to the President.

That bill would have funded prescription drugs with the savings that we would have obtained by reforming Medicare. Until the last minute, it looked as if we would get the 11, but President Clinton had his four appointees all vote no.

When that happened, President Clinton held a press conference and released a program and said: If you would give me $168 billion, I can fund prescription drugs for American seniors. That was in 1999.

Then in the year 2000, the Senate debated a proposal, that Senator Robb was the sponsor of, that basically said if you will give us $242 billion, we can provide prescription drugs for America's seniors.

Then last year, Senator BAUCUS said we could fund a program that meets every need that the American people have, all the needs of our seniors, for just $311 billion.

Then when we wrote a budget, the Democrat proposal in the Budget Committee, which was never adopted by the Senate, and we were told—actually $168 billion, $242 billion, $311 billion—that is not enough, we need $500 billion. Then on the bill on which we did not waive the budget point of order last week, we were told that it would require $600 billion.

When we fill up the gaps, when we project out for 10 years, we have been seriously debating on the floor a proposal that would spend a trillion dollars, that has never been reported by any committee, that has never had a systematic consideration by a committee of the Senate, and that was designed from the beginning to fail.

I wish to conclude by making the following points: The proposal by Senator GRAHAM of Florida and Senator SMITH of Oregon that is before us, that we are going to vote on in the morning, is being sold as a catastrophic coverage proposal that is quite similar to a proposal that Senator HAGEL, Senator ENSIGN, and I offered that got over 50 votes.

I would like my colleagues to understand that this proposal is nothing like our proposal. It is better than the original Graham-Miller proposal, it is more affordable, but it is not the proposal that Senator HAGEL, Senator ENSIGN, and I made. Our proposal said that we can set up a simple program where every senior in America will be able to engage, through a private company, in buying pharmaceuticals competitively so that we can bring down the cost of pharmaceuticals between 20 and 40 percent for everybody.

Then we had a stop loss, a maximum out-of-pocket expenditure, that for moderate-income seniors was about $100 a month. They would be spending that $100 a month through these private companies that would be purchasing pharmaceuticals competitively, and they would be spending their own money and therefore would be cost conscious. When they reach that $100 a month and the Federal Government starts picking up the cost, they have already entered into a situation where they are buying pharmaceuticals competitively.

Secondly, we did not have the same stop loss for everybody. One of the reasons the bill before us costs $400 billion over 10 years and provides such little coverage is that Bill Gates has the same stop loss that my mother has. Ross Perot has the same stop loss that the poorest recipient of Medicare in America has. This is not at all like the Hagel-Ensign bill, where the stop loss was dependent on one's income.

I remind my colleagues that was an affordable proposal. It was the only proposal that we have voted on that was within our budget, for the simple reason that it put the money toward helping the people who needed the help the most.

The problem with all of these other proposals is that for every 10 people they help, 8 people do not need it. We are displacing massive amounts of private health insurance in the name of helping people who do not have health insurance. The advantage of the Hagel-Ensign proposal, the reason it was within budget and these other proposals are not, is that it put the focus of attention on helping people who fell into two categories. Either they had relatively low income and substantial drug bills, or they were moderate and upper income with astronomical drug bills. In either case, they got help. But if their drug bills are low relative to their income, they did not get help and, quite frankly, people who have incomes and retirement that run into the hundreds of thousands of dollars and have private health insurance are not the people in need. It is the people who do not have health insurance and who are having a very difficult time with

paying for their pharmaceuticals who need help.

I hope this amendment will be rejected. When we do not have enough unity of purpose to pass a bill out of the committee of jurisdiction, in this case the Finance Committee, we should not be engaged in a political exercise on the floor where we are literally committing ourselves to a trillion dollar expenditure over the next 10 years. We are talking about the largest commitment of money that this Nation has undertaken in 37 years, and yet there is no substantial bipartisan agreement. Every proposal is tailored to some political constituency. We are dealing with a process that was designed to fail by not reporting a bill out of committee, by not staying within budget and, therefore, having to get 60 votes. So my own opinion is that the sooner this charade ends, the better off America will be.

Let the record show there has been only one proposal that was within budget. There has been only one proposal that was fully funded by the budget and that was logically consistent, that encouraged efficiency and economy and met the needs of the people who need the help the most, and that was the Hagel-Ensign bill.

I urge my colleagues to reject the amendment that is currently pending before the Senate. We are going to vote tomorrow. It has a budget point of order. It is $100 billion above the budget. When we adopted this year's budget last year, we said we were going to spend up to $300 billion on providing prescription drug assistance. This amendment, by the most generous scoring that can be made, costs $400 billion. I urge my colleagues, do not waive the budget point of order, sustain the budget process, and reject this amendment.

I yield the floor.

The PRESIDING OFFICER (Ms. CANTWELL). Under the previous order, the Senator from Nevada is recognized.

Mr. ENSIGN. Madam President, I wish to talk about the Graham-Miller amendment for prescription drugs. First, I compliment the people who have been working on it. We think they are at least going in the right direction. They have adopted some of the parts of the bill that Senator HAGEL and I had proposed, but I believe there are some fundamental flaws in the amendment as currently drafted.

I was in a working group yesterday. I tried to point out some of these flaws, and I want to point those out on the floor because I think these are very important issues that we get fixed in any prescription drug bill that we eventually, hopefully, pass out of the Senate and someday get to the desk of the President.

In the Graham-Smith amendment, for the people above 200 percent of poverty, they use the catastrophic bill; they use basically what Senator HAGEL and I had talked about, where seniors pay out of pocket for the first x dollar figure and then above a certain dollar figure the Government would step in and take care of the costs.

The problem is in the category of people below 200 percent of poverty, they basically give them full coverage with very little expected of the senior—only $2 for generic drugs on a copay and $5 for name brand drugs. Those seniors in that income category are not going to be held accountable. That is not enough money out of pocket to affect their behavior, in my opinion. The reason they have to be held accountable for the behavior is because we do not want people abusing the system and taking drugs.

People say, well, these are prescription drugs. Why would anybody just get prescriptions? I happen to be a veterinarian by profession and have worked with people coming in with their pets. Talk to any pediatrician, any family practitioner in human medicine, it does not matter, they will tell you that people come to them, however they are feeling, if they are feeling ill, regardless of whether they need antibiotics, they expect them or they expect some kind of a prescription. With children in this country, we understand when their parents bring their kids to the doctor for an ear infection—almost all of those ear infections are caused by viruses.

Viruses do not respond to antibiotics, yet almost every time when somebody walks out of the doctor's office for their kids' ear infection, that child is put on antibiotics. It is one of the reasons we have so many drug-resistant secondary bacterial infections in ear infections—because we treat with antibiotics. The virus is there, it kills normal-growing bacteria, and you get a secondary bacterial infection, which is a reason that a lot of kids need to have tubes put in their ears, along with all kinds of other problems.

It is the same problem with a lot of seniors. If you are sick, you go to the doctor—you have a virus, whatever it is; you have a complaint, you expect to get better. A lot of times, physicians will prescribe medicine simply as a placebo effect. They know if I do not give this person something, they will go to another doctor. If the person is paying out of pocket, there is some incentive to ask the questions: Do I need these medications? Can I get a better price? Maybe I should buy the generic. The only difference between $2 and $5, generic versus brand name, is not necessarily that great incentive, but if they paid the first dollars out of their pocket, which is what our bill required, based on income—a sliding scale based on income—they would pay the first dollars out of pocket.

For instance, somebody who made around $15,000 to $17,000 a year under our bill would pay, on average, $100 to $120 a month out of pocket. After that, other than a small copay, the Government would pick up the costs. That person with diabetes, taking five or six different drugs, would have gotten the help they need without losing all of their assets. Right now, they get no help, and our bill would have given them the help.

Because we had some complaints about our bill—that if you make $1 more than $17,700 a year, you went from a maximum out-of-pocket expense of $1,500 to $3,500—we are trying to build more of a gradual scale into our bill so there will not be the dramatic dropoffs. We are also trying to put some of the money and give low-income seniors a little more help under our bill. We think we will be able to do this and still be within the $300 billion budget.

What is important about being in the $300 billion budget? The fact is, unless we are within $300 billion, we are violating the budget we set up. That is the reason it needs a 60-vote point of order. If our bill were reported out, if it were done properly, if we would take our bill, report our bill out of committee, and take all of the bills that have been voted on, report them out of committee, our bill is the only one that could become law because it is the only one that only would have needed 51 votes. Our bill got 51 votes.

The bill tomorrow that will be voted on, from what I understand, will only get 54 or 55 votes and therefore will not be able to waive the budget point of order.

If the majority leader would take our bill to the Finance Committee, let that bill be reported out of the Finance Committee, we actually could have this process go forward. Our bill, within the budget, would not need the 60 votes. It does not seem as though any proposal will get the necessary 60 votes. So let's work together, go through the process, through the Finance Committee, and report out a bill like this. We are willing to work with people on the numbers. As long as we can fit within the $300 billion budget number, we will not have to get the 60 votes and we can get a bill reported out of the Senate.

If we want to look at seniors this next year and say, we are really going to be helping you, I believe our proposal should get serious consideration from people. For those seniors who truly need the help, I don't believe we should look at them, especially with the November elections coming up, and say, sorry, politics got in the way again.

The Republicans are blaming Democrats, Democrats are blaming Republicans, and the bottom line is seniors are not getting the help they need. I truly believe we need to give the seniors some prescription drug benefit. However, I also believe we need to do it in a fiscally responsible way for the young people in the United States. If we do not do that, we will regret it in the future. Let's work together on this and pass a real prescription drug benefit that we can afford.

I yield the floor.

The PRESIDING OFFICER (Ms. CANTWELL). The Senator from Massachusetts.

Mr. KENNEDY. I understand I have 10 minutes. I yield myself 9 minutes.

I have had the opportunity to spend a good deal of time in the Senate over the past days and had the chance again this afternoon to listen to many colleagues describe what is before the Senate. I have listened to the recent comments of my friend from Texas, saying this is just all about politics, and others saying we cannot consider the proposal of Senator GRAHAM or Senator SMITH because of gaps and loopholes. I have heard a great deal of characterization of what is before the Senate.

What is before the Senate is an opportunity to make a very important downpayment for the seniors of this country, in a partial fulfillment of the promise we made to them in 1965 when we passed Medicare. That was a solemn pledge to the senior citizens of this country that said, play by the rules, pay into the system, and you will have health security when you retire.

That was the commitment. That is what everyone remembers. And I had the opportunity of being there. Our majority leaders, our minority leaders, those in support of that program made that commitment to the American people. They made it to the workers at that time and to the parents and to the grandparents of that time: Health security will be yours.

We all have an opportunity now to travel back to our hometowns and to listen to our seniors. Anyone who does that knows that we are failing that commitment every single day. Why? Because we provided hospitalization and we also provided physician services, but we have not provided prescription drugs. That is something we all understand. No one can say to our senior citizens: We have met our responsibility to you.

If we do not pass a good benefit package here, we are continuing to fail our senior citizens.

That may be described as politics to the Senator from Texas, and it can be described as $400 billion by the Senator from Nevada. Our proposal that provided the comprehensive care, where we got 52 votes and if we would have had 8 votes from our Republican friends, we would be on our way to conference this evening to try to guarantee that kind of protection. But no, we say we cannot do that. Then all afternoon, we had hearings about gaps in this proposal or that proposal. If you go from approximately $800 billion down to $400 billion, you are going to find out that you are not going to have the same benefit package. And if that is what you want on that side to agree to, we will agree to that. But I tell you something else we agree to: We make our commitment when we get this passed, and passed with the help of some courageous Republicans, we are not stopping there; we are coming back and we are going to complete the job. That is our commitment to the seniors tonight and tomorrow, that this is a downpayment. But it is only the beginning, no matter how concerned you are about why we are considering this legislation on the floor of the Senate.

I was here for 4 of the last 5 years when we could never get this bill out of the Finance Committee—buried, buried, buried by Republican leaders on the floor of the Senate and leaders on the Finance Committee. Finally, we have a courageous Democratic leader who puts this before the Senate.

Then we hear: Oh, no, we cannot consider that because that is politics. What was political was denying the ability for the Senate to consider this over the period of the last 4 years. Where have you been? Where have you been?

I can tell you where we are. I can tell you where BOB GRAHAM is, and Senator SMITH is, and that is here tomorrow and they are going to be saying: This is a downpayment. This doesn't do all the job. We all want to have a better benefit package, but we are denied that opportunity. We were denied that by the failure of the votes on that side; make no mistake about it.

Who are the people we are talking about? We are talking about, as has been described earlier in this debate—we are talking about the greatest generation, those who have fought in World War II, who have come back, and are now in their golden years. Those are the people we are talking about. That is what is at issue here. Are we going to meet our responsibility to men and women who fought in World War II, fought in the Korean war, some, perhaps, could even be qualified from the Vietnam war—men and women who brought the country out of the Depression, served, and built the Nation to the great Nation it is; and they need prescription drugs. And we are rattling around down here wondering how we gain political advantage. That is what is motivating those of us on this side, to meet that responsibility, Senator.

We heard the same arguments I heard when we were battling Medicare. I have read the history and we heard the same arguments when they were passing Social Security: We cannot do it. We should not do it. We can't make that kind of commitment. Medicare was the exact same thing: We can't afford it. It is socialized medicine. I haven't heard about socialized medicine out here since 1994 when we were debating a comprehensive health care program. I have not heard socialized medicine, but that is what we were talking about in the Medicare debate. They spared us that, but they still bring it up in opposition. And I don't question that because that side of the aisle was opposed to Medicare, and they were opposed to Social Security. Are we in any doubt they are opposed to this endeavor?

Tomorrow, make no mistake about it, this will be the key vote in terms of prescription drugs. I wish we were back to the time that we were considering the more comprehensive program that made sure we were going to attend to all the needs of our senior citizens, all of those needs. That is what we ought to be doing, but we cannot do it because we have been defeated on that. But we are not giving up. We are coming back again. We are making the commitment, if we are able and successful, to get this downpayment. It will make an important difference to the quality of lives for millions of our senior citizens.

Look what the CBO talks about. The program will reach almost half—49 percent of our neediest senior citizens, and for those above the $3,300—another 15 percent. If you add those together, it is virtually two-thirds of all of our seniors. We wish it were 100 percent, but they wouldn't give us the eight votes. This is two-thirds. It may not have all the benefits, let alone the other advantages in terms of the lower discount rates that will benefit those even in that third. But it is a sincere effort, the best effort that could be done over the period of these last 2 days, to try to continue this battle and continue the struggle.

That is what this is all about. We reject those who say this is not the time, this is not the place. I listened with great interest to those who were defending the program that was advanced earlier last week. That had a drug program for $330 billion, and they are trying to compare that to the one that was introduced by Senator GRAHAM, saying it was more comprehensive, it was more complete, it would provide our seniors with better services? Then why didn't the seniors support it? That is our simple answer. Why didn't the seniors support it? You couldn't get the support because it failed to do that.

We welcome the fact that the senior organizations support the Graham-Smith program. They supported our efforts a week ago when we were trying to get the comprehensive program. Over the period of these last days, they have looked the range of different options being proposed. These groups that represent seniors understand what is at risk and what opportunities lie before us now, and they are supporting our efforts to get this downpayment.

When we get this downpayment, that is what it will be. It will be a downpayment. We will hear voices continuing to harp on the other side that would really like to take even more hundreds of billions of dollars and give it to the wealthiest individuals in this country and reduce their taxes, but this is about making sure that we are going to walk the walk and give to our senior citizens that same kind of prescription drug program that my friend PHIL GRAMM has, right over here, in the well of the Senate. He has a comprehensive program. He pays about a 25-percent copay on his program. Every Member of the Senate has it.

Should we retreat on a commitment to try and do for the people of this

country what the Members of the Senate have already done for themselves? I say vote for the Graham proposal. We will make the commitment that this will be a downpayment and we will see the day when our senior citizens will be able to raise their heads high and know they will not have to fear when they hear from their doctors that they need prescription drugs in order to live a healthy and happy life.

I think the time has expired.

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

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

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

TRADE ACT OF 2002—CONFERENCE REPORT—MOTION TO PROCEED

Mr. REID. Madam President, I move to proceed to the conference report to accompany H.R. 3009, the Trade Act of 2002, and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. NICKLES. I announce that the Senator from North Carolina (Mr. HELMS) is necessarily absent.

I further announce that if present and voting the Senator from North Carolina (Mr. HELMS) would vote ''no''.

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

The result was announced—yeas 66, nays 33, as follows:

[Rollcall Vote No. 198 Leg.]

YEAS—66

Allard	Domenici	Landrieu
Allen	Edwards	Lieberman
Baucus	Enzi	Lincoln
Bayh	Feinstein	Lott
Bennett	Fitzgerald	Lugar
Biden	Frist	McCain
Bingaman	Graham	McConnell
Bond	Gramm	Miller
Breaux	Grassley	Murray
Brownback	Gregg	Nelson (FL)
Bunning	Hagel	Nelson (NE)
Burns	Hatch	Nickles
Cantwell	Hutchinson	Roberts
Carper	Hutchison	Santorum
Chafee	Inhofe	Smith (NH)
Cleland	Inouye	Smith (OR)
Cochran	Jeffords	Specter
Collins	Johnson	Thomas
Craig	Kennedy	Thompson
Crapo	Kerry	Voinovich
Daschle	Kohl	Warner
DeWine	Kyl	Wyden

NAYS—33

Akaka	Conrad	Ensign
Boxer	Corzine	Feingold
Byrd	Dayton	Harkin
Campbell	Dodd	Hollings
Carnahan	Dorgan	Leahy
Clinton	Durbin	Levin
Mikulski	Sarbanes	Stabenow
Murkowski	Schumer	Stevens
Reed	Sessions	Thurmond
Reid	Shelby	Torricelli
Rockefeller	Snowe	Wellstone

NOT VOTING—1

Helms

The motion was agreed to.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3009), to extend the Andean Trade Preference Act, to grant additional trade benefits under that Act, and for other purposes, having met, have agreed that the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment, signed by a majority of the conferees on the part of both Houses.

The PRESIDING OFFICER. The Senate will proceed to the consideration of the conference report.

(The report will be printed in the House proceedings of the RECORD)

The PRESIDING OFFICER. The majority leader.

CLOTURE MOTION

Mr. DASCHLE. Madam President, I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The assistant 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 the debate on the conference report to accompany H.R. 3009, the Andean Trade bill.

Harry Reid, Max Baucus, Dianne Feinstein, Ron Wyden, Robert G. Torricelli, John B. Breaux, Thomas A. Daschle, Thomas R. Carper, Blanche L. Lincoln, Zell Miller, Charles E. Grassley, Larry E. Craig, Phil Gramm, Jon Kyl, Frank H. Murkowski, Trent Lott.

The PRESIDING OFFICER. The majority leader.

EXECUTIVE SESSION

NOMINATION OF D. BROOKS SMITH TO BE UNITED STATES CIRCUIT JUDGE

Mr. DASCHLE. Madam President, I now ask that the Senate proceed to executive session, as provided under the previous order.

The PRESIDING OFFICER. The Senate will proceed to executive session, and the clerk will report the nomination.

The assistant legislative clerk read the nomination of D. Brooks Smith, of Pennsylvania, to be United States Circuit Judge for the Third Circuit.

The PRESIDING OFFICER. There are now 4 hours for debate, evenly divided between the chairman and ranking member.

The Senator from Pennsylvania.

Mr. SPECTER. Madam President, it is with considerable pride that I urge my colleagues to vote to confirm a very distinguished Federal judge, D. Brooks Smith, now Chief Judge of the Western District of Pennsylvania, whose nomination is now before the Senate for the Court of Appeals for the Third Circuit.

Judge Smith comes to this position with an outstanding academic background, having received his bachelor's degree from Franklin and Marshall College in 1973, his law degree from Dickinson Law School, and then engaged in the active practice of law for 8 years before becoming district attorney of Blair County, PA, a populous county whose county seat is Altoona.

He then became a judge of the Court of Common Pleas of Blair County in 1984, serving for 4 years until he became a judge for the United States District Court for the Western District of Pennsylvania where he is now the chief judge, and for now almost 14 years has had very distinguished service there.

I came to know Judge Smith when he appeared before the bipartisan nominating panel which had been established by Senator Heinz and myself, and I found him very well qualified and have known him on a continuing basis rather well over the course of the past 14 years. I have talked to him on many occasions and met with him on many occasions, discussing problems of the courts administratively, and issues that may come before the Judiciary Committee. He has been an outstanding jurist.

Judge Smith enjoys a unique reputation among all of the people who know him. During his confirmation hearings, large groups of people who knew him rallied to his defense and came forward to attest to his erudition, his scholarship, his good character, and his judicial temperament.

Certain issues have been raised which had delayed the confirmation. One involved a fishing club in which he was a member, but that club did not practice what is called invidious discrimination because it was a social club only. While in confirmation hearings for the district court, he had said he would resign from the club if they did not change their membership rules. It was later determined in 1992 in an opinion of precedential value that the club did not engage in invidious discrimination, so there was no reason for him to leave the club.

An issue arose on a case, where he presided for a relatively brief period of time, as to whether there should have been an earlier recusal. The matter was inquired into, investigated at length by former Gov. Dick Thornburgh and former Attorney General of the United States, and in an elaborate statement, he went through the case in detail and found, as I concluded as well, that the judge had made a timely recusal.

Some issues were also raised as to a speech which Judge Smith made on the Violence Against Women Act. He had concluded that there was not Federal jurisdiction for that particular statute.

I, frankly, disagreed with him about his conclusion on that, as lawyers are wont to do, even lawyers who become judges or lawyers who become Senators. In fact, the Supreme Court of the United States ultimately agreed with Judge Smith on the point.

I mention these issues in passing because I think they are not worth any more comment. The issues were considered at great length by the Judiciary Committee, and in a 12-to-7 vote, the Judiciary Committee recommended Judge Smith's confirmation.

As is well known, Judge Smith's nomination came before the Judiciary Committee at a time of considerable controversy involving the timing and the confirmation of nominees submitted by President Bush.

Senator BIDEN, Senator KOHL, and Senator EDWARDS all voted to confirm Judge Smith in an atmosphere where there was, to say the least, at least some element of partisanship.

I only mention those issues. I think they do not bear any more comment than I have given them.

When a man such as D. Brooks Smith undertakes public service in a Federal judgeship, I think it ought to be noted that there is a very considerable personal and financial sacrifice. I thank Judge Smith for serving on the Federal bench, and I thank all the Federal judges for serving on the Federal courts which are the pillars of justice and the pillars of our democratic society.

Judge Smith has undergone a difficult period in this confirmation process which has taken quite a considerable period of time. I compliment him for his steadfastness and for his determination in staying the course and in working through on this confirmation.

There is no doubt of Judge Smith's qualifications—his educational background, temperament, judicial experience, and experience being a district attorney. Judge Smith has a broad range of experience.

The Third Circuit is in desperate need of judges. They are in an emergency situation. I ask unanimous consent that a letter from Chief Judge Edward R. Becker be printed in the RECORD at the conclusion of my remarks.

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

(See exhibit 1)

Mr. SPECTER. I am confident, based on my personal knowledge of Judge Smith and his outstanding record, that he will be a credit to the Court of Appeals for the Third Circuit.

I thank my distinguished colleague from Utah and my distinguished colleague from Vermont for permitting me to speak at this time.

EXHIBIT 1

U.S. COURT OF APPEALS
FOR THE THIRD CIRCUIT,
Philadelphia, PA, July 15, 2002.

Hon. ARLEN SPECTER,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR SPECTER: Because the exercise of my responsibility to assure that efficient administration of justice for over 21 million Americans within the Third Judicial Circuit is being seriously impaired by the current impasse in the Senate over judicial nominations, I feel constrained to cry out. A total of eleven—yes eleven—judges within the Third Circuit, whose presence is desperately needed, would, I believe, have been confirmed and entered on duty but for the impasse.

Let me begin with the United States Court of Appeals for the Third Circuit. But for the impasse, Judge D. Brooks Smith would now be on my Court, which has three vacancies, two of them of long standing. I have scheduled him to sit in the early Fall, and we need him. We ''borrow'' judges in 45% of our cases, which is too much. But that situation pales in comparison with that of the District Court for the Western District of Pennsylvania. There are five vacant judgeships on that Court; as of September 30, 2002, these judgeships will have been vacant for a total of 161.7 months. If it were not for the impasse, the following judges would likely have entered on duty: Joy Flowers Conti, who I understand has resigned from her law firm partnership, anticipating a July swearing-in-date (and is now without income); David S. Cercone; Terrence F. McVerry; and Arthur J. Schwab. The Western District is in desperate straits. Motions are piling up, and trials are being delayed.

Other courts within the Third Circuit are similarly disadvantaged. Two nominees to the Middle District of Pennsylvania are awaiting floor votes: John E. Jones, III and Christopher C. Conner, both nominated to fill vacancies that are well over a year old. Two nominees to the Eastern District of Pennsylvania, one of the busiest courts in the nation, are also being held up: Timothy J. Savage and James Knoll Gardner. We also have problems in New Jersey where we have five vacancies. Stanley R. Chesler and William J. Martini are awaiting floor votes. There are also putative nominees for the other three vacancies: Jose Linares, Freda Wolfson, and Robert Kugler, whose progress is obviously being slowed by the impasse. Their presence is needed there to take up the slack caused by my assignment of Senior Judge Alfred Wolin, who had a full docket, to handle the mega-asbestos bankruptcy cases in Delaware, one of the nation's most important judicial assignments.

I have always respected the processes of the United States Senate. I came to the bench from politics, and understand the senatorial prerogatives. I have been tempted to speak out before, yet because of my background, held back. But the current impasse is too much even for me, hence this letter. As a judge of over three decades of experience on the federal bench, I understand the weighing and balancing process, and I believe that it is out of all proportion to the exercise of senatorial prerogative that these eleven nominees (and scores of others) be held up so long. I urge you to press my plea before your colleagues.

Sincerely yours,

EDWARD R. BECKER.

The PRESIDING OFFICER (Mr. DURBIN). The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I thank the Senator from Utah for yielding me some time, and I also thank the Senator from Vermont for allowing Senator SPECTER and I to speak first on this nominee.

I, too, like Senator SPECTER, am very proud tonight to praise the nomination of Brooks Smith to the Third Circuit Court of Appeals and to congratulate the President on an excellent nominee. I certainly urge all of my colleagues on both sides of the aisle to vote for his confirmation. I truly hope they look at his record of 17 years of judicial service and experience on both the Federal and State level.

He is someone of paramount integrity, someone who is obviously academically qualified, having been confirmed already as a Federal judge some 13 years ago. He has impeccable credentials academically and professionally prior to being a judge, and I think his service on both the trial court level and the common pleas court of Blair County, as well as on the Federal bench of the western district, now serving as chief judge of the western district, has been exemplary.

He is someone who has been a model judge, someone who has steered a course, as most people who have described his nomination, right down the center, someone who follows the law and is very steadfast to what the role of a judge is, which is not to go out and make law but simply to serve in the capacity of meting out justice in a fair and equitable way that meets the expectations of the litigants. He has been highly praised by everyone.

He has gotten a letter of support from almost the entire Pennsylvania congressional delegation, Democrats and Republicans alike. He has been rated well qualified by the ABA and highly recommended by the Allegheny County Bar Association, which is their highest rating. Allegheny County is the bar where the Western District of Pennsylvania is located. He has gotten support from every prior U.S. attorney from Jimmy Carter on through President Clinton's appointments to the U.S. attorney position in the western district. They have all come out in support of him.

His colleagues on the statewide bench from the supreme court, superior court, on down, have written letters of support, both Republicans and Democrats alike, for his nomination.

One of the most disturbing aspects of this nomination was what some on the far left-wing groups have done to try to impeach Judge Smith's integrity. Senator SPECTER reviewed the three things that have been brought up in a 17-year career. Probably the most outrageous of all of them is the fact that Judge Smith belonged—I know this might be shocking to some of my colleagues—to a sportsman club that only has male members. I know that none of my colleagues have ever heard of such a thing, but believe it or not most sportsman clubs in America, I would suggest, have limitations on memberships. If anyone is interested in the opposite, where sportsman clubs limit membership only to women, go to www.womensflyfishing.net, and they will find 60 organizations where only women are permitted to be members.

At this particular club, the Spruce Creek Rod and Gun Club, only men are allowed to be members, but women certainly are allowed on the premises and

allowed to use the facilities. They simply cannot be members of the club.

This club is a beautiful place. It is right in the heart of Pennsylvania. It has attracted many people from around the country because of its fabulous fly fishing. One such person who is an annual visitor, according to his own article on the subject, to this limited club is former President Jimmy Carter.

Former President Jimmy Carter goes to this club to which Judge Smith used to belong. When President Carter was President, my colleagues may recall the incident when the rabbit attacked his boat. That was somewhat of a famous incident during the Carter Presidency. That happened at the Spruce Creek Rod and Gun Club. This is purely a social organization.

When Judge Smith was before the Judiciary Committee, it was unclear whether he should continue to belong to such an organization. He was confirmed nonetheless. He promised at that time, when it was unclear whether that membership was unethical in some respects, that he would try to reverse the policy, and if he was unsuccessful he would resign. Subsequent to that, in 1992, the judicial code was changed and, as Senator SPECTER said, this kind of club does not fall into the ethical category of invidious. Therefore, as a result, he was not required under the judicial conduct code to resign.

Nevertheless, he tried for several years. Every year at their meetings, he would try to have women allowed to become members, but he failed. Eventually, I think after 9 or 10 years, he decided he would give up that quest and leave. This was some 5 years ago.

I understand there are a lot of women's groups that are complaining about this. To be candid, the complaint should be not that he resigned too late but that he is not still there trying to change it. That, to me, would be legitimate, to say he should have continued to stay there to try to get women as members. Instead, he gave up the fight, as some might suggest, and decided simply not to belong.

I think they have sort of missed the point, and the point is—this is ridiculous is really the point. The point that he belonged to this club has nothing to do with his ability to be a jurist. Probably the worst aspect of this whole thing is it brought up this tenor that somehow Judge Smith was anti-woman. Well, we had the president of the NOW organization in his home county, Blair County, former Democratic county commissioner, come to the Senate, to the LBJ room. She did a press conference talking about how Judge Smith, when he was a common pleas court judge, did more to help her in her role as county commissioner than anybody else she met in county government, and that he had an excellent record in regard to violence on women, and a variety of other things, as he did as a common pleas court judge.

Then later on, we heard from members of the women's bar association of western Pennsylvania going on at length about how Judge Smith was the best judge they had to deal with, who was the most respectful of women in the courtroom, most accepting of women in the courtroom.

This is the most frustrating part for the judge, and I know Senator SPECTER commented how difficult a process this has been for him, to be attacked for things that are so spurious and tangential to this whole process, and trying to then frame them for something that he has worked all his life to prove that he was not. It was really unfair.

Senator SPECTER went through the other two issues that have been highlighted. One is a case where he should have recused himself earlier. The trustee in the case, the former Attorney General and Governor, Richard Thornburgh, who said he would have been the aggrieved party in the case, as it turned out, said, no; that Judge Smith handled the case properly and forthrightly. The judge who eventually was assigned the case commented she would have handled the case in the precise manner Judge Smith handled the case. The Securities and Exchange Commission looked at this and stated Judge Smith did nothing improper.

There is absolutely nothing there when it comes to these ''improprieties'' of Judge Smith on the bench. This is reaching. This is trying to find a reason to oppose someone who has an impeccable record of service in the judicial community of western Pennsylvania, someone who has been outstanding in everything he has attempted. He is an incredibly well-qualified person for this position. He has done nothing but prove that his nomination for the Third Circuit is warranted.

I am very hopeful that my colleagues again on both sides of the aisle—and I thank Senator SPECTER, Senator EDWARDS, Senator KOHL, and Senator BIDEN for their support of this nominee in committee—will be joined by many others on the other side of the aisle to confirm, as the ABA said, a well-qualified, very solid candidate, for the Third Circuit Court of Appeals.

Mr. LEAHY. Mr. President, I yield myself such time as I may consume.

I ask consent that following me, the Presiding Officer recognize the senior Senator from Utah; at 7:50 this evening, without using time from either side, the senior Senator from New Jersey be recognized for 10 minutes; and then we revert back to whichever member of the Judiciary Committee sought recognition.

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

Mr. LEAHY. Mr. President, the Senate is debating the nomination of D. Brooks Smith to the United States Court of Appeals for the Third Circuit. This, incidentally, is the 13th circuit court nominee to be considered by the Senate since the change in Senate majority and reorganization of the Judiciary Committee fewer than 13 months ago. That is an average of one court of appeals judge a month since the Democratic majority has been in place. That does set a record.

We voted and confirmed three judges yesterday, one a circuit court of appeals judge. There are 10 other judicial nominees on the calendar. All have been approved on the Democratic side of the aisle. We have no objection to going forward with votes on them. I commend the Senator from South Dakota, the majority leader, Senator DASCHLE, who worked very hard to overcome the Republican objections so we can vote on President Bush's nominees to the judiciary.

We set a record on the number of courts of appeals nominees who have been given hearings and votes. We have moved forward, including confirming one yesterday, and we will vote on another circuit court nominee tomorrow. That will be 13 in less than 13 months, plus more than 60 other judicial nominees for whom we have held hearings or on whom we have already voted. This seat on the Third Circuit is another example of the different ways in which the Republican majority and Democratic majority have proceeded.

Today's debate is taking place in broad daylight. Under the Democratic majority, Judge Smith received a hearing less than 4 months after receipt of his ABA peer review. In contrast, Judge Cindrich was previously nominated for the same vacancy on the Third Circuit by President Clinton. He sat there for 10 months. You may wonder what happened at his hearing. He never got a hearing. You may wonder what happened on his vote. He never got a vote. He was never allowed a hearing; he was never allowed a vote. Four months after Judge Smith came up with his ABA papers, we had a hearing.

This is one of the many court of appeals vacancies for which President Clinton nominated qualified and moderate nominees but the Republican majority would not allow a vote—neither a hearing nor a committee vote. Bonnie Campbell, Allen Snyder, and so many others—I am sure they have not been treated as fairly as Judge Smith's nomination.

It is not enough to say some of the Republicans did not want those judicial nominees to be confirmed. I will vote against this nominee. I am the Chairman of the Committee. I could have refused to hold a hearing on Judge Smith. I could have refused to put his nomination on the calendar for a vote in our Committee. I did not. Even though, after the hearing, I made my up my mind to oppose this judge, I allowed the Committee to vote on his nomination and, if he got a majority vote in the Committee, allowed it to come to the Senate floor. That has always been the Democratic practice, and a practice that I follow.

Every Senator, Democrat and Republican, will vote his or her conscience

about the merits of Judge Smith's promotion to the appellate bench. I do not question the conscience of any Senator in doing that. While the course charted by the Democratic Senate to improve the process and hold judicial nominees is an honorable, difficult and time-consuming course, it is a road not taken in many instances by the Republicans in the recent past.

Some nominees, such as Judge Smith, are a portrait of contradiction. Those on the other side can extol his accomplishments and his popularity, but they omit his failings. They minimize his troubling record on ethical issues and his decisions as a judicial officer. Some, we heard tonight, may belittle the genuine concerns raised by many and shared by some Members of this Senate. I believe they are legitimate concerns.

As I said, I could have refused to allow him to have a hearing. I could have refused to allow him to have a vote in the Committee. I did not. I do have genuine concerns.

Some on the other side may try to castigate or caricature those who express opinions that are in opposition to the confirmation of a nominee. They may even choose to vilify those who dare to vote against a nominee who may be popular but who may be flawed in so many important respects. All of these contrasting views and accusations might cause an outside observer to wonder what exactly is the truth. The fundamental questions are whether this particular nominee should be confirmed, whether he should be promoted to a higher court, and whether his record of conduct on and off the bench warrants promotion. A lifetime appointment to review the decisions of other judges is not a right.

With the Supreme Court hearing fewer than 100 cases per year, it is the circuit courts that are really the courts of last resort for thousands of cases each year. These cases affect the Constitution, as well as statutes intended by Congress to protect the rights of all Americans; for example, the right to equal protection of the laws, the right to privacy, as well as the best opportunity to have clean air and clean water, not only for ourselves but for our future generations.

These courts are where Federal regulations will be upheld or overturned, where reproductive rights will be retained or lost, and where intrusive Government action will be allowed or curtailed. They are courts where thousands of individuals have their final appeal in matters affecting their financial future, their health, their lives, their liberty. I believe this record does not demonstrate that Judge D. Brooks Smith merits this promotion.

In saying this, I mean no disrespect to the senior Senator from Pennsylvania, Mr. SPECTER, who strongly supported the confirmation of this nominee, nor disrespect to the nominee who is well-liked by many. I genuinely mean no harm to Judge Smith, no matter how we vote tomorrow. He has a lifetime appointment and a lifetime salary as a Federal judge. It is fair to say, however, that this nominee's record is problematic in a number of ways. Among my many concerns is the fact that Judge Smith's action creates an appearance that is too often beholden to special interests. The Federal courts are supposed to be an independent judiciary that is not beholden to anyone—the left, the right, or any economic interests. An independent judiciary is the people's bulwark against the loss of their freedom and rights.

A number of judges and lawyers in Pennsylvania have written to the Senate to support Judge Smith's confirmation. A number of individuals and groups from Pennsylvania and elsewhere in the Third Circuit and throughout the country have written to the Senate, have called and e-mailed our office to express their deep concerns about this nomination.

We have heard from many Americans who are concerned about Judge Smith's record as a judge, including, incidentally, a resolution that was passed by the City Council of the City of Philadelphia. It was sent to us after the vote in the Judiciary Committee. It called for his nomination to be rejected.

I am going to put in the RECORD at the end of my statement this City Council resolution, as well as the opinions of two ethics professors.

I am disappointed that Judge Smith's record on and off the bench has resulted in this kind of controversy. As I reviewed his record as a judge, that record raised significant doubts in my mind as well.

The issue for me is whether Judge Smith's record justifies this promotion from the lifetime Federal judgeship he now holds to the higher lifetime Federal judgeship. In this case, it is to a court that is only one step below the Supreme Court. Appellate judges in the circuit courts write opinions that become law, affecting all of us, whether we live in Pennsylvania, Utah, Vermont, or Illinois. I do not believe Judge Smith's record justifies this promotion.

For one thing, he failed to keep his promise to resign from a discriminatory country club. Incidentally, that was not a promise that is something given in a political statement or to somebody in the press in response to an impromptu question. This was a promise Judge Smith made in a sworn statement before the Senate a few years ago. He belonged to a discriminatory club for more than a decade after he swore, after he took an oath, that he would quit if the rules were not changed to allow women to become members, in 1988.

He stood there, he raised his right hand, he swore to tell the truth, and he told us that he would resign if women were not admitted by 1989. He did resign from this Spruce Creek Rod and Gun Club in 1999, 10 years later.

What do you suppose was the thing that finally made him keep his word? A cynic would say that a vacancy had arisen on the court he wanted to be promoted to, and suddenly he thought: Wait a minute. I know I swore to resign by 1989—I had a lifetime judgeship and why do I have to resign from a club I like—but then suddenly, whoops, I might be promoted to even a higher Federal judgeship, maybe I better dust off that promise. I realize I am 10 years late, but better late than never.

I find that extremely troubling.

We had testimony by his supporters in letters that, well, the Spruce Creek is just a little fishing club, an itty-bitty fishing club of no consequence, kind of like a shack in the woods where a group of male friends might store their gear.

It is not exactly an itty-bitty club. This here is the itty-bitty club.

I have a little farmhouse in Vermont. My house probably would fit in the garage of this itty-bitty club. Look at this stately club. The Republicans may have missed one thing when they previously referred to this itty-bitty clubhouse, this inconsequential clubhouse as ''rustic.'' Maybe they didn't realize that, because it is such a stately and important place, it is on the National Registry of Historic Places.

I bet your home, Mr. Presiding Officer, is not on the National Registry of Historic Places. Mine is not on the National Registry of Historic Places. I will bet the senior Senator from Utah's home is not on the National Registry of Historic Places. But this little no-consequence, little tiny fishing club, the itty-bitty fishing club, is on such a prestigious list.

For nearly a century, this itty-bitty fishing club has been an exclusive recreational sportsmen's club that hosts its members and guests at its beautiful clubhouse. It has dining facilities. This itty-bitty clubhouse has fireplaces. It has bedrooms for overnight guests. It is not just a little bend in the road; it sits on hundreds of acres of prime real estate.

We can joke about it. It is obvious that Judge Smith and his supporters thought we would not actually go and find a picture of the club. I think they probably wish that we would not go back to his sworn testimony in which he promised to resign 10 years before he did. But let us be clear about what this is. The sports club—it does not make a difference whether the sport pursued is fishing or golfing. There are a number of women's fly fishing clubs attesting to the interest of women in that sport, and that is fine.

If men want to go off and go fly fishing themselves, that is fine. If women want to go off and go fly fishing, that is fine. But when they have facilities to conduct business and when businesspeople go there to conduct business and that is how you may be able to get ahead in the business world if you exclude women from it, if you say, women, if you want to be in business, you are not going to be able to

join the moguls of the business or legal community here, then it is exclusionary.

Women anglers who might have a fly fishing association could not walk into the Spruce Creek clubhouse. They could not fish in the stream called Spruce Creek that runs through the land owned by the club—unless a man, who is a member, condescended to invite them.

Frankly, it does not make any difference whether you exclude women or you exclude African Americans or you exclude people of particular religious faiths—it is still exclusion. That is why it is particularly troublesome that, when Judge Smith was up here the last time before the Senate seeking a lifetime appointment, he swore in sworn testimony to the Judiciary Committee and to the Senate of the United States that he would resign if he could not promptly get the club to change its exclusionary rules.

Judge Smith did not resign within a year, or 2 years, as he had sworn. In fact, he did not resign within the time that the ethical rules that he was sworn to uphold as a judge required. He did not resign until 10 years later and then only when a new position on a higher court for someone from Western Pennsylvania opened up and he hoped to be appointed to it.

There is no reasonable, logical explanation for why he waited for more than 10 years to follow through except that one: There is now a vacancy on a court that he wanted to go to, the Third Circuit from Western Pennsylvania. Claims that the ethical rules changed to allow his continued membership are groundless.

The reason I stress this is that we have judicial nominations hearings, and the distinguished Senator from Utah, the distinguished Senator from Illinois, we have all sat in these hearings. You ask for certain commitments from judicial nominees because once they are confirmed they have a lifetime position.

When a nominee comes before the Senate and makes a commitment, we must rely on his or her word to honor that the promise will be kept. With Federal judges that is especially true. Once confirmed, they have lifetime appointments. Impeachment is not a realistic way to enforce such commitments and, unlike Republicans in the House and Senate a few years ago, I have never suggested impeachment of Federal judges.

If we allow such a promise, whether it is about club membership or some other issue, to be so flagrantly broken with no consequence, then promises and assurances to the United States Senate will mean very little. I think that is a bad precedent. I think that is a bad message to send to future nominees to the courts and to the executive branch: just tell us what we want to hear and then ignore those commitments without any consequence.

I cannot think of another occasion in which a judicial nominee has promised to take specific actions and then been confirmed, after failing to keep his word. It is true that some judicial nominees have been confirmed after resigning from a discriminatory club, but none have ever been confirmed after telling the Senate that they would resign and then failing for years to do so. The closest analogy I recall is the failed nomination of Judge Kenneth Ryskamp to the 11th Circuit, because Judge Ryskamp was on notice that membership in discriminatory clubs was impermissible, but he continued his membership in a discriminatory club anyway.

As a district court nominee of President Reagan in 1986, Judge Ryskamp admitted that he was then a member of the University Club, which had a rule against allowing women as members, and the Riviera Club, which had no race-specific membership rules, but which in practice had no Jewish or African American members. During his 1986 hearing, Senator Simon asked Ryskamp if he thought he should resign from the University Club, and Ryskamp promised the Senate, ''I will resign from any club the Committee feels is inappropriate.'' In 1986, he was not asked specifically about the Riviera Club, which he later said he did not consider to be a discriminatory club. He subsequently resigned from the University Club, but not the Riviera Club.

During his nomination by the first President Bush to the Eleventh Circuit, Judge Ryskamp's two-decade long membership in the Riviera Club was questioned extensively. For example, Senator KENNEDY noted that the fact that the Senate had not specifically asked Judge Ryskamp to resign from the Riviera Club did not lessen his responsibility to follow the ethical rules anyway and resign. I recall that Judge Ryskamp told me that he resigned shortly before his confirmation hearing in March 1991 because his continued membership created the appearance of impropriety, not because, in his view, the Club discriminated. In April 1992, the motion to report favorably Judge Ryskamp's circuit nomination to the floor was defeated. The subsequent motion to send the nomination to the floor without recommendation also failed.

Unlike Judge Smith, Judge Ryskamp never promised to resign from the club at issue, although several Senators believed Judge Ryskamp should have done so following his first confirmation. I think it only reasonable that Judge Smith's conduct regarding his previous promise to the Senate would lead a reasonable person to doubt the sincerity of his assurances to the Senate this year in other areas, as well.

Breaking a promise to the Senate, or misleading the Senate into believing that certain action would be taken, is an independent yet unusually strong reason for the rejection of a judicial nominee. I do not think Judge Smith should be given a promotion after failing to keep his word to the Senate. If his statements to the Senate in 1988 were not promises, then he most assuredly misled the Senate into believing he was going to resign, and he did not do so within any period that can be considered reasonable. On this basis alone, I feel I must vote against Judge Smith's confirmation to the Third Circuit.

Spruce Creek invidiously discriminates against women. Prior to his nomination to be promoted to the Third Circuit, Judge Smith never informed the Senate that he did not have to keep his promise to the Senate. He acknowledged in both his 1988 and 2001 Senate Questionnaires that the Club violated the ethical rules against judges belonging to clubs that engage in invidious discrimination. In fact, when Judge Smith finally resigned from the Club in December of 1999, he told the Club's president that the Club's men-only membership rules ''continue to be at odds with current expectations of Federal judicial conduct.'' It is only now that questions have been raised about his very late resignation does he belatedly assert for the first time that the Club is ''purely social'' and so the rules against discriminatory club membership do not apply. The exception he seeks to create would swallow the rule. His statements on this point really give me pause with respect to how Judge Smith would follow the law as an appellate judge or whether he would seek to bend it to his personal purposes. Public officials should not have to be told, repeatedly, not to belong to clubs that discriminate.

We have received a letter from Professor Stephen Gillers, the Vice Dean of the New York University School of Law, observing that the ethical rules against discriminatory club membership do not apply to purely private social clubs that do not allow business or professional meetings. However, both Professor Gillers and Professor Monroe Friedman, a distinguished ethics scholar, have noted that if club members can or do sponsor events or meetings at the club that are business or professionally related then the club cannot be called purely private and the club's discrimination against membership for women is ''invidious'' within the meaning of the Code of Conduct's prohibitions. This is true even if women are allowed, by the men who belong to the club, to attend some or all business and professional meetings hosted by the club's members.

I understand that, in fact, Spruce Creek has always allowed members to host business and professional meetings at its facilities. We know that members have hosted business meetings and gatherings of their professional colleagues at the Club. The President of the Club, who has been a member for decades, told Senate staff that members can use Club facilities for any meetings or occasions they want, without any oversight, but he refused to discuss the specific ways the

Club is used by members for business meetings.

We also know that the Club's constitution and by-laws do not discourage the members from hosting business, professional or political meetings at the Club. Women, regardless of their standing in the community or in their profession, cannot invite their colleagues to Spruce Creek for business meetings because they are explicitly and intentionally excluded from membership.

Additionally, according to Professor Gillers, Judge Smith had an obligation to make sure that the Club maintained a purely social purpose, if he was going to claim that his membership was exempt from the ethical rules. He could not merely assume that it did. There is no ''don't ask, don't tell'' exception to the ethical rules. Given his previous assurances to the Senate and his own admissions up to and including his resignation in 1999, he can hardly assert that the Club is ''purely social'' now, as an after-the-fact justification for his conduct. He has made no showing in support of this belated contention.

Professor Gillers' view of this obligation to inquire is consistent with the guidance in the Judicial Conference's Compendium to the Code of Conduct for United States Judges. Judge Smith also did not follow the Compendium's advice regularly to re-evaluate club membership policies and practices. Judge Smith also did not seek an ethics opinion from his fellow Federal judges about whether the rules against discriminatory club membership somehow exempted this Club to which he so badly wanted to belong.

Judge Smith now says that he did not seek an ethics opinion because it was so clear to him that the ethics rules did not apply to this Club after amendments in 1992 that supposedly let him off the hook. This is another implausible and self-serving assertion. As Professor Gillers noted, the 1992 amendments to the Code of Conduct for United States Judges without a doubt strengthened the prohibition against discriminatory club membership by adopting the language of the ABA code referred to in the Senate Questionnaire that Judge Smith promised to follow when he swore to the Senate that he would resign. The only significant difference is that the rule Judge Smith promised to follow in 1988 allowed judges one year to get discriminatory rules changed or resign, while the 1992 rule gave judges up to two years, from learning of discrimination according to the Code's new, tougher rules, to change the club's practices or resign. Yet, Judge Smith did not resign in 1989, 1990, 1991, 1992, 1993, or 1994. He did not resign until a chance for a higher position in the Federal courts became available in 1999.

I recall that more than a decade ago the Senate Judiciary Committee considered this issue at length. There was testimony from women and men from across the country describing the impact of discriminatory private clubs on the women and people of color excluded. From time to time, I suppose, reminders of these lessons are necessary.

In 1990, 2 years after Judge Smith was confirmed and promised the Senate that he would resign from the mens-only Spruce Creek Club, the Senate Judiciary Committee passed a sense of the Committee resolution on the issue of discriminatory clubs. The resolution stated that discrimination at clubs where business is conducted and which intentionally exclude women and minorities is ''invidious'' and ''conflicts with the appearance of impartiality required of persons who may serve in the federal judiciary.'' The Committee's resolution that was adopted on August 2, 1990, provides a bright-line rule for public officials. It defines the clubs at issue as those where members bring business clients or professional associates to the club for conferences, meetings, meals, or use of the facilities. Spruce Creek meets this definition. It is also obviously a place where contacts valuable for business purposes, employment and professional advancement are formed. The Club, by arbitrarily and intentionally excluding women from membership, practices invidious discrimination as defined by the Senate Judiciary Committee. Public officials should not have to be told repeatedly not to belong to clubs that discriminate.

All judges, no matter how popular, have a solemn obligation to ''avoid the appearance of impropriety in all activities,'' under both the Judicial Conference's Code of Conduct for United States Judges and the ABA's model code. That is because, in the words of those codes, ''Public confidence in the judiciary is eroded by irresponsible or improper conduct by judges. A judge must avoid all impropriety and appearance of impropriety. A judge must expect to be the subject of constant public scrutiny. A judge must therefore accept restrictions on the judge's conduct that might be viewed as burdensome by the ordinary citizen and should do so freely and willingly.''

This prohibition applies ''to both the professional and personal conduct of a judge.'' The Judiciary Committee's club resolution similarly sets a high standard of conduct for Federal judges in their personal conduct with regard to club memberships and association. Judge Smith has failed in those obligations. He may very well be a nice person and courteous to women litigants in his courtroom, but that does not excuse him from following the ethical rules that govern his conduct as a lifetime appointee to the Federal courts. Ethical rules apply to all judges equally, regardless of popularity.

Judge Smith had an obligation to resign from the Spruce Creek Rod and Gun Club, both by virtue of his promise to the Senate and because of his responsibilities under the ethical codes, and he failed to do so in a timely fashion. His conduct should not be rewarded with a promotion.

I would also like to set the record straight on one final related point. Supporters of Judge Smith have referenced President Jimmy Carter visiting the Club. According to Carter's memoirs, however, one time in the late 1970s President Carter and the First Lady were invited by the ''Spruce Creek Hunting and Fishing Club for a day of fishing on a portion of their leased stream.'' That day, they met the man who actually owned that parcel of land and thereafter they visited and stayed at his farm, not the Club. The chapter in his book called ''Spruce Creek'' relates to the creek, not the Club. There is no evidence that President Carter has ever endorsed the Club's intentional, invidious discrimination against women.

Judge Smith failed to recuse himself promptly from conflicts of interest. I am also concerned about Judge Smith's late recusal, or disqualification, in two cases involving his substantial financial investments. According to two distinguished professors of legal ethics, Professor Gillers and Professor Friedman, Judge Smith also violated ethical rules due to his late recusal from the Black cases, a 1997 investment fraud case and a related 1999 criminal case. This is because it is undisputably true that Judge Smith and his wife had substantial investments (valued at between $200,000 and $500,000 together) in the bank or holding company that faced significant financial liability in those cases and because his wife also worked at the bank.

In one of those cases, Judge Smith waited five months to recuse himself. In the other case, he waited about a week to recuse himself after realizing that the bank was involved, but he issued significant orders in the intervening period. In both cases, Judge Smith revealed only his wife's employment at the bank to the lawyers in the cases. He never disclosed their substantial financial investments to the lawyers in either the civil or the criminal case. Judge Smith contends that he was not required to recuse himself but did so only in ''an abundance of caution.'' He also contends, basically, that nobody was harmed by his late recusal.

In the opinions of two ethics experts, however, Judge Smith was required to recuse himself from any case in which the judge or his spouse has any interest that could be substantially affected by the outcome of the case, in accordance with the rules passed by Congress in 28 U.S.C. § 455 (a) and (b) (4), and with cases of the Supreme Court and Third Circuit. These rules against conflicts of interest, which are intended ''to avoid even the appearance of partiality,'' are largely self-enforcing. Parties may not know that a judge has substantial financial investments affected by the case and may not move to disqualify a judge unless the judge fully discloses such information. Judge Smith, again reading ethical rules narrowly, did not

do so. Such facts do not give one confidence in his conduct on the bench.

I do think this Senate should take seriously a lifetime appointee's failure to follow ethical rules, in this area and others, such as discriminatory club membership. It is problematic to confirm someone to the Court of Appeals who would read the ethical obligations so narrowly. This is especially so because, under the structure of the Federal courts, it is the circuit court judges who preside over ethics complaints against lower federal judges. I do not think those who read such rules narrowly should be elevated and given that special responsibility.

Judge Smith's remarks as a Federal District Court judge: Another troubling area is Judge Smith's insensitive and activist speeches. A number of these remarks call into question Judge Smith's judgment and fairness. For example, as a sitting federal judge he has given speeches in which he calls ''legal spam'' cases that affect the rights of ordinary Americans, such as cases involving their financial security, social security appeals, pension plan collection cases, and bankruptcy appeals. Such a characterization is shocking for its insensitivity to the importance of such cases to the individuals seeking a fair hearing of their claims in federal court. It calls into question how seriously Judge Smith has taken his oath as judge to administer justice to all persons equally and to ''do equal right to the poor and to the rich.''

Judge Smith also spoke out in favor of parties being required to pay each other's costs in responding to discovery requests. That idea—like the idea of requiring the loser in a case to pay the winner's expenses, which he also endorsed has been widely rejected because it would impose significant financial burdens on individuals suing corporations, for example, for personal injuries caused by a defective product. Such a rule could make it impossible for individuals to pursue legitimate grievances for which Congress has provided a federal court forum.

Another concern is Judge Smith's speeches to conservative ideological groups in which he basically gives advisory opinions about the constitutionality of federal statutes. For example, in 1993, as a sitting judge, he gave a far-reaching speech to the Federalist Society in which he advised the audience that the proposed Violence Against Women Act (VAWA) was unconstitutional. He said this landmark legislation could not be justified as within the power of the federal government. He was also very critical of Congress's extensive findings of fact in VAWA, calling them a ''promiscuous invocation of the Commerce Clause.'' This lack of deference and respect to the legislative findings of a co-equal branch of government is troubling.

Judge Smith told the Federalist Society his own principles for deciding such cases: ''First, ask whether the subject matter is within the power of the national government by express delegation in the text of the [C]onstitution, or impliedly through a historically honest reading of the necessary and proper clause. If not stop!'' Such a subjectively narrow reading of the Constitution could ostensibly result in the overturning of many laws intended to protect the rights of individuals. He assured the Senate at his recent hearing that he would not read the Constitution so narrowly if he were promoted, but in 1988 he also assured the Senate that he would resign from a discriminatory club the following year, a promise he did not keep. I am not sure his assurances on the important issue of the scope of Congressional power should be credited now.

Similarly, Judge Smith gave a speech at the 1997 National Convention of the Federalist Society on ''The Federalization of Criminal Law.'' In it he criticized the invocation of federal jurisdiction via the Commerce Clause in a ''routine'' car bombing case under 18 U.S.C. § 844, as well as the ''rape-shield'' amendments to the Federal Rules of Evidence which generally bars evidence of a rape victim's sexual history. Judge Smith took issue with federal intrusion into these areas of the law, stating that using that statute in car bombing cases and rules like the rape-shield rule reflect ''elitism: a mind set on the part of Congress and some federal prosecutors that the state court systems can't be trusted to 'get it right' . . . never mind the text of the Constitution.'' Such statements are unsettling. It seems as though Judge Smith has a deep distrust that Congress does not follow the Constitution, despite the precedent that requires judges to give congressional enactments a presumption of constitutionality.

Judge Smith has also written an article endorsing an idea he calls ''benign judicial activism'' in which a judge intervenes early in a case to help reach a speedy and just resolution. While this idea has superficial appeal, in practice this approach may not be so benign. In about half of Judge Smith's more than 50 reversals, the Third Circuit reversed his decisions either to grant summary judgment in whole or in part to defendants in civil cases or to dismiss plaintiffs' complaints with prejudice. In a number of such reversals which span his years on the bench the Third Circuit took issue with his early intervention in cases in ways that denied plaintiffs the opportunity to have their cases adjudicated or tried on the merits. Thus, the Court of Appeals to which Judge Smith is now nominated has repeatedly reversed decisions of his which improvidently granted summary judgment or dismissals in favor of civil defendants, often big, corporate defendants. This pattern, combined with his speeches and conduct, raises concern.

Judge Smith's participation in seminars at resorts paid for by special interests is problematic. Another area of concern is that Judge Smith has attended a large number of educational seminars funded by corporations and groups with an interest in interpreting the law a particular way, in a politically or ideologically conservative way favoring corporate interests. As a sitting federal judge, Judge Smith has spent more than 72 days on junkets at luxury resorts on trips valued at more than $37,000 which were funded by corporations and conservative special interest groups. Judge Smith has taken three trips to seminars funded by the Foundation for Research on Economics and the Environment (FREE), which promotes ''free market environmentalism,'' opposes environmental regulations, and gives lectures on topics like ''Liberty and the Environment: A Case for Principled Judicial Activism.'' He has also taken nine trips funded by the Law and Economics Center (LEC), which is affiliated with George Mason Law School and which sponsors seminars with anti-regulatory bent on topics like ''Misconceptions about Environmental Pollution and Cancer.''

My colleague on the Senate Judiciary Committee, Senator FEINGOLD, has spent a great deal of time trying to address the problem of these junkets. The current ethical rules do not clearly prohibit such judicial education seminars at luxury resorts paid for by special interests, and it is difficult for outsiders to obtain information about who is really footing the bill. According to one report, however, Judge Smith has presided over at least two dozen cases involving corporations that funded LEC and he is one of the most frequent fliers to such seminars. I do think it is difficult to maintain the appearance of impartiality under such circumstances. It is axiomatic that judges must be perceived as fair and impartial, and actually be so, for our system of justice to work. I am troubled by Judge Smith's insensitivity to such matters.

Judge Smith's reversals for dismissing plaintiffs' claims: I am also concerned about the unsettling anti-plaintiff pattern in Judge Smith's judicial decisions. Judge Smith's published and unpublished decisions reveal numerous instances in which he has been more solicitous to corporations than to plaintiffs and pro se litigants. Judge Smith has been reversed by the Third Circuit dozens of times for denying plaintiffs the opportunity to try the merits of their cases. In cases involving personal injuries, toxic torts, employee rights, and civil rights claims by prisoners, Judge Smith has been reversed for improvidently granting defendants' motions for summary judgment, prematurely dismissing plaintiffs' complaints, and inappropriately denying motions for injunctive relief without giving the plaintiffs a hearing.

Overall, Judge Smith has been reversed 51 times, including 18 unpublished reversals, in 14 years. In contrast, Judge Pickering was reversed 28 times in 11 years and Judge Barrington Parker, one of President Bush's nominees who was confirmed last fall, was

reversed nine times in 11 years on the district court bench. The Third Circuit's reversals suggest that Judge Smith's political philosophy greatly influences the outcome in cases before him. Of the many problematic reversals and published, as well as unpublished, decisions of Judge Smith on the district court, three are particularly illustrative of his approach to claims of plaintiffs, but there are many others that raise concerns.

In *Metzgar* v. *Playskool*, 30 F.3d 459 (3d Cir. 1994), for example, three Reagan appointees reversed Judge Smith's dismissal by summary judgment to the corporate defendant that had been sued for the death of a 15-month-old child who choked on a wooden block marketed without a warning label. Judge Smith granted summary judgment to the corporation on his theory that choking is an obvious danger and therefore no express warning was necessary. The Third Circuit was ''troubled'' by Judge Smith's analysis and his reliance on flawed statistics. The appellate court concluded that Judge Smith should have given the jury a chance to consider whether the blocks were so obviously dangerous that no specific warning was needed for parents of toddlers.

In *Wicker* v. *Consolidated Rail Corporation*, 143 F.3d 690 (3d Cir. 1998), Judge Smith was reversed for granting summary judgment to an employer sued under the Federal Employees Liability Act (FELA) for injuries caused by exposure to toxic solvents, degreasers and paints illegally dumped and buried by the employer. Smith granted the corporation's motion for summary judgment on the ground that the workers had signed a release settling prior, unrelated injury claims against the railroad. The Third Circuit reversed and held that FELA was intended to protect workers in these situations and that the releases seized on by Smith were invalid.

In *Brown* v. *Borough of Mahaffey*, 35 F.3d 846 (3d Cir. 1994), Judge Smith improvidently granted summary judgment to a city that refused to allow the plaintiff and his Pentecostal ministry access to tent revival meetings in violation of their rights under the Free Exercise Clause of the First Amendment. The city had intentionally locked a recently-erected gate to impede access to the Christian revival meetings. Judge Smith concluded erroneously that these actions, even if manifesting anti-Christian bias, did not constitute a substantial burden on the exercise of their religion. The Third Circuit reversed, holding that Judge Smith's analysis was ''inappropriate for a free exercise claim involving intentional burdening of religious exercise'' because ''[a]pplying such a burden test to non-neutral government actions would make petty harassment of religious institutions and exercise immunity from the protection of the First Amendment.'' The Third Circuit completely disagreed with Judge Smith's hostile decision in which he stated that the plaintiff's ''invocation of the First Amendment provisions guaranteeing religious liberty in so glaring a piece of spiteful litigation is insulting to the principles protected by that constitutional amendment.'' I was shocked by Judge Smith's rough and disrespectful treatment of the legitimate claims of people of faith in this case.

This unsettling pattern created by Judge Smith's judicial decisions, his high level of participation in right wing, special interest-funded junkets, his activist and insensitive speeches, his late recusal in cases involving his substantial financial interests, and his very belated resignation from a discriminatory club create a very unfavorable impression. Judge Smith's defense to each of these significant problems seems to be that he actually is a fair judge despite the appearance that he is not. I am not convinced that his record warrants a promotion to a higher court.

Judge Smith's cramped and self-serving approach to the ethical rules that are supposed to govern federal judges is particularly troubling. He seems to think he is above the rules. His actual record of conduct on and off the bench creates a negative impression that is not reflected in Judge Smith's apparent popularity among his friends. I have no doubt that Judge Smith is an intelligent and charismatic person. What his record as a whole, not just as a colleague or friend, calls into question is his sensitivity, his fairness, his impartiality and his judgment. It calls into question how seriously he has taken his promises and assurances to the Senate in the past and recently, as well as how seriously he has taken his oath as judge to administer justice to all persons equally and to do equal right to the poor and to the rich. The record Judge Smith's own record of performance as a federal judge over these past 14 years does not merit his promotion to one of the highest courts in the land. Based on that record, I will vote against confirmation.

My good friend from Utah is waiting patiently. I withhold the remainder of my time.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Mr. President, hearing my colleague, one might forget that this is the U.S. Senate rather than some whacky politically correct college campus—Berkeley on the Potomac. The fact is, this judge is one of the most respected judges in all of Pennsylvania. He has virtually everybody in western Pennsylvania on his side. He has served 14 years on the Federal bench and has done a very good job in doing so. He is highly respected and has the highest rating from the American Bar Association—the gold standard, according to our colleagues from the other side. And he did not break his word.

The fact is, the law was different than was explained to him when he appeared before the committee, and it is still different than the distinguished Senator from Vermont has been making out here today.

I often hear my colleagues talk about the Clinton nominees who were left at the end of the 106th Congress, but I rarely hear them mention the 54 nominees who were left at the end of the Democratic-controlled 102nd Congress when George Herbert Walker Bush was President. If we are going to waste our time looking back on nominations past instead of looking ahead, let's not forget the 54 nominees the Democratic-controlled Senate left at the end of the 102nd. That is 13 more than the number of Clinton nominees left at the end of the 106th whom we hear so much about, and about 17 of them didn't have a chance anyway. The rest of them there were for reasons. Some of them, the blue slips weren't returned by Senators. You can't call them up.

I don't really think to talk about past congressional action on nominations in any way furthers the work we have been doing as a committee. However, it is difficult to listen to only a select portion of what has occurred in the past without trying to set the record straight. Those Bush 1 nominees who were never confirmed are just as important as these Clinton nominees who have been complained about, and there were far more of them than there were Clinton nominees left over. It is just a matter of fact. Whoever is President, you have some nominees left over. But there were a lot more left over by Democrats than there were by Republicans.

Let me name some of them: Jay C. Waldman of the Third Circuit, nominated for the Third Circuit; Franklin Van Antwerpen, Third Circuit; Lillian R. BeVier, Fourth Circuit; Terrence W. Boyle, Fourth Circuit, who has been sitting here for 14 months, nominated again 10 years later; Francis Keating II, current Governor of Oklahoma, the Tenth Circuit; Sidney A. Fitzwater, Fifth Circuit; John G. Roberts, again, nominated by the second Bush 10 years later, sat there all those months in the first Bush, and now he is sitting here for 14 months in this administration; John A. Smietanka, Sixth Circuit; Frederico Moreno, Eleventh Circuit; Justin P. Wilson, Sixth Circuit; James R. McGregor, Western District of Pennsylvania; Edmund Kavanagh, Northern District of New York; Thomas Sholtz, Southern District of Florida; Andrew O'Rourke, Southern District of New York.

There are plenty of names and an awful lot more than were left at the end of the Clinton administration, and with very little justification. They have seldom mentioned that the all-time confirmation champion was Ronald Reagan with 382 judges. He had 6 years of a favorable party Senate. His own party controlled the Senate. He got 382 judges through. President Clinton, with the opposition party controlling the Senate, with me as chairman,

as a member of the opposition party, got 377 judges through, virtually the same number as the all-time confirmation champion, Ronald Reagan.

Continuing my list of judges: Tony Graham, Northern District of Oklahoma; Carlos Bea, Northern District of California; James Franklin Southern District of Georgia; David Trager, Eastern District of New York; Kenneth Carr, Western District of Texas; James Jackson, Northern District of Ohio; Terral Smith, Western District of Texas;, Paul Schechtman, Southern District of New York; Percy Anderson, Central District of California; recently confirmed; Lawrence Davis, Eastern District of Missouri; Andrew Hane, Southern District of Texas; recently confirmed; Russell Lloyd, Southern District of Texas; John Walter, Central District of California; recently confirmed; Gene Vougts, Western District of Missouri; Manuel Quintana, Southern District of New York; Charles Banks, Eastern District of Arkansas; Robert Hunter, Northern District of Alabama; Maureen Mahoney, Eastern District of Virginia; James Mitchell, District of Nebraska; Ronald Leighton, District of Oklahoma; William Quarles, District of Maryland; James McIntyre, Southern District of California; Leonard Davis, Eastern Northern District of Texas; recently confirmed; Douglas Drushal, Northern District of Ohio; Christopher Hagy, Northern District of Georgia; Lewis Leonatti, Eastern District of Missouri; Raymond Finch, Northern District of Vermont; James McMonagle, Northern District of Ohio; Katherine Armentrout, District of Maryland; Larry Hicks, District of Nevada; Richard Casey, Southern District of New York; Edgar Campbell, Middle District of Georgia; Joanna Seyvert, Eastern District of New York; Robert Kostelka, Western Northern District of Louisiana; Richard Dorr, Western District of Missouri; has had a hearing; James Payne, District of Oklahoma, confirmed this congress; Walter Prince, District of Massachusetts; George O'Toole, Jr., District of Massachusetts; William Dimetroulas, Southern District of Florida; Henry Saad, Eastern District of Michigan—not to mention Kenneth Ryskamp, who, like Charles Pickering, was voted down in committee and never received a full Senate vote.

Let me also say I am going to get into this because I didn't think we would get down to the point where we started talking about a 115-member club that is a social club, not a business club, and virtually everybody knows it. To make that the big brouhaha that this is supposed to be is just almost beyond belief to me. I didn't want to have to talk about that, but I will be happy to.

I rise today to express my strong support for Judge D. Brooks Smith whom the President nominated on September 10 of last year for the Third Circuit Court of Appeals to be confirmed today or tomorrow. It has been over 5 months since his committee hearing. It has been over 60 days since the Judiciary Committee reported Judge Smith's nomination favorably to the Senate. I am disappointed, however, with the treatment Judge Smith is getting from those whose well-funded business it is to oppose President Bush's nominees.

I have warned before of the growing power of the extreme left of mainstream special interest groups upon the judicial confirmation process. Almost all of them are right here in this town. My colleagues know full well that when I was chairman of the Judiciary Committee, I did not welcome conservative groups telling the committee how to vote and what to do. I told them to get lost. I even directed my staff to refuse briefings from them and even meetings with them. But the evidence indicates a very different relationship now to liberal special interest groups that seem to call the shots.

Newspapers from the Wall Street Journal to the Washington Post have commented on these liberal special interest groups and on their control of this process. But it is not a matter of opinion; here is the evidence. I would like to have printed in the RECORD evidence of this unfortunate relationship. First is a fundraising letter from People for the American Way taking credit for the rather shameless defeat of Judge Charles Pickering's nomination; second, a letter from a liberal Hispanic organization telling the committee not to bring up the nomination of Miguel Estrada until August to give them time to prepare a Pickering-like campaign against him. The President nominated Miguel Estrada over 1 full year ago. He would be the first Hispanic to sit on the Nation's second most influential court. But the Democratic leadership refuses to give him a hearing. Now I think we know why.

Lastly, I want to have printed in the RECORD a press release from the National Organization For Women, issued just hours after the Judiciary Committee voted to report favorably the nomination of Judge Brooks Smith to the full Senate. It appears that NOW and other radical liberal groups have demanded that the Democrat leadership come to the floor and fight to defeat Judge Smith.

I ask unanimous consent that the documents I have just referenced be printed in the RECORD.

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

PEOPLE FOR THE AMERICAN WAY,
Washington, DC, April 5, 2002.

In the past couple of weeks, the Wall Street Journal's notoriously right-wing editorial board has twice attacked People For the American Way—and me personally—in particularly venomous language. Being called a ''race-card specialist'' is not the best way to start the day. (You think I'd be used to it given that the Journal's editorial board has run more than two dozen attacks on me over the years, especially during my tenure at the Leadership Conference on Civil Rights as I chaired the successful coalition battle to keep Robert Bork off the U.S. Supreme Court.)

But there's good news in those unfair and inaccurate poison-pen editorials. As a longtime progressive ally recently reminded me, they don't come after us like that unless they think we're winning.

In this case their fears were well founded. On March 14, the Senate Judiciary Committee voted to reject the nomination of Judge Charles Pickering to a lifetime appointment to the U.S. Circuit Court of Appeals. People For the American Way played a crucial leadership role in the broad progressive coalition effort to defeat this nomination in the face of attacks from the far right, the GOP Senate leadership, and the White House. Even before the vote, the far right had been coming after us with all the rhetorical fury they can muster. I can only imagine what will happen now that it is clear we won't let them complete their ideological takeover of the federal courts without a fight.

Pat Robertson recently told millions of his television viewers that People For the American Way is ''bad news for America. They don't tell the truth, and what they're doing is essentially smearing this man.'' Robertson's son Gordon, the heir apparent to the evangelist's empire, used the same television platform to accuse People For the American Way of ''anti-Christian bigotry,'' telling viewers we opposed Pickering because he is a Christian. Phyllis Schlafly's Eagle Forum has denounced People For the American Way and our allies as an ''Unholy Alliance'' while calling Democratic members of the Senate Judiciary Committee the ''Tyrannical Ten.''

Ultra-conservative senators like Trent Lott, Orrin Hatch and Mitch McConnell have gone after us and other Pickering critics. And right-wing pundits on the Internet are even worse, making totally irresponsible and inflammatory remarks.

The increasing frequency and harshness of the attacks directed against People For the American Way reflect more than anything else our leadership role in the progressive movement and the effectiveness of our work. We've been accused of aiding America's enemies for standing up to Attorney General John Ashcroft and his assaults on the Constitution. We've been attacked as anti-Christian bigots for defending separation of church and state. And now we're being attacked for fighting to preserve the federal courts as a refuge for people seeking to have their civil rights and civil liberties protected.

The recent Judiciary Committee vote was the first victory in what will certainly be a long and fierce struggle over the future of the federal judiciary and the rights and freedoms protected by our Constitution.

I hope that you will take this opportunity to become a member of People For the American Way or to continue your support. At this watershed moment in our history, we would be proud and honored to march forward with you as our partner.

Sincerely,

RALPH G. NEAS,
President.

MEXICAN AMERICAN LEGAL DEFENSE & EDUCATIONAL FUND, NATIONAL ASSOCIATION OF LATINO ELECTED & APPOINTED OFFICIALS, NATIONAL COUNCIL OF LA RAZA, NATIONAL PUERTO RICAN COALITION, PUERTO RICAN LEGAL DEFENSE & EDUCATION FUND,

Washington, DC, May 1, 2002.

Hon. PATRICK LEAHY,
Chairman, Committee on the Judiciary,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: As national Latino civil rights organizations, we write on a matter of great importance to U.S. Latinos, and all Americans—the nomination of Miguel Estrada to the D.C. Circuit Court of Appeals. Although historically we have expressed our views on judicial nominees with different levels of frequency, we are united in our view that all federal judicial appointments are important because they are life-long appointments, because they are positions of great symbolism, and because federal judges interpret the U.S. Constitution and federal laws serving as the balance to the legislative and executive branches of the federal government. While the Supreme Court is the highest court, the appellate courts wield considerable power. During its most recent term, the Supreme Court heard only 83 cases, while the circuit courts decided 57,000 cases. As a practical matter, circuit courts set the precedent in most areas of federal law.

We are united at this time around our belief that Mr. Estrada's nomination deserves full, thoughtful, and deliberate consideration. The President proposes to place Mr. Estrada, who has no judicial experience, on arguably the single most important federal appeals court to decide a myriad of statutory and regulatory issues that directly affect the Latino community. Every appointment to a powerful court is important as we recently witnesses in the Supreme Court's 5–4 decision in Hoffman Plastics that stripped undocumented workers of certain labor law protections. This decision, which inevitably will result in increased exploitation of the undocumented, as well as weaker labor standards for all low-wage workers, underscores the importance of nominations such as this one, not just to Hispanics, but all Americans.

This decision comes on the heels of a series of Supreme Court decisions which, in our view, have unnecessarily and incorrectly narrowed civil rights and other protections for Latinos. While we look to see if judicial nominees meet certain basic requirements such as honesty, integrity, character, temperament, and intellect, we also look for qualities that go beyond the minimum requirements. We look to see if a nominee, regardless of race or ethnicity, has a demonstrated commitment to protecting the rights of ordinary U.S. residents and to preserving and expanding the progress that has been made on civil rights, including rights protected through core provisions in the Constitution, such as the Equal Protection Clause and Due Process Clause, as well as through the statutory provisions that protect our legal rights.

We are aware that some are demanding a commitment from you and the Judiciary Committee to announce a date certain for action on Mr. Estrada's nomination. We agree with the proposition that every nominee deserves timely consideration. For this reason, we urged the Senate to act on the nomination of Judge Richard Paez to the Ninth Circuit Court of Appeals, who was forced to wait for four years before being confirmed. We also believe, however, that if a nominee's record is sparse the Judiciary Committee should allow sufficient time for those interested in evaluating his record, including the U.S. Senate, to complete a thorough and comprehensive review of the nominee's record. We therefore respectfully request that you consider scheduling a hearing no earlier than August, prior to the scheduled recess. This leaves sufficient time for action prior to adjournment if his record is strong enough to receive substantial bipartisan support.

In the interim, we pledge to conduct a fair and thoughtful assessment of Mr. Estrada's record, and to communicate our views on his nomination to you, Ranking Member Hatch, and other Committee members in a timely manner.

Sincerely,

ANTONIA HERNANDEZ,
President and General Counsel, Mexican American Legal Defense and Educational Fund.
RAUL YZAGUIRRE,
President, National Council of La Raza.
MANUEL MIRABAL,
President, National Puerto Rican Coalition.
JUAN FIGUEROA,
President and General Counsel, Puerto Rican Legal Defense and Education Fund.
ARTURO VARGAS,
Executive Director, National Association of Latino Elected and Appointed Officials.

[From the National Organization for Women, May 23, 2002]

JUDICIARY COMMITTEE VOTE INSULTS WOMEN; NOW VOWS CAMPAIGN IN FULL SENATE

(By Kim Gandy)

The field of credible Democrats running for President was significantly narrowed today when two rumored candidates insulted every employed woman, every woman in business, and every woman who has been a victim of violence in this country. In casting their votes to promote Judge D. Brooks Smith to the Third Circuit Court of Appeals, only one step below the Supreme Court, rumored candidates Sen. Joseph Biden, D-Del., and Sen. John Edwards, D-N.C., disregarded the extensive evidence of unethical behavior and discriminatory conduct that caused the Washington Post, New York Times and Los Angeles Times to oppose Smith's confirmation.

In an embarrassingly convoluted rationale, Biden expressed disappointment in Smith's strong criticism of the Violence Against Women Act (VAWA), but said it would be a ''double standard'' to vote against Smith because Supreme Court Chief Justice William Rehnquist held a similar opinion on VAWA. Apparently Biden doesn't recall that his vote for Rehnquist was cast many years before VAWA was even introduced. As for a ''double standard,'' someone should tell Sen. Biden that double nothing is still nothing. Biden's previous leadership on violence against women is just that—previous. He has jettisoned it in favor of friendship—his stated presumption of supporting any nominee sponsored by Sen. Arlen Specter, R-Pa. No doubt the people of Delaware will want to know that they have elected a Republican from Pennsylvania to represent them.

Another Presidential wanna-be, Sen. Edwards, hid out in his office across the hall from the hearing, and didn't even have the courage to case his ''Yes'' vote in public. Sen. Herbert Kohl, D-Wis., joined all of the committee Republicans, whose cowardly votes betrayed the women of their states by recommending elevation of a judge whose repeated ''ethical lapses'' deserve censure, not promotion.

The Senate's reputation as an ''Old Boys Club'' was reinforced by today's vote, in which both of the women on the Judiciary Committee voted against Smith, but he won anyway because 12 of the 17 men voted in his favor. To promote a judge who will have to decide on cases of discrimination, when that judge has himself cavalierly participated in discrimination and even ruled in favor of discriminatory practices, is the height of irresponsibility by those who are charged with that duty.

NOW commends both of the women who serve on the Judiciary Committee, Senators Dianne Feinstein, D-Calif., and Maria Cantwell, D-Wash., whose votes against confirming Smith spoke volumes, as well as Committee Chair Patrick Leahy, D-Vt., who spoke eloquently about discrimination against women, and Senators Richard Durbin, D-Ill., Russ Feingold, D-Wis., Edward Kennedy, D-Mass., and Charles Schumer, D-N.Y.

NOW intends to seek a filibuster in the Senate against Judge Smith's confirmation, and will urge every Senator to participate who cares about protecting the last 40 years of progress women have made. The Judiciary Committee's vote for D. Brooks Smith made a mockery of judicial standards. Unless the full Senate reverses, it will send a message to women that they can't expect to have civil rights—or ethics—taken seriously by the Senate or the courts.

Mr. HATCH. Referring in the most vitriolic terms to my friends, Senators Biden and Edwards, voting for Judge Smith in committee, NOW begins by saying:

The field of credible Democrats running for President was significantly narrowed today. . . .

This is simply because these Senators exercised their independent judgment and supported Judge Smith. Honoring the President's prerogative to nominate judges should hardly be a cause to attack my Democrat colleagues or take them out of a potential Presidential candidacy or race.

Rather than speak further about Judge Smith's enemies, I would like to speak about his friends. I think an editorial in the liberal Pittsburgh Post-Gazette put Judge Smith's nomination best when they wrote:

Outside Washington's world of partisan politics, Smith seems to have no enemies, only admirers. Those who have watched him work say an exemplary 14-year record in the Federal bench in Western Pennsylvania is being twisted by political opportunists. His popularity outside the capital extends even to members of the opposing political party, who describe him as fair, hard-working, and respectful to all.

I hope I am not alone in this Senate in finding this home-town report much more reliable and convincing than the hit pieces circulated by the Washington left-wing special interest groups, or for that matter the New York Times, which I read faithfully everyday and respect in many ways—but not in this instance.

But given the bipartisan support Judge Smith enjoys from the people who know him best, and his stellar

record, I find it most difficult to accept that the opposition to him has centered on his belonging to an all-male, family oriented fishing club where his father first taught him to fly fish—the same rustic club that Jimmy and Roslyn Carter have visited to escape, relax, and fish.

If this is the kind of thing that members of the body use as an excuse for thwarting the President's judicial nominations, then the American people will have a big laugh at our expense. And rightly so.

In fact, there are hundreds of small, family-oriented fishing clubs like the one Judge Smith belonged to all across this country from Washington to North Carolina. I even pointed out the website called *www.womensflyfishing.net*, which lists the 60 or so women-only fishing clubs across the country.

We are far from those days when prestigious downtown clubs kept women out of their facilities, and in any case that is not the nature of Judge Smith's family-oriented, fly-fishing club. The special interest groups out to get Judge Smith on this count are proving that when the only tool you have is a hammer, everything you see starts looking like a nail.

In fact, there is a rich mosaic of single gender social clubs in this country that are entirely unobjectionable to any reasonable person. You should not be surprised to know, Mr. President, that this country is well-served by over 6,500 women's only clubs of every size.

Are Judge Smith's opponents in this Senate really prepared to say that the members of the important Francesca Club in San Francisco or the powerful Raleigh Women's Club, or the Junior Leagues throughout the South and all over the country, or the Masons, or the Knights of Columbus cannot serve as judges?

Perhaps the reason for this misguided line of attack on Judge Smith lies in the fact that, in his 1988 confirmation hearing before the Judiciary Committee, he stated that he believed the Judicial Code would require him to try to open the club to women, and to resign if he failed. But the fact is that he was wrong in that belief. The Judicial Code does not require resignation from clubs whose principal purpose is social, that do not function as public accommodations serving food to the public, or whose principal purpose is other than business.

Mr. President, the building you saw has a living room, a kitchen, two bathrooms, and six bedrooms on the second floor. It is not a great big building, even though they blew up a picture to make it look like it was. Even if it was, it is used only for social purposes, and then by a membership of 115.

By the way, that club does not have public accommodations. It does not serve food to the public. It does not do business with the public.

No legalistic parsing of words can change this fact, even though any motivated lawyer can certainly confuse the issue, as we have seen in the Judiciary Committee.

It is not surprising, of course, that the Judge Smith's detractors have chosen to disregard the clear constitutional standards articulated by the Supreme Court as well as the letter of the public accommodations law of Pennsylvania. After 1988, when the issue of single gender clubs was at its most heated peak, the Judicial Conference adopted standards pursuant to Supreme Court's decisions. It made clear that there was nothing—absolutely nothing—improper about a judge or nominee belonging to single-gender clubs, which exist in great numbers for both women and men in this country, so long as the association or club exhibits certain attributes of privacy first articulated by the Supreme Court in the 1984 case of Roberts v. Jaycees.

Judge Smith was under no obligation to make efforts to open the club to women—as he promised this committee—or to resign from the club. But he did both, even though he had no obligation to do so.

Opposing Judge Smith because he used to belong to a fisher-men's club is most absurd when contrasted with Judge Smith's record. Judge Smith, who currently serves as Chief Judge for the Western District of Pennsylvania, has earned a reputation for competence, fairness, and judicial temperament during 14 years as a Federal judge.

I used to practice law in that district and tried cases in the Federal District Court of Western Pennsylvania.

Judge Smith was appointed to that job at age 36—he was one of the youngest Federal judges in the country—and he came to it with experience as a state court judge, as a prosecutor, and as a private practitioner.

His nomination is supported by lawyers, judges, and public figures from across the political spectrum. The Pittsburgh Post-Gazette, a respected newspaper with a liberal editorial viewpoint, has endorsed his nomination three times.

The accounts of the people who know Brooks Smith best became real to me a few weeks ago when I listened to tremendously moving stories of women lawyers from Pennsylvania who recounted emotionally powerful events where Judge Smith bent over backwards to help them succeed as pregnant women and mothers in the practice of law.

The truth is that Judge Smith is supported in the strongest possible terms by the women leaders and members of the Women's Bar Association of Western Pennsylvania, the Allegheny County Bar Association, and the Blair Bedford Domestic Abuse Advisory Board, to name a few.

The Women's Bar Association gave Judge Smith their Susan B. Anthony Award ''because of his commitment to eradicating gender bias in the court system.'' That is a remarkable laud. The officers of the Women's Bar have also stated that they ''did not receive a single complaint concerning Judge Smith.''

To attempt now to taint Judge Smith as being insensitive to women's rights or interests is really beyond the pale of fairmindedness, if not decency.

Judge Smith, who is currently the Chief Judge for the Western District of Pennsylvania, has earned a reputation for competence, fairness, and judicial temperament during his 13½ years as a Federal judge. He was appointed to that job at age 36—he was one of the youngest Federal judges in the country—and he came to it with experience as a State-court judge, as a prosecutor, and as a private practitioner.

I briefly recount Judge Smith's record because it highlights the nature of the prejudice that occurs when a nominee or any person is judged on a single, private and lawful lifestyle choice. It seems to me that the root of all intolerance begins with just that act: to judge a person's entire worth based on a single characteristic, whether it be how a person exercises his or her freedom or religion or his of her freedom of association, which, like religion, has contributed so much to this Nation's unmatched vitality.

I believe the Senate suffered a great shame when it ruined whole careers in the 1950s by asking a single infamous question intruding into the freedom of association. I was ashamed when the Judiciary Committee echoed this question last year by questioning nominees about the Federalist Society, as distinguished an association of lawyers as there could be. Now the special interest groups are asking the Senate to deny the President's nominee a confirmation on the basis of a fly fishing club.

I fear the American people, are going to roll their eyes at the Senate with these type of accusations. But the truth of it is that if we disregard the right of lawful association, it will be no laughing matter.

The Supreme Court first recognized the freedom of association in 1958 as an extension of first amendment free speech in NAACP v. Alabama, and most recently it reaffirmed the right in Boy Scouts of America v. Dale.

It is a right, as Justice Thurmond Marshall wrote, ''which our system honors'' and that encourages ''all-white, all-black, all-brown, all-yellow clubs, as well as all-Catholic, all-Jewish as well as all-agnostic clubs to be established.'' And, it is a right that applies, Mr. President, as Justice Sandra Day O'Connor noted, to clubs whose purposes would be ''undermined if they were unable to confine their membership to those of the same sex, race, religion, or ethnic background.''

We should be glad that our personal politics are trumped by this American freedom because it has protected groups as diverse as the Communist Party and the Moose Lodge, and from the NAACP to the Boy Scouts of America. The freedom of association has

protected the thousand points of light that have made this country's public life so vibrant. And it helps to distinguish us from those foreign places where people are shunned or even imprisoned for mere memberships in unpopular associations.

While the constitutional right of association at first related to expressive association and protected unpopular groups, like the NAACP, in 1984, the Supreme Court articulated the right of intimate association concerning clubs such as Judge Smith's small fishing club. It did so while enforcing Minnesota's public accommodations law against a large single gender organization organized principally for business purposes. That is not the case here. The Court described the attributes of such intimate associations that the Constitution honors, including ''relative smallness.'' That is the case here. Judge Smith's former club has only 115 members. It has been around for a lot of years and has had both women and men enjoy the benefits.

An intimate association, said Justice Brennan, writing for the Court, must be protected ''as a fundamental element of personal liberty,'' and ''must be secured against undue intrusion . . . because of the role of such relationships in safeguarding the individual freedom central to our constitutional scheme.'' As Justice Brennan explained, such small clubs transmit our culture and ''foster diversity.'' They foster pluralism.

I for one stand by our freedom of association. As Justice Thurmond Marshall pointed out, it is a freedom that has helped make this country great, and a freedom we honor. I hope that all on this Committee do also, and that Judges, or people who might want to be Judges someday, are just as free as anyone else to exercise that right lawfully.

Now, Senators who do not share my reverence for this First Amendment right will be interested to know that the State of Pennsylvania has a law against clubs that discriminate on the basis of gender. Pennsylvania has not sought to regulate the club Judge Smith resigned from—and for a good reason: that club does not violate the law against discrimination.

In fact, Pennsylvania courts have found single-gender clubs to be permissible not on the basis of First Amendment rights, but as a privacy right, citing Griswold v. Connecticut. It would certainly be an entertaining footnote to Griswold jurisprudence if opponents of Judge Smith, who have seen fit to probe Judge Smith's views on Griswold, voted against him for exercising privacy rights emanating from that very case.

The special interest groups that are working to discredit Judge Smith apparently think that President Bush's circuit court nominees deserve to have their records distorted and their reputations dragged through the mud. But I don't think that any judicial nominee deserves such treatment, and that was something I practiced as chairman for 6 of President Clinton's 8 years in office.

I strongly agree with the Washington Post editorial of February 19, 2002, and nobody would suggest the Washington Post is a conservative newspaper, that ''opposing a nominee should not mean destroying him.'' The Post pointed out, ''The need on the part of liberal groups and Democratic senators to portray a nominee as a Neanderthal—all the while denying they are doing so—in order to justify voting him down is the latest example of the degradation of the confirmation process.''

I continue to hope that my colleagues will be sensitive to the dangers to the judiciary and to the reputation of this body that will certainly result from the repeated practice of degrading honorable and accomplished people who are will to put their talents to work in the public service. I urge my colleagues to examine Judge Smith on his record, and not on superficial and unsubstantiated allegations.

When Judge Smith comes for a vote we will have the opportunity to show that the senate is focused on the merits of President Bush's nominees, and is not out to obstruct them in the name of sensibilities far from the mainstream of the American people. I hope we take it. I hope we vote favorably on a fine judge.

My colleague has made a point in the past that somehow men's clubs are problematic and powerful and that women's clubs are somehow different and poorer. That is not a problem. I have a photo of an all-women's club. This is the Sulgrave Club of Washington. I, for one, believe they have a right to have an all-women's club.

If my colleagues have trouble seeing the club, it is a mansion. It is not just a living room, kitchen, and six bedrooms upstairs. It is the building behind the Jaguar, the Lexis and, of course, the Mercedes. It is not ittybitty by anybody's stretch of the imagination. And it is probably in a historical landmark situation.

My colleague has also mentioned the ethicists who have written to condemn Judge Smith. Other ethicists have written to support Judge Smith.

One of these Democrat ethicists, by the way, is the one standing on the car. If my colleagues cannot see it because it is a little dark, maybe the camera can come in a little closer. That is one of the ethicists they can get to write almost any opinion they want. This ethicist has argued in favor of introducing false testimony into a trial and argued perjured testimony to a jury.

This is a photograph of another of the regulars who write to denounce President Bush's nominees. I might add, again, he is the one standing on top of the police car. We expect to have a lot of other letters from this particular ethicist.

This is the type of stuff we are putting up with. I think it is time to stop it. I think it is legitimate for people to differ on a judge's qualification from time to time, but there is little or no reason to differ on this one. This is a good man.

I hold a license in that area. I know the top lawyers in that area. I tried against a number of the top lawyers in that area. I have to say I do not know any of them who are not in favor of Judge Smith, and that ought to count more than some of these bits of calumny that have been thrown his way by some who do not like President Bush's nominees.

Mr. KENNEDY. Mr. President, I will vote against the confirmation of Judge D. Brooks Smith to the United States Court of Appeals for the Third Circuit. While Judge Smith is an intelligent jurist, I believe that his serious ethical lapses, and his record of reversals by the Third Circuit in cases concerning civil rights, and the rights of workers, environmental protection and consumer safety suggest that Smith has not met his burden of showing that he should be elevated to the Third Circuit.

Judge Smith's handling of his membership in the Spruce Creek Rod and Gun club, a club whose by-laws explicitly forbid the admission of women, gives me great concern. I am disturbed by Judge Smith's failure to resign from the Spruce Creek Club in a timely manner despite his sworn oral and explicit written promise to this committee at the time of his 1988 confirmation hearing. Smith promised that if he was unsuccessful in trying to change the club's membership policies he would resign, but he failed to do so for another 11 years, until 1999.

Rather than provide a simple explanation, or an apology, for his failure to fulfill this promise, Judge Smith claimed at his hearing that the Judicial Code of Conduct, the ethical rules governing judges, did not actually require resignation from the club. According to Smith, the Spruce Creek Club is purely a social club and is thus exempt from the rules. This strikes me as disingenuous. Judge Smith's 1999 resignation letter to Spruce Creek made clear that he was resigning from the club because its male-only admissions policies ''continue to be at odds with current expectations of Federal judicial conduct,'' suggesting that he knew the club's membership policy was in conflict with the Judicial Code of Conduct.

Contrary to Judge Smith's representations, it also appears that the Spruce Creek Club is not merely a social club, but a place where business is conducted. Three ethicists, including one who wrote at the behest of the Ranking Minority Member of the Judiciary Committee, have written that if the Spruce Creek Club can be used for business purposes, its exclusion of women would violate the Judicial Code of Conduct. The President of Spruce Creek Club has acknowledged that members of this club are allowed to host a variety of meetings on the premises, and

the committee has learned that business and political meetings have been held at the club. The Code of Judicial Conduct is clear that exclusion of women, minorities, and others from clubs where business is conducted is prohibited. In addition, in 1990, this committee adopted a resolution stating that membership in organizations that practice invidious discrimination was inappropriate for a judicial nominee. The resolution reflects our belief that because such membership ''may be viewed as a tacit endorsement of the discriminatory practices, it conflicts with the appearance of impartiality'' that is required of federal judges. We recognized that exclusion of women and racial, ethnic or religious minorities from social clubs that also perform business denies these groups opportunities to make contacts with important members of the community, contacts that are often crucial to professional advancement.

I am also troubled by Judge Smith's approach to cases implicating Federal rights important to victims of discrimination, workers and the disabled, and his disturbing, consistent pattern of favoring business and employers in these cases. Judge Smith has been reversed 51 times by the Third Circuit, often by panels of conservative judges. In many of these cases, Smith takes a narrow view of the laws protecting plaintiffs against abuses by businesses and employers.

For instance, in Wicker v. Conrail, a case brought under the Federal Employer's Liability Act, FELA, Judge Smith was reversed by the Third Circuit for dismissing claims by workers who were exposed to toxic chemicals at their job site. The company knew the job site was contaminated, but the workers did not, yet Smith found that the workers had waived their claims by signing a general release settling prior, unrelated injury claims. The Third Circuit reversed, holding that claims relating to unknown risks cannot be waived under FELA, and emphasized the Supreme Court's directive, ignored by Judge Smith, that FELA be given a ''proemployee'' construction.

Similarly, in Ackerman v. Warnaco, the Third Circuit reversed Smith for granting summary judgment to the company with regard to ERISA claims brought by former employees who were denied promised severance pay after the company, unbeknownst to the workers, changed its written policy to deny severance pay shortly before laying off the workers. Again, in Unity Real Estate v. Hudson, Smith ruled against workers in a case concerning the Coal Industry Retiree Health Benefit Act. Amazingly, Smith held that coal act, which Congress passed in 1992 to require companies to enforce collective bargaining agreements promising lifetime health benefits for longtime workers, amounted to an unconstitutional taking. One year later, in a similar case, the Third Circuit effectively overruled Smith's holding on this score, noting that every Court of Appeals to have considered a ''takings'' challenge to the coal act had rejected it.

In addition, Judge Smith has a disturbing pattern of ruling against plaintiffs in civil rights cases. For instance, in United States v. Pennsylvania, Judge Smith ruled that an institution for the mentally disabled, whose violations included serving pest-infested food, improperly confining residents, failing to provide appropriate medical treatment, and overmedicating residents—did not violate the Constitution's due process clause. In another case, Schaefer v. Board of Public Education, Judge Smith was reversed by the Third Circuit, for dismissing the sex discrimination claim of a male teacher who claimed that the school board's family leave policy, which entitled women, but not men, to one year of unpaid leave for childbirth or ''childrearing'' violated Title VII.

Judge Smith's pattern of ruling in favor of business is particularly troubling when coupled with his frequent attendance at seminars funded by pro-business corporations and groups. Judge Smith spent more than 72 days on junkets at luxury resorts. The trips were valued at more than $37,000 and sponsored by groups that promote ''free market environmentalism,'' and oppose environmental regulations. I am troubled by the appearance of partiality caused by Judge Smith's frequent attendance at such junkets given the pro-business pattern of his rulings.

Judge Smith's narrow view of congressional power to pass legislation under the commerce clause, as expressed in a 1993 speech to the Federalist Society, also gives me great concern. In this speech, Judge Smith criticized the Violence Against Women's Act, which passed both Houses of Congress by overwhelming majorities, as exceeding Congress's power under the commerce clause. Judge Smith advanced a cramped reading of Congress' commerce clause power, stating that ''the Framers' primary, if not sole, reason for giving Congress authority over interstate commerce was to permit the national government to eliminate trade barriers.'' Not only would Judge Smith's reading of the commerce clause render Congress powerless to pass statutes like the Violence Against Women's Act but, under Judge Smith's reasoning, it appears that any Congressional enactment other than those aimed at eliminating trade barriers would be constitutionally suspect, including statutes such as the Fair Labor Standards Act, the Equal Pay Act, the Clean Air Act, and the Clean Water Act.

In sum, I do not believe that Judge Smith has shown he has the integrity and commitment to core constitutional values required to justify his elevation to the Third Circuit. I therefore oppose his nomination.

Mr. HATCH. Mr. President, I ask unanimous consent that I be allowed to speak as in morning business.

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

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

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

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

Mr. SCHUMER. Mr. President, I will say a word about the nomination of D. Brooks Smith to the Third Circuit. For me, my concerns with Judge Smith are not about ethics but about ideology. My questions are about his record. My worries are about what kind of judge he has been at the trial level and what kind of judge he will be at the appellate level.

Time and time again, the President says he is going to nominate conservatives in the mold of Justices Scalia and Thomas. Every indication is that he is following through with that promise.

At least by my standards, that is not OK. I certainly want legal excellence at the highest order. Diversity ought to be at the highest courts. We ought not have a bench of all like men. But I also want moderation and ideological balance. Unfortunately, as they nominate judge after judge, hard right, out of the mainstream, far further to the right than President Clinton's nominees were to the left, it is clear that this administration is committed to imbalance on the courts. Frankly, that is a strategy I cannot get behind.

When it comes to D. Brooks Smith, there are some red flags raised. As a city district court judge, he gave a speech in which he criticized the constitutionality of the Violence Against Women Act, something I am pretty proud of because I was the author, along with Congresswoman LOUISE SLAUGHTER in the House of Representatives. Senator BIDEN did a great job here in the Senate. Now, this was years before the Supreme Court had addressed the Violence Against Women Act and when there was still a possibility it would come before him as a judge. That is some very unjudge-like behavior.

I asked him some simple, written questions about his views on the law. I asked him about his views on the right to privacy. I asked him to reconcile his views on VAWA with his views on other Federal laws such as the Endangered Species Act. The response I got, I regret to say, was inadequate.

Judge Smith told me what the precedence said, not what he personally believes.

That might be OK if you are a nominee to the district court where you do

not have as much of a chance to make law. These days when you are nominated to an appellate court, when the Supreme Court takes virtually 75 cases a year, that argument does not fly. So I wrote back to Judge Smith, and again I asked him about his views. I made it clear I wanted to know about his personal views, not what the law was, but what his personal views were because we all know that influences a judge greatly when they make decisions.

This idea that judges are part of an ideological system and read the law in the same way is poppycock.

Why is it judges nominated by Democratic nominees read the law differently than judges nominated by Republican nominees? We know ideology plays a role. There is nothing wrong with that. But we ought to let it into our decisionmaking.

Judge Smith dodged again.

I think I am entitled to know what a nominee thinks. I am not going to go about blindly confirming nominees to lifetime seats on the Federal courts without those answers. I am not going to vote to give the judge a lifetime appointment, tremendous power, the most unaccountable power that our Founding Fathers gave to any single person. I am not going to give that judge the power to invalidate the laws passed in this legislative, duly elected body; laws that protect privacy, laws that protect working people, laws that protect women, the environment. I am not going to give a judge the power to validate those laws unless I know what they think of our power, the Congress's power as a coequal branch of Government, when it comes to these important issues.

I have an obligation on behalf of the 19 million New Yorkers I represent to learn those views. They want to know if the judge is too far left or too far right. They want to know about things that affect their lives: How much money they are going to make; safety in the workplace; how the environment is going to be treated; and if they are a member of a minority group, how the judge regards civil rights. They want to know this. I want to know.

I am not going to make the mistake that this body made with Clarence Thomas, who came before this body. I was not here then. I was in the House. We don't, of course, vote on judges. He said he had no views on Roe v. Wade. I am not making that mistake again. I don't think any Member should. We all know Judge Thomas had strong views on Roe v. Wade, but he came here and said he had none, he had never discussed it.

If D. Brooks Smith had given me legitimate answers to my questions, I might have supported him. But his answers were not answers at all.

Now, I understand we cannot ask judges to precommit themselves on issues that come before them, even though that is what Judge Smith did in his VAWA speech. I don't want to put nominees in that position. When it comes to issues already decided, when it comes to discussing their judicial philosophy, when it comes to Supreme Court cases that will never come before this judge, I don't get why we shouldn't know what that judge thinks.

Every semester, first year law students are asked to critique Supreme Court opinions. But someone up for a Federal judgeship will not tell us what they think about the seminal Supreme Court cases?

On the latest nominee for whom we had a hearing, Judge Owen, I asked her views. She said she doesn't think that way. She was asked to write papers in law school. She was asked to make opinions this way. She did not want to tell us.

There is a trend here. There is a trend. They don't want us to know what they think because they are so far out of the mainstream that they never could get picked if they told us their real views. They would never get supported by this body. They will not be honest about their views regarding Brown v. Board of Education or Korematus v. United States or Miranda v. Arizona or Roe v. Wade?

Judge Smith says what he thinks about the constitutionality of a statute the Supreme Court has yet to rule on, but he will not say what he thinks about Supreme Court opinions that have already been issued? Something is wrong with that. This nominee has it all turned around and it doesn't make sense.

The fact is, we are in the midst of a conservative judicial revolution. The very same people who decried the liberal activists, who took too many things too far—I am very critical of some of those opinions—are now doing the same thing themselves. When the hard right members of the conservative movement in the 1980s realized they could only get so much of their agenda implemented through elected branches because they were too far over for the American people, they turned their focus to the courts. They started a campaign that ran through the Reagan administration, through the first Bush administration, and continues through this administration. President Bush would like to portray himself as a moderate to the American people. Maybe he is. When I talk to him he sounds that way to me, one-on-one.

But if you look at who he nominates, there is hardly a moderate among them, particularly at the appellate court level. The nominees are committed to an ideological agenda which turns the clock back to maybe the 1930s, maybe the 1890s. They hate the Government and its power, by and large. They think the Federal Government has far too much power, which, let me tell you, in our post-September 11 world makes no sense.

So for the better part of the last decade, the commerce clause has been under assault and a whole host of laws protecting women, senior citizens, the disabled, and the environment have been invalidated. Now they turn their attention to the spending clause. To the average person, this sounds like mine-numbing stuff. But unfortunately, it has real impact on real people and it has to stop.

D. Brooks Smith is going to become a judge. We all know he has the vote. Tomorrow morning he will join a long line of judges, confirmed by the Senate, who appear to be intent on curtailing congressional power to protect the people who elect us.

At some point this Senate needs to wake up to the fact that our President and his Department of Justice are playing by different rules when it comes to nominating judges. They are using ideology as litmus tests, and then, when we want to ask about ideology, they say no, that is off the table. They are doing it to the detriment of the courts and the people the courts are supposed to protect.

I yield the floor.

The PRESIDING OFFICER. In my capacity as a Senator from Nevada, I suggest the absence of a quorum.

The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

The PRESIDING OFFICER. Under the previous order, the Chair now recognizes the Senator from New Jersey, Mr. TORRICELLI.

SENATE ETHICS COMMITTEE INVESTIGATION OF SENATOR ROBERT TORRICELLI

Mr. TORRICELLI. Mr. President, for the last 7 months, the Senate Ethics Committee has reviewed documents and statements relating to allegations made against me by a former political contributor and friend. I am now in receipt of the conclusions of the committee.

I thank the members of the Ethics Committee for their hours of deliberation. I also apologize to each of them for subjecting them to the painful ordeal of sitting in judgment of a colleague.

In closing its preliminary inquiry into this matter, the Ethics Committee has concluded that in several specific instances rules of the Senate were violated. As a consequence, the committee has admonished me. I want my colleagues in the Senate to know that I agree with the committee's conclusions, fully accept their findings, and take full personal responsibility.

It has always been my contention that I believed that at no time did I accept any gifts or violate any Senate rules. The committee has concluded otherwise in several circumstances and directed me to make immediate payment in several instances to assure full compliance with the rules of the Senate. I will comply immediately.

I apologize to the people of New Jersey for having placed the seat of the Senate that they have allowed me to occupy in this position. The day I was elected to the Senate remains among the most cherished of my life.

During recent weeks, I have spent long nights tormented by the question of how I could have allowed such lapses of judgment to compromise all that I have fought to build. It might take a lifetime to answer that question to my own satisfaction.

The question I want every person in New Jersey to have answered today is that all during this ordeal I never stopped fighting for the things in which I believe. I never compromised in the struggle to make the lives of the people I love better.

I am grateful that this matter has come to a close, regretful as they might be, sorrowful as I remain. I thank my colleagues for their time and their attention.

Mr. President, I yield the floor.

GREATER ACCESS TO PHARMACEUTICALS ACT

Mr. HATCH. Mr. President, I rise to speak again on the pending legislation—S. 812—the Greater Access to Pharmaceuticals Act.

First, let me say that I am hopeful the on-going talks among interested Senators and affected parties will succeed in reaching an acceptable compromise on a Medicare Prescription Drug Benefit. That is a promise to seniors we need to honor. I remain committed to achieving that goal.

I think that Senator SNOWE made a good point when she said earlier today that there is no reason to pull the bill down and halt the negotiations over the Medicare drug benefit at his point. Why not encourage these talks to continue over the August recess?

Although we got off to a rocky start when the Majority Leader decided to by-pass the Finance Committee to avoid the Tripartisan bill being reported by the Committee, I remain hopeful that we can come together if we stick to it.

Whether those talks succeed or fail, the Senate will have to dispose of the underlying legislation, S. 812. This is the legislation first introduced by Senators MCCAIN and SCHUMER that was almost completely rewritten by the HELP Committee via the Edwards-Collins substitute amendment.

In many respects, the Committee substitute is an improvement over the McCain-Schumer language. Let me hasten to say, though, there are still major problems with the language.

I have laid out in some detail the shortcomings in the provisions of the bill that purport to fix the problems associated with the statutory 30-month stay. We designed this stay to permit a reasonable period of time to litigate the status of pioneer drug patents, but has been used in several cases by brand name drug manufacturers to forestall improperly generic competition.

As this barely three-weeks old language is scrutinized by experts, many are concluding that it comes up short. For example, there is an interesting and growing correspondence between the architect of the pending legislation, my friend from Massachusetts, Senator KENNEDY, and the organization that represents the Nation's biotechnology companies—BIO, the Biotechnology Industry Organization.

In its letter of July 22, 2002 to Senator KENNEDY, BIO complains about the:

> carte blanche authority of FDA to determine testing methods applicable to full NDAs, [New Drug Applications] loss of the ability to protect our intellectual property because of failure to meet new filing deadlines under food and drug law, and an unwarranted private right of action afforded generic companies to sue members in efforts to ''delist'' patents or ''correct'' patent information. Whatever the purposes of these provisions, we fundamentally disagree with their consequences perhaps the result of producing totally new provisions only 36 hours before mark-up.

Actually, I think this completely new language was not available until 24-hours before the markup.

It is also my information that a meeting last Friday between Senator KENNEDY's staff and BIO staff did little to clear up these objections.

I have no doubt that Senator KENNEDY is aware this bill is opposed by the Massachusetts-based biotech firm, Millennium Pharmaceuticals, as well as the Massachusetts Biotechnology Industry Organization.

As I have laid out previously, in addition to the policy question of the extent to which these new provisions upset the balance of Hatch-Waxman, a broad spectrum of legal analysts who range from Susan Estrich to Judge Bork have raised a number of concerns about the pending legislation on a wide variety of issues, including concerns that the bill runs afoul of the Takings Clause as well as violates the GATT Treaty's intellectual property provisions.

Last week, I included in the RECORD a letter from the American Intellectual Property Law Association opposing the patent forfeiture and private right of action provisions of the bill.

This week I want to highlight a letter to Chairman KENNEDY from the Intellectual Property Owners Association expressing severe reservations about the bill.

The IPO represents U.S.-based owners of patents, trademarks, copyrights, and trade secrets. The organization includes some 100 American firms that are among the largest patent filers in the United States. The membership of the Intellectual Property Owners Association submit about 30 percent of all patents filed with the Patent and Trademark Office.

The IPO letter raises concerns about how the Substitute to S. 812 might conflict with the international Agreement on Trade Related Aspects of Intellectual Property Rights—the TRIPS provisions. Specifically, the IPO complains about the file-it-or-lose-it and sue-on-it-or-lose-it provisions of the bill. The letter states, in part:

> We believe these rigid barriers to enforcement of patent rights may conflict with ''normal exploitation of patent rights'' as that term is used in Article 30 of the TRIPS agreement, or could set a very damaging precedent for interpretation of Article 30 that would be used against the U.S. by its trading partners in other areas of intellectual property enforcement.

The new, untested, Edwards-Collins language has not been embraced by the intellectual property bar nor by the mainstream organizations that represent the interests of America's inventors.

The Administration has already issued a statement in opposition to S. 812.

Before we take any action to adopt the language that has agitated nearly everyone in the IP community, don't you think it would be prudent to factor in what the Patent and Trademark Office has to say about this new language that completely re-wrote the McCain-Schumer bill?

Commissioner James Rogan wrote to me today to give us PTO's initial reactions to re-write of S.812. Here is part of what the Commissioner of Patents and Trademarks says in his letter to me:

> USPTO does recognize that some changes to current law may be necessary to encourage appropriate access to generic substitutes and prevent abuses of the patent laws. But S. 812 clearly is not the answer. In fact, this bill would likely do the opposite of what its title suggests by limiting access to cutting-edge drugs, decreasing innovation, and ultimately harming the quality of treatments available to patients.

In addition to these significant concerns raised by the PTO, I would think that the report that was issued earlier today by the Federal Trade Commission, after a unanimous vote of the Commissioners, would compel my colleagues in the Senate to question the wisdom of adopting the HELP substitute to S. 812. While I am still studying the details of the report, it seems abundantly clear that the major recommendations of the Federal Trade Commission in no way mirror the legislation pending on the floor.

With respect to the 30-month stay, the FTC suggests a policy of one stay per generic drug application for all patents listed in the official FDA Orange Book prior to the date on which the generic drug application is filed.

This is precisely the position I advocated before the HELP Committee back in May.

This is the position that the Ranking Republican Member of the HELP Committee, Senator GREGG, attempted to get adopted by the HELP Committee during the mark-up.

The narrowly-tailored FTC recommendation in this area should be contrasted with the overly-broad Edwards-Collins language that contains the offensive file-it-or-lose-it and sue-

on-it-or-lose-it provisions, the new and unprecedented—and unnecessary—private right of action in the Federal Food, Drug, and Cosmetic Act, as well as the rule that allows the 30-month stay only for those patents issued within 30-days of the approval of the pioneer drug.

I know which policy I prefer—and it came from the FTC after its comprehensive year-and-a-half study of these issues, not from any secret backroom drafting sessions of various lawyers and lobbyists.

Let me now focus my comments on another major area addressed by the HELP Committee substitute to S. 812: the problem of collusion between brand name and generic drug manufacturers with respect to the rules in current law that grant 180-days of marketing exclusivity when a generic drug firm successfully challenges or navigates around a pioneer firm's drug patents.

The 180-day marketing exclusivity rule has been highly controversial in recent years.

The reason for this attention is simple. In a few number of documented cases, generic drug manufacturers entered into agreements with brand name manufacturers not to sell generic drugs.

As I will explain, due to the way the existing law—the Drug Price Competition and Patent Term Restoration Act of 1984—is written and has been interpreted by the courts, some of these arrangements had the effect of delaying multi-source generic competition well beyond the contemplated 180-days.

I should first note that the existing statute—the Waxman-Hatch Act—included this 180-day marketing exclusivity as an incentive to encourage patent challenges. If patents were found to be invalid, or if non-infringing ways to produce generic drugs were developed, consumers could benefit from the earlier-than-anticipated introduction of generic drugs into the marketplace.

In enacting these provisions, it was the intent of Congress to award this exclusivity only to a generic drug applicant that was successful in defeating a pioneer firm's patents.

FDA's 1994 regulations implementing the Hatch-Waxman Act required the generic drug challenger to defend successfully the lawsuit that a pioneer firm must initiate within 45-days after being notified that the generic firm was challenging the patent.

It must be emphasized that the reason the generic drug firm is the plaintiff in the suit, rather than the defendant, is that the statute contains a special protection allowing generic firms to conduct what would normally be infringing activities in order to secure FDA regulatory approval. This is the so-called Bolar Amendment, a provision of law that, in my opinion, has not been adequately recognized by the proponents of S. 812.

Essentially, the Bolar language trumps the general rule against patent infringement codified in section 271(a) of the patent code. The Bolar Amendment, codified in section 271(e) of the patent code, allows generic drug firm to infringe patents in order to win FDA approval and gear up production and creates an artificial act of patent infringement at the moment that the generic firm files an abbreviated new drug application with the FDA.

Once the application is filed, the pioneer firm has 45-days to file a lawsuit in order to take advantage of the statutory 30-month stay designed to allow the patent litigation to be completed before generic may be permitted to enter the marketplace.

For over a decade after Hatch-Waxman was enacted in 1984, it was thought that only a generic firm that was successful in the litigation, that is, a firm that had successfully defended the suit brought by the pioneer firm, could qualify for the 180-days of marketing exclusivity.

In 1997, FDA's successful defense requirement was struck down by the D.C. Circuit Court of Appeals in the case of Mova Pharma v. Shalala.

The following year, in 1998, the D.C. Circuit decided the case of Purepac Pharm v. Shalala. This decision upheld FDA's new system of granting the 180-day exclusivity to the first filer of a generic drug application even if the pioneer firm did not sue for patent infringement.

That same year, the Fourth Circuit Court of Appeals issued its opinion in Granutec v. Shalala. This case held that the exclusivity of the first filer could be triggered by a court decision with respect to a second, third, or subsequent filer.

Essentially, these decisions added up to one thing: mischief.

Once the exclusivity was awarded to the first filer of a generic drug application divorced from any requirement for a successful patent challenge, it became apparent to some that the first filer—with a financial inducement from the patent holder—could effectively forestall multi-firm generic competition by simply not going to market. If the 180-day clock never started, multi-source generic competition could be forestalled until the patents expired.

This could last for years.

As a coauthor of the Drug Price Competition and Patent Term Restoration Act, I can tell you that I find these type of reverse payment collusive arrangements appalling.

I must concede, as a drafter of the law, that we came up short in our draftsmanship. We did not wish to encourage situations where payments were made to generic firms not to sell generic drugs and not to allow multi-source generic competition.

To date, there are known to have been relatively few such agreements. The FTC has obtained consent decrees in two cases: with Hoescht and Andrx over the drug, Cardizem, and with Abbott and Geneva over the drug, Hytrin.

The agency suffered a set-back recently in the third case it brought in this area which involved an agreement between Schering-Plough, Upsher-Smith, and American Home Products with respect to the compound K-Dur 20, a widely prescribed potassium chloride supplement. While the FTC settled with American Home products, an Administrative Law Judge recently rejected the agency's argument in the case against Schering and Upsher-Smith. The ALJ's opinion looked at the facts of competition in the potassium chloride market and concluded that FTC had not proven its case given the highly-competitive nature of this particular market.

However the K-Dur case ultimately is decided, I commend FTC Chairman Tim Muris for indicating he will continue the agency's policy of zealously reviewing these type of reverse payments cases to determine whether such agreements run afoul of the antitrust laws.

In my earlier statements, I commended both the enforcement actions of the FTC and the development of the Drug Competition Act, S.754, by Senator LEAHY for creating a climate unfriendly to the execution of any additional collusive deals not to compete between generic and brand name companies.

Today's release of the report: Generic Drug Entry Prior to Patent Expiration: An FTC Study underscores the importance of Senator LEAHY's work in developing the Drug Competition Act. This bill was reported by the Judiciary Committee last year.

I was pleased to work with him to refine the bill before the Committee adopted this measure. I am particularly pleased that he became convinced it was wise to abandon a patent forfeiture feature very similar to the provisions contained in the Edwards-Collins substitute to S. 812 that so many biotech and pharmaceutical firms and intellectual property experts find so objectionable.

I did have a few additional suggestions for improving S. 754, but in the interest of moving the legislation forward in a bipartisan fashion, I supported the bill in Committee.

Frankly, one of my suggestions is very simple and amounts to recognition of the importance of the bill. This simple suggestion would be to codify the bill as part of the Clayton Act, rather than let the language float as a statute-at-large.

Here are the other concerns that I have with S. 754.

The Leahy bill exempts three types of agreements: first, purchase orders for raw material supplies; second, equipment and facility contracts; and third, employment or consulting contracts.

These three categories were also exempted by the FTC in its recently completed study of the pharmaceutical industry. To these three, I would suggest adding two other classes of non-germane agreements: first, packaging and labeling agreements and, second, confidentiality agreements. It seems to me

that the thrust of the legislation is to get a quick review of actual executed agreements relating to settlements of patent non-infringement or patent invalidity cases arising out of Hatch-Waxman Paragraph IV certifications.

Garden variety packaging and licensing agreements or mere agreements to talk about possible settlements in a confidential manner are not what we are after with this legislation.

I think we should start with the presumption that the law will be followed. Given this perspective, I favor the total deletion of proposed Section 8, subsection (b) which creates a special rule for contract unenforceability. My understanding is that this is a relative recent addition to the Leahy bill and that only current sections 8(a) and 8(c) were in the original Leahy bill and, in fact, precisely mirror the long-standing Hart-Scott-Rodino enforcement language. In short, what does this new section 8(b) accomplish that is not included in the more general provision of section 8(c) that grants a broad authority for equitable relief?

And what is the real chance that one or both parties will not comply with the statute in the first place? And if one party reports, what could possibly be gained by the other party not reporting the agreement? For that matter, it might be preferable to change the bill to require a joint submission of a certified copy of the agreement because one can hardly imagine some poor FTC staff attorney doing a side-by-side, word-by-word reading of documents to make sure both parties sent the same agreement.

In addition, I think that language should be added to make explicit that nothing in this Act should be construed to discourage or prohibit legitimate settlements between brand name and generic drug companies. The Joint DOJ/FTC guidelines smile upon such settlements so long as they do not run afoul of other laws such as the antitrust statutes. The FTC Administrative Law Judge's decision in the K-Dur 20 case reminds us of this fact, no matter how the case is finally decided.

The essence of S. 754 is to see that every agreement between pioneer and generic firms that raises antitrust questions are promptly reported to the FTC and DOJ for appropriate scrutiny.

I think the emergence of the Leahy bill—and I must give credit as well to the McCain-Schumer bill, coupled with the strict FTC enforcement in this area and the agency's extensive industry-wide survey helps explain why these so-called reverse payment cases appear to be dwindling, and perhaps have completely halted for the time being.

Senator LEAHY should be pleased that the chief recommendation that the FTC is making today with respect to the collusive 180-day marketing exclusivity agreements amounts to an endorsement of S. 754.

The FTC report recommends that Congress:

> Pass legislation to require brand-name companies and first generic applicants to provide copies of certain agreements to the Federal Trade Commission.

This straight-forward recommendation is a far cry from the complex, barely comprehensible, 180-day marketing exclusivity fix that emerged from the HELP Committee.

As a Wall Street Journal article yesterday described the discussion of the Edwards-Collins substitute: ''In a remarkable session, it became clear that many lawmakers didn't understand the complex bill.''

Why should that be surprising given the fact that this completely new, incredibly- intricate, highly-technical language was made available the day before the mark-up? A review of proceedings of the two-day HELP Committee mark-up is very revealing and I would urge that the press and the public make the effort to review this discussion. I can see why Senators GREGG and FRIST are so frustrated about some changes in language that appear to have been agreed to one moment, only to vanish the next. One can only wonder who, how, where, when, and why such language was drafted—although yesterday's Wall Street Journal article may shed some light on some of the actors behind the scenes.

In many ways, the Edwards-Collins substitute misses the mark, and is too complicated to boot.

Nevertheless, I do think we need to re-examine the statute in this area in light of the potential for these type—or perhaps new types of—anticompetitive agreements to crop up in the future given how the current statutory language and court decisions work together to help create a climate for mischief.

The McCain-Schumer bill addressed the 180-day collusive reverse payments situation by a so-called rolling exclusivity policy. This rolling exclusivity means that if the eligible generic drug filer does not go to market within a specified time period, the 180-day exclusivity rolls to the next filer.

I do not favor rolling exclusivity.

I agree with what Gary Buehler, then Acting Director of FDA's Office of Generic Drugs, told the Judiciary Committee last year:

> We believe that rolling exclusivity would actually be an impediment to generic competition in that the exclusivity would continue to bounce from the first to the second to the third if, somehow or other, the first was disqualified.

I believe a better course of action was advanced by FDA in its 1999 proposed rule which suggested a use it or lose it policy. This simple rule is that if the first eligible generic drug applicant did not promptly go to market, all other approved applicants could commence sales.

Molly Boast, Director of the FTC Bureau of Competition, testified last May that, at the staff level, FTC supported FDA's use it or lose it proposal.

My first reading of the summary of the new FTC Report leads me to conclude that the agency favors a very aggressive use it or lose it policy. In this regard I must point out that the FTC Report contains three minor recommendations that center on the 180-day provision:

First, the agency would run the 180-day clock if a generic firm marketed the pioneer's product under a license, not an ANDA.

Second, FTC would codify current case law and run the 180-day clock from the time of any court decision, not an appellate decision as allowed under the HELP Committee language.

Third, the Commission would trigger the 180-days if a court dismissed a declaratory judgment for lack of case or controversy.

While I am just beginning my review of the FTC report, it appears that the FTC is advocating a very aggressive form of a use-it-or-lose-it policy.

As I have argued on a number of occasions, my view is that rolling exclusivity delays the day when multi-generic competition can commence. It appears to me that the FTC shares this view.

If our goal is to maximize consumer savings after a patent has been defeated, I find it difficult to see how rolling exclusivity achieves this goal. I certainly prefer a use it or lose it approach over the McCain-Schumer brand of rolling exclusivity.

I commend the sponsors of the Edwards-Collins substitute for rejecting the McCain-Schumer rolling exclusivity policy in favor of what Senator EDWARDS calls modified use-it-or-lose-it. Having said that, I am disturbed to learn that during the HELP Committee mark-up Senator EDWARDS and HELP Committee staff stated that, in fact, the exclusivity could roll indefinitely.

I understand the intent is to transfer the exclusivity once and only once, but having reviewed the language of the bill and the discussion at the mark-up, I am not convinced that the exclusivity will roll over only once.

In any event, even if the exclusivity only rolled over once, I question the rationale behind a policy that only delays the day when multi-source generic competition can commence.

It is only after the time when many generics enter the market that consumers receive the full benefits of price competition.

During the first 180-days when only one generic is on the market, the change in price may be marginal. This is so because when there is only one generic competitor during this 180-day time frame, neither the pioneer firm nor the generic firm is under any tremendous pressure to cut the price. The report, Drug Trend: 2001, published by Express Scripts, notes this dynamic:

> The A.P. [average wholesale price] for the first generic is usually about 10 percent below the brand. After the six month exclusivity granted to the first generic manufacturer, the price paid . . . for the generic quickly falls, often by 40 percent or more, as multiple manufacturers of the same generic product compete for market share. Moreover, it appears that the value of the 180-day

marketing exclusivity incentive may be worth much more today that it was back in 1984.

I understand that, in 1984, the number-one selling drug in the United States was Tagamet, with U.S. sales of about $500 million.

Today, it is estimated that Lipitor, the anti-cholesterol medicine, has a domestic market of over $5 billion annually. In nominal dollars, Lipitor sales today are 10-times higher than Tagamet sales were in 1984. In real dollars, I am told that this amounts to about a six-fold increase.

If we are going to open up the 180-day provisions of the 1984 law—and I think we should so long as we do it carefully and thoughtfully—I think we should reexamine other aspects of the 180-day rule such as whether we should retain the 180-days or some other number of days given the substantial six-fold growth in potential value of this incentive.

Why should we be locked into 180-days? The dirty little secret of the 180-day provision is that both the pioneer firms and generic firms like this provision because it delays the full price competition that only occurs when many generic enter the market.

I think that the mutual economic interest of the generic and the pioneer firms is not in perfect alignment with the interests of consumers with respect to the 180-day incentive.

Moreover, even if we could perfect the modified use it or lose it language of the Edwards-Collins substitute and the first qualified generic manufacturer could not, or would not, commence marketing and the exclusivity moved to the next qualified applicant, why should the second manufacturer get the full 180-days? Why not 90 days? Why not 60 days?

Frankly, I am disturbed that, in some circumstances, the Edwards-Collins language appears to grant exclusivity not to the successful generic litigant—but to a firm which was merely first to file papers with the FDA that triggered a legal proceeding.

I understand the rationale for this is that it will supposedly ensure multiple patent challenges. But, when we start rewarding the first to trigger lawsuits in place of actually winning the challenge, it strikes me as out of sync with the traditional American value of rewarding the actual winner.

I am all for assuring that there are sufficient incentives to ensure patent challenges. But, isn't there a limit beyond which we should direct these potentially enormous profits back to consumers?

While I have not seen any formal estimates, one would think that 180-days of marketing exclusivity for a $5 billion seller like Lipitor must mean hundreds of millions of dollars, and perhaps even $1 billion, in lost consumer savings.

Would we rather see 25 percent to 40 percent of that money in the hands of the trial attorneys who brought the case? Or, would we rather see that at least some of those funds earmarked for attorneys' fees be channeled to help citizens lacking access to prescription drugs?

Shouldn't we get more facts concerning the change in value of the 180-day marketing exclusivity today compared to 1984 and make any appropriate adjustment to this incentive? We don't want to set the incentive so low as to discourage challenges to non-blockbuster patents, but we don't want to set the incentives too high either.

As a matter of fact, some have questioned the need for retaining the 180-day marketing exclusivity at all.

For example, Liz Dickinson, FDA's senior, career attorney in this area, has asked:

> I suggest we look at whether 180-day exclusivity is even necessary, and I know that there is this idea that it is an incentive to take the risk. I say the facts speak otherwise. If you have a second, third, fourth, fifth generic in line for the same blockbuster drug . . . undertaking the risk of litigation without the hope of exclusivity, is that exclusivity even necessary?

Ms. Dickinson, a fine lawyer with no political axe to grind, went on to make the following observation with respect to the 180-day rule,

> We have got a provision that is supposed to encourage competition by delaying competition. It has got a built in contradiction, and that contradiction . . . is bringing down part of the statute.

Similarly, Gary Buehler, FDA's top official in the Office of Generic Drugs agreed with his colleague's assessment when he testified before the Senate Judiciary Committee last year:

> . . . we often have the second, third, fourth, fifth challengers to the same patent, oftentimes when the challengers actually realize that they are not the first and there is no hope for them to get the 180-day exclusivity. So with that in mind, I would agree with Liz's statement that generic firms will continue to challenge patents. Whether the 180-day exclusivity is a necessary reward for that challenge is unknown, but it does not appear that it is.
>
> I personally favor retaining some incentive to ensure vigorous patent challenges. But in light of this testimony and other factors, I do not believe there is a need to be locked into the current incentive—the 180-day exclusivity benefit.

I find it curious that neither the McCain-Schumer bill, nor the Kennedy mark, nor the Edwards-Collins amendment, proposed any changes in the current 180-day regime in light of the views of the FDA officials, the dramatic increase of the potential value of 180-days of exclusivity, and other factors.

This may have been partly due to the fact that neither the FDA nor FTC nor any representatives from the Administration testified at the HELP Committee hearing on May 8th. In fact, no committee of Congress has ever held a hearing of the language that was marked-up and reported by the HELP Committee.

On any number of occasions, I have heard Senator SCHUMER and others argue that the simple goal of this legislation is to close loopholes in order to return to the original balance in the 1984 law.

But what if conditions have changed and the original policies of the 1984 need to be reassessed?

Or what if there were an area that we didn't get right the first time?

For example, consider how Paragraph IV litigation treats patent invalidity and patent non-infringement challenges. These are lumped together, and both, if proven, can result in identical 180-day marketing exclusivity awards. In truth, invalidity and non-infringement are two very different types of claims.

I want to remind my colleagues of, and challenge them to question the implications of, lumping these two concepts together. We need to re-think this policy. As Al Engelberg, a smart and tough-as-nails attorney who specialized in attacking drug patents on behalf of generic drug firm clients, has said about this difference:

> In cases involving an assertion of non-infringement, an adjudication in favor of one challenger is of no immediate benefit to any other challenger and does not lead to multi-source competition. Each case involving non-infringement is decided on the specific facts related to that challenger's product and provides no direct benefit to any other challenger. In contrast, a judgment of patent invalidity or enforceability creates an estoppel against any subsequent attempt to enforce the patent against any party. The drafters of the 180-day exclusivity provision failed to consider this important distinction.

Once again, as one of the drafters of this law, I accept my share of responsibility for failing to fully appreciate the implications of this distinction.

The 180-day rule acts as only a floor in non-infringement cases. A particular non-infringer's marketing exclusivity can extend beyond the statutory 180-days. This period of marketing exclusivity can last until such time as another non-infringer might enter the picture or until the underlying patents are invalidated or expire.

Conversely, it can be argued that the 180-day floor actually works to the detriment of consumers whenever the 180-days of exclusivity acts to block entry of a second non-infringing generic product during the 180-day period. Why shouldn't a second or third non-infringer be granted immediate access to the market as would occur in any other industry? Consumers could enjoy the savings that accrue from immediate price competition.

I would hope that my colleagues working on the bill, and others interested in this debate carefully consider the distinctions between invalidity and non-infringement challenges. This is an area where we might have gone off-base in 1984.

While I am of the mind to retain a strong financial incentive to encourage vigorous patent challenges by generic drug firms, I am unconvinced at this point that we should retain the old language that grants identical rewards for

successful invalidity and non-infringement claims. I welcome debate and discussion on this matter.

Before we change the law, let us have a serious re-examination of whether to retain the 180-day marketing exclusivity in its current form both in terms of the length of the exclusivity period and whether the rewards for successful invalidity and non-infringement challenges should be treated identically.

My purpose in raising these points is to get an indication from the sponsors of this legislation and other interested parties, such as patient advocacy organizations, state Medicaid agencies, and insurers, whether there is interest in discussing the advisability of passing on more of the value associated with the current 180-day marketing exclusivity to consumers if it appears it is fair and appropriate to do so?

If there is interest, I would be willing to help fashion an appropriate amendment. It seems to me that we need to provide enough of an incentive to assure vigorous patent challenges, but we should give away no more exclusivity than is necessary. Every day of marketing exclusivity awarded to a generic firm comes at the expense of consumers. While we want to ensure vigorous patent challenges, we don't want to set the benefit too high at the expense of consumers.

I think we can and should explore this area further.

Frankly, I am not certain that I completely understand how the forfeiture language in Section 5 of the bill works. I do not think I am alone in this confusion. I understand that this language was the source of much confusion during the mark-up in the HELP Committee.

At some point, I would like to engage in a colloquy with the bill managers to ask some questions designed to clarify precisely how this provision works.

Let me say that if the bill reinstates the successful defense requirement and gives awards to the successful challenger so long as the firm goes to market in a timely fashion, I may be supportive of the general concept. I do wonder if the language in the HELP substitute overturns the effect of the *MOVA*, *Purepac*, and *Granutec* cases that I described earlier?

I must say that I think that there are some real advantages to Senator GREGG's simple and straight-forward policy of more closely following FDA's old-fashioned, easy to understand use-it-or-lose-it proposal.

I will continue to study the particulars of the three minor recommendations that the FTC has made in connection to the 180-day issue.

I must also indicate that part of the confusion concerning the effect of this new Edwards-Collins language stems from the discussion of the provision at the mark-up. I understand that when Senator EDWARDS first explained this section of the bill he said that the exclusivity could roll over one time if the first qualified applicant did not use it. I am told that Senator EDWARDS indicated his language would eliminate the possibility that this could just continue to roll over and over and over during which time the exclusivity in the marketplace continues.

However, upon questioning from Senators GREGG, FRIST, and SESSIONS, the Committee staff then explained that if the second generic firm qualified does not use the exclusivity then the process would start all over again. The HELP Committee staff went on to explain, apparently in direct contradiction to Senator EDWARD's first explanation, that the exclusivity could roll indefinitely if there is no generic ready to go to market.

On the second day of the mark-up, Senator EDWARDS seemed to indicate that the Committee staff had it right and he had it wrong when he at first said that the provisions of Section 5 of the bill eliminated the policy of rolling exclusivity. In fact, I am told that Senator EDWARDS then acknowledged that if there were nobody to compete, then the exclusivity could keep rolling over and over.

I am afraid that the Edwards-Collins brand of modified-use-it-or-lose-it is, at least, very confusing. At worst, it is just another version of rolling exclusivity.

I want to learn what the FTC thinks about the Edwards-Collins language.

What the proponents of this language have failed to do is to explain why any third, fourth, fifth, or subsequent filer should be given 180-day of very valuable marketing exclusivity?

Moreover, why for example should a fifth filer be treated any differently than a sixth filer if neither has won a patent challenge and both are ready to go to market?

This dog just won't hunt.

Recall that some experts at FDA don't even think this incentive is necessary.

As I stated earlier, I am somewhat sympathetic to the concerns of generic drug firms that any exclusivity awarded should be measured from the time of an appellate court decision. But this principle may not hold up if any form of rolling exclusivity is adopted or if we have multiple patents and multiple challengers, some of whom are attacking on invalidity and some of whom are attacking on non-infringement.

Frankly, in light of the FTC report just issued this morning, I feel compelled to reconsider if my sympathies are consistent with my use-it-or-lose-it view even in the case, increasingly rare, I am told, of one patent and one challenger.

I am troubled by the provision of the bill that appears to grant each generic firm that qualifies for the benefit of the 180-day marketing exclusivity incentive a 30-month period to secure FDA approval. This is measured from the time of the filing of the generic drug application.

If the first firm eligible to take advantage of the 180-day benefit drops out for some reason, it seems to me that the best thing for consumers would be to approve all applications that are ready to go without singling out any of these applications for 180-days of exclusivity. If, for example, the second firm eligible under the terms of Section 5 is in a dispute with FDA over a good manufacturing practice inspection and can't go to market, it is consumers who will suffer. In a case where, say, there are 14-months remaining on the 30-month clock allowed under Edwards-Collins, it does not seem fair if the next firm eligible on the list already has satisfied all of the FDA requirements and is ready to go to market.

I would hope that the proponents of the substitute amendment will help us all understand just how Section 5 is intended to work.

It is difficult for me to see why we should adopt a policy whereby the balance of the 30-month period described in Section 5(a)(2)''(D)(i)(III)(dd)'' on page 44 of the bill could conceivably be greater than the 180-days of marketing exclusivity. Upon default of the first qualified applicant, why should we wait for a second eligible drug firm to obtain FDA approval when there may be a third, fourth, or fifth applicant in line with FDA approval ready to go?

I hope the sponsors of the legislation are not locked into their so-called modified-use-it-or-lose-it policy. The discussion at the HELP Committee mark-up suggests that the language is, in fact, just another elaborate version of the flawed rolling exclusivity policy. While I can readily see why rolling exclusivity is attractive to generic drugs firms—and their lawyers—who routinely challenge patents, I don't see where this policy is good for the American people.

Whatever happened to the American tradition that rewards success in litigation, not just filing papers with FDA and making a claim in court?

For all of the reasons I have just discussed, I think it would be wise for Congress to take time and reassess the wisdom of retaining the 180-day marketing exclusivity provision in essentially the same form as enacted in 1984.

As I argued last night, the Senate would be well-served if we had a more orderly discussion of the facts and recommendations contained in the new FTC study.

I see that my friend from Massachusetts is trying to spin the FTC study as supporting the changes in patent law contained in the HELP Committee substitute.

But the fact is, and it is a fact that will be better understood over time, that the FTC recommendations are at variance with the major provisions of the bill on the floor.

Let me just spell some of them out for you.

The FTC urges adoption of legislation that would allow one 30-month stay, measured from the time that each generic drug application is submitted while S. 812 limits the stay to

those patents issued within 30-days of the approval of the pioneer drug.

The HELP Committee Substitute contains several provisions that require innovator firms to list all, and sue on, their patents related to each particular pioneer drug or forfeit their customary patent rights; the FTC makes no such recommendations regarding patent forfeiture.

The HELP Committee Substitute creates a new private right of action to attack the listing of patents with FDA, while the FTC report makes no such recommendation.

The HELP Committee Substitute embraces a form of 180-day marketing exclusivity that allows the exclusivity to roll from one generic drug manufacturer to another in, I might add, a very complicated fashion that potentially has no clear endpoint. The FTC Report appears to support a very aggressive form of a use-it-or-lose-it policy which, for example, would trigger the 180-day period from the time of a district court decision. The pending legislation allows generic competition to be delayed until after an appellate court rules.

The FTC recommends that certain potentially anti-competitive arrangements between pioneer and generic firms be reported to the FTC in a fashion similar to Senator LEAHY's legislation, S. 754, the Drug Competition Act. The HELP Committee is silent in this respect.

So the differences are significant between the bill on the floor and what the FTC recommends.

No amount of spinning in the press will change these facts. In light of the FTC study and some of the arguments that I have made here today, I wonder if some of those who are backing S. 812 because they were told it is a good bill will now reconsider what the bill does and decide that they are being sold something of a bill of goods?

I would urge my colleagues, as well as consumer organizations and pharmaceutical purchasers such as insurers and self-insured businesses to reflect upon what I have said on this subject today.

This is an area in which I think we would be wise to reject Senator SCHUMER's argument that all we are doing with this legislation is restoring the balance of the old Hatch-Waxman Act.

On a number of occasions, I have commended Senator SCHUMER and Senator MCCAIN for moving their legislation forward. Even if the bill that came out of the HELP Committee does not resemble very closely their bill, and even if I still have major problems with this hastily considered floor vehicle, I commend them again today. I just hope that they, and Senators KENNEDY, FRIST, COLLINS, and EDWARDS will work to improve this legislation.

I think that over the last two weeks that I have made a case for taking the time to get this legislation right.

We all know that S. 812 was plucked from the calendar to be used as a vehicle to debate the Medicare Prescription Drug Benefit, not because it was some finely tuned consensus bill.

As I said last night, let us not rush to adopt legislation in this area before the ink is dry on the FTC report. We need to understand and debate the FTC report and its recommendations. My first reading of the Executive Summary of the FTC Study reveals a fundamental disconnect between the agency's recommendations and the legislation that emanated from the HELP Committee. The floor of the Senate is not the best place for the type of discussion the FTC Report warrants.

We need to allow the Judiciary Committee to play a role in fashioning legislation that is fundamentally an antitrust bill with patent law and civil justice reform implications. Certainly, the FTC smiled upon what the Judiciary Committee was doing in this area. And just as certainly, the PTO did not smile upon how the substitute to S.812 treats longstanding patent rights.

The detailed criticism that I have made to the pending bill in no way minimizes the importance of the matters that are the subject of the pending legislation, because they deserve Congressional attention.

Let me be clear. We should make some changes in the Hatch-Waxman Act. No law so complex cannot be improved.

But let's do it the right way because the American public deserves both the newest medicines and the most affordable medicines.

I do not believe, moreover, that S. 812 even identifies the most important issues we should address in Hatch-Waxman reform.

I hope to return to the floor to discuss some ideas for a more comprehensive approach to reforming the Drug Price Competition and Patent Term Restoration Act. I suspect that many others, including my friend, Henry Waxman, will want to participate in such a discussion.

I am unconvinced that focusing on how best to bring the law back to the old days of 1984 is the right way to go about reforming the Hatch-Waxman Act.

I think we may be well served if we attempt to modify the law in order to help usher in a new era of drug discovery while, at the same time, increasing patient access to the latest medicines.

Let us not adopt this hastily-crafted bill in the last week before August recess. Please do not hold your nose and close your eyes and vote for this bill by telling yourself that we can fix it in conference. We can do better.

We would do better in the long run for the American people if we put S. 812 aside for the time being and devote our attention to passing the Omnibus Trade Promotion Authority, Trade Adjustment Assistance, and Andean Pact legislation before this week runs out. We need to get the economy going again and trade can help us achieve that goal.

Let's face it. S. 812 is not ready for adoption, but the trade legislation is long overdue.

I ask unanimous consent that the letters from the PTO and BIO, discussed earlier in my speech, be made part of the RECORD.

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

BIOTECHNOLOGY INDUSTRY ORGANIZATION,
Washington, DC, July 22, 2002.

Hon. EDWARD KENNEDY,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR KENNEDY: Thank you for your prompt response to my letter of July 15 objecting to several new provisions of S. 812, the Schumer-McCain legislation. No one was more surprised than members of the biotechnology industry at these last-minute changes, which pose significant problems for our companies. At this stage in the debate, we must strongly object to these provisions and urge that they be deleted from the bill under consideration on the floor of the Senate.

The Biotechnology Industry Organization quite intentionally took no position on the particulars of the original version of the Schumer-McCain bill, leaving debate on the practices described in your letter to others. But the bill has been changed radically, without opportunity for members of our industry to provide legal and policy reaction to the new provisions on bioequivalence, loss of rights to sue for patent infringement, and a right of action for generics to sue our companies to ''correct'' patent information filed with the Food and Drug Administration.

In BIO's July 15 letter, I pointed out the potentially damaging consequences to our emerging industry that could result from these provisions—*carte blanche* authority of FDA to determine testing methods applicable to full NDAs, loss of the ability to protect our intellectual property because of failure to meet new filing deadlines under food and drug law, and an unwarranted private right of action afforded generic companies to sue members in efforts to ''delist'' patents or ''correct'' patent information. Whatever the *purposes* of these provisions, we fundamentally disagree with their *consequences*—perhaps the result of producing totally new provisions only 36 hours before markup.

We also point out that we were assured by committee staff that the bioequivalence provision was intended only to confirm FDA's authority to craft tests for bioequivalence for products not easily absorbed in the bloodstream. We were also assured that this provision (section 7) would be worked out before floor consideration. This has not occurred, despite the fact that BIO provided draft language that accomplishes precisely the stated purposes of the bioequivalence section.

BIO retains its admiration for you and your staff and appreciate very much your past efforts to respond to challenges that confront our industry in Massachusetts and across the nation. We have no doubt that you did not intend that the bill's new provisions pose threats to BIO companies, and look forward to an opportunity to work with you to remove from S. 812 the provisions on bioequivalence, loss of rights to sue for infringement and the private cause of action during its consideration on the Senate floor.

Sincerely yours,

CARL B. FELDBAUM,
President.

UNITED STATES PATENT
AND TRADE OFFICE,
Washington, DC, July 30, 2002.

Hon. ORRIN HATCH,
U.S. Senate,
Washington, DC.

DEAR SENATOR HATCH: In a few months, the United States Patent and Trademark Office (USPTO) will celebrate its 200th year in existence. During that time, we have been the only Federal agency charged with administering this Nation's patent laws and determining whether inventions are patentable. USPTO plays a critical role in promoting and protecting intellectual property and the work of our Agency helps to stimulate American innovation and investment.

At your request, USPTO is providing its views on the advisability of the changes in patent laws in S. 812, the Greater Access to Affordable Pharmaceuticals Act. This letter is intended to inform you of our objections to the current language in S. 812.

First, in some cases, S. 812 would forfeit unnecessarily the core right of patent holders—the right to exclude others from practicing the invention for the entire patent term. After years of research and development and significant investment, the patent right is extinguished for the mere failure to satisfy an administrative task or respond in a timely manner. For example, if a patent holder fails to list the patent with the Food and Drug Administration within a certain time period, the patent is invalidated. Furthermore, if a patent owner fails to bring an infringement action within 45 days of receiving notice (also known as 'Paragraph IV') from a drug manufacturer that the patent is invalid or not infringed by the generic drug, then the patent right is forfeited. In this circumstance, the patent owner is barred from ever bringing an infringement case in connection with the generic drug at issue.

Second, we are concerned with the bill's disparate treatment of patents depending on issue date. The Hatch-Waxman Act gives a patent holder an automatic 30-month stay to defend a challenge to the patent by a generic drug company. S. 812 would apply this 30-month stay only to patents that issue within 30 days of the new drug application approval. This limitation is arbitrary and unrealistic. The timing of issuance bears no relation to the importance of innovation. Moreover, the patent applicant often has no control over when a patent issues. Therefore, affording certain benefits to patents that issue only within a certain time frame would be unworkable and unjust.

Finally, USPTO believes it is vital to consider each patent rigorously and uniformly to determine whether the application satisfies the standards of patentability. All patent applications are examined with equal scrutiny and all patents must satisfy the same criteria of utility, novelty, and nonobviousness before they are issued. Each pharmaceutical patent, like all other patents, is entitled to a presumption of validity and should be judged accordingly.

USPTO does recognize that some changes to current law may be necessary to encourage appropriate access to generic substitutes and prevent abuses of the patent laws. But S. 812 clearly is not the answer. In fact, this bill would likely do the opposite of what its title suggests—by limiting access to cutting-edge drugs, decreasing innovation, and ultimately harming the quality of treatments available to patients.

Before considering any future legislative efforts, we should applaud the success of the time-tested Hatch-Waxman Act and respect the delicate industry balance it forged. In all cases, any changes should incorporate the expertise of the Committees on the Judiciary of Congress, in addition to the appropriate Government agencies. Only through a carefully conducted analysis can a result be reached that benefits consumers while promoting the progress of science and innovation.

I hope this information is helpful and I would welcome the opportunity for consultation on future endeavors.

Sincerely,

JAMES E. ROGAN,
Under Secretary and Director.

AMERICA MEMORIALIZES TWO MORE VIETNAM WAR HEROES

Mr. LOTT. Mr. President, I rise today in remembrance of a fellow Mississippian, Fred C. Cutrer Jr. and his navigator Leonard L. Kaster, who died serving their country during the Vietnam War. Captain Fred C. Cutrer Jr. was a pilot on a B57 Canberra Bomber, and during his service for his country, he became instantly known around his base as a loving husband and an immensely proud father of two sons. He would often be found showing pictures of his family to his friends and squadron. Fred was also courteous and friendly, exemplifying the character of a true southern gentleman. Jimmy Speed, a child-hood buddy described his charming character by stating,

I use to call him good-humor man. He was a very smart man, and people liked him immediately. I always felt that if he had gotten to the ground alive, those people wouldn't have hurt him because he was so likeable and friendly that he would have fit into any crowd.

On August 6, 1964 Cutrer and 1Lt. Leonard L. Kaster, unknowingly flew the skies for their last time. They were flying over South Vietnam, North East of Tan Son Nhut, and according to Defense Intelligence data, their airplane came under heavy fire from Viet Cong forces, causing them to crash and explode near the Sang Dong Nai River in Long Khan Province. Both men were classified ''Killed in Action, Body Not Recovered,'' and Cutrer was promoted to the rank of Major.

In the spring of 1997, the Department of Defense, with the help of a Vietnamese native, helped bring closure to Cutrer's family by finding Cutrer's dog tag and aircraft identification plate that had been buried one meter beneath the surface of a jungle bog. This discovery led to the declaration of these men's ceremonial burial for June 6, 2002, with full military honors. I am thankful to say that both of these men, nearly forty years following their patriotic death for their country, now lay buried in Arlington National Cemetery.

Both the Cutrer and Kaster families flew from Mississippi to attend the ceremony, and Air Force General Frank Faykes presented flags to the families of both men. Buried alongside Cutrer is his wife, Shirley, who was killed in an automobile accident four years ago. The children were pleased to see their father properly honored as a hero and their mother rightfully buried beside him.

American troops have a slogan stating, ''We leave no man behind.'' I believe this manifests the pride and patriotism of our troops. Cutrer's sister, Lillie Cutrer Gould, promised her younger brother that if anything were to happen to him in Vietnam, then she would bring him back home. Not too many days ago, Mrs. Gould successfully achieved her promise to her brother, and America again exercised its duty and commitment to its soldiers.

I salute John C. Cutrer Jr. and Leonard L. Kaster for serving their country and helping make America a better and safer place to live. I am thankful that I reside in a country where we take pride in our soldiers, and we carry a strong commitment never to forget their courageous acts nor to leave anyone behind. I want to thank God for allowing John and Shirley Cutrer to eternally lay side-by-side in Arlington's National Cemetery, and I want to thank America for again making me proud of our citizens. I know my colleagues will join me in memorializing and commending the lives of John C. Cutrer Jr. and Leonard L. Kaster, two American heroes.

REMEMBERING MR. JOHN M. McGEE

Mr. LOTT. Mr. President, I rise today to pay proper tribute to Mr. John M. McGee, a devoted husband, father, and grandfather as well as a memorable American patriot. John was born in Brookhaven, MS on September 16, 1933, and in February 23, 2002, John passed away as a result of a sudden heart attack. In his high-school years, John was blessed with speed and athleticism that contributed to his becoming an extraordinary football player and an excellent athlete. John's athleticism led him to set the state record in the 100-yard dash. John attended my alma mater, the University of Mississippi, where he played football for the Ole Miss Rebels. John's patriotism towards his country convinced him to interrupt his education at Ole Miss and enlist with the U.S. Navy where he served on the destroyer tender *Shenandoah* and the destroyer *Willard Keith*. During his duty in active service, John took part in the decisive Inchon invasion commanded by General Douglas McArthur.

John went on to earn his bachelor's degree in engineering from the Armed Forces Institute. After an honorable discharge, he pursued his career in engineering until 1966 when he accepted a job with the Department of Defense where he conducted operations in Vietnam, Cambodia, Laos, and Thailand until 1969. During John's service in Vietnam, he discovered and exposed extensive corruption in American military operations. The Governmental Accounting Office confirmed these allegations, and John's discovery revealed the theft of 5.5 million gallons of fuel that had been originally intended for U.S. Military forces but had been penetrated and used by the enemy. John's inquiry helped save the lives of many

Americans. His discovery ultimately led to a Senate Sub-Committee chaired by the Honorable Senator William Proxmire of Wisconsin to investigate the scandal. This incident is memorialized in the U.S. CONGRESSIONAL RECORD and in the books Report from Wasteland- America's Military Industrial Complex, by Senator William Proxmire and The Pentagonists, by A. Earnest Fitzgerald.

Our hearts are saddened with the loss of such a precious man, but at the same time we are grateful for his contributions to our country, the state of Mississippi, and his family. I know my colleagues will join me in honoring and appreciating the remarkable life of Mr. John M. McGee.

ELIMINATION OF THE WEP AND GPO

Mr. KERRY. Mr. President, today I have asked Senator FEINSTEIN to add me as a cosponsor to her bill, S. 1523, which would amend the Social Security Act to permanently repeal the Government Pension Offset and the Windfall Elimination Provision. I am pleased to support my colleague Senator KENNEDY and others in their support of this bill.

Massachusetts is one of 15 states in which the Government Pension Offset and the Windfall Elimination Provision hits employees and retirees particularly hard, because it is one of the few remaining states where many state employees, such as teachers, do not pay into the Federal Social security system. Rather, they pay into a state pension fund. For many workers, the formulas in the law that reduce Social Security benefits for these workers can have troubling and unintended consequences.

Listen to the testimonial of one educator from my state. This constituent writes:

> I served 13 years in the military and am a wartime veteran. I did not receive a military pension; however, I did pay into Social Security. I am shocked to learn that I may receive virtually nothing from Social Security. My teaching pension in Massachusetts will be small if I retire at 60 with only 22 years of teaching service. I had previously thought that Social Security would help to make up for the smaller teaching pension. I feel that the Federal government is unfairly penalizing those who have embarked on second careers as teachers. They have created a disincentive that will work against filling projected teaching shortages. I feel especially cheated as I did sacrifice much during my military career. It is obvious that I would be much better off financially had I not served at all. I hope this is not the message that the government wants to send.

The government pension offset has a significant impact on the benefits of many retired public employees just like this one. For example, a disabled former school employee and widow who retired in 1986 receives $403 a month from her school pension. That income results in the elimination of a $216 monthly Social Security survivor's benefit, to which she would otherwise be entitled. As a result, her total income is about 70 percent of the Federal poverty level. Another constituent, a retired widow who worked as a school cook, receives $233 a month from her school pension. Her Social Security widow's benefit is reduced by $155 because of the automatic offset. Her combined total income is about 76 percent of the Federal poverty level.

It is clear that the GPO and WEP, complex though they are, are causing pain and confusion. They also negatively impact teacher recruitment efforts, at a time where we sorely need teachers, yet the potential reduction in Social Security benefits makes it unlikely that people will turn to teaching for a few years at the tail end of their careers. Consider the irony: Individuals who have worked in other careers are less likely to want to become teachers if doing so will mean a loss of Social Security benefits they have earned, and yet our State and Federal policies are aimed at recruiting just those individuals to teaching as a second career. Retired teachers are also reluctant to return to teaching to help fill urgent needs because of the impact of the GPO and WEP. Finally, there is a fear that current teachers are likely to leave the profession to reduce the penalty they will incur upon retirement.

The reforms that led to the GPO and WEP are almost 20 years old, nearly a generation. They were passed before many of us were members of this body. Now that were are witnessing some of the impacts these 20-year old decisions are having on people's lives, we understandably want to help our constituents, and I support that effort. However, while I support the repeal of the GPO and WEP, I know that if we continue to address Social Security issues on a piecemeal basis, even expanding benefits as certain social needs dictate, without fixing the program's underlying imbalances and demographic challenges, we will make real reform more difficult when the time finally comes.

However, for the reasons outlined above, and the effect the provisions are having on my constituents, I believe it is essential that the GPO and WEP be repealed, preferably as part of an overall reform to Social Security, but by themselves if need be. My State, and others affected by the GPO and WEP, cannot afford to provide disincentives to be teachers or other public servants at this critical time.

LOCAL LAW ENFORCEMENT ACT OF 2001

Mr. SMITH of Oregon. Mr. President, I rise today to speak about hate crimes legislation I introduced with Senator KENNEDY in March of last year. The Local Law Enforcement Act of 2001 would add new categories to current hate crimes legislation sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred May 14, 1995 in Brooklyn, NY. A gay man was attacked by another man who used anti-gay slurs. The assailant, John McHenry, 25, was charged with second-degree assault, criminal possession of a weapon, and harassment in connection with the incident.

I believe that government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act of 2001 is now a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

ADDITIONAL STATEMENTS

TRIBUTE TO THE ARKANSAS MEMBERS OF THE MILITARY ORDER OF THE PURPLE HEART

• Mr. HUTCHINSON. Mr. President, it is my distinct privilege to recognize and pay tribute to the heroes of Arkansas who have been awarded the Purple Heart. This distinguished group of Americans are the recipient of our nation's earliest military decoration and the oldest in the world in present use. The Purple Heart is a combat decoration awarded in the name of the President of the United States to members of the armed forces who are wounded by an instrument of war in the hands of the enemy.

The Purple Heart was originated by General George Washington in 1782 to recognize ''instances of unusual gallantry.'' Referred to then as the Badge of Military Merit, the decoration was awarded only three times during the Revolutionary War. The modern Purple Heart was brought into existence by Army Chief of Staff, General Douglas MacArthur. The medal was designed by Miss Elizabeth Will, in the Office of the Quartermaster General, and was introduced by the War Department on February 22, 1932, the bicentennial of George Washington's birth.

The Military Order of the Purple Heart provides a loud and clear voice on behalf of veterans and the issues that concern them. The crucial work that they do reminds us of just how precious freedom is, and that those who have unselfishly risked everything in freedom's name are worthy of every benefit a grateful nation can afford.

On behalf of the United States Senate, I thank the Arkansas members of the Military Order of the Purple Heart for the sacrifices that they have made in defense of this great nation. •

HAPPY 275TH ANNIVERSARY BOW, NEW HAMPSHIRE

• Mr. SMITH of New Hampshire. Mr. President, I rise today to give my congratulations to the town of Bow, New Hampshire on their 275th anniversary.

Bow, New Hampshire is a quaint and inviting city and home to nearly 7,200

proud residents. The town was chartered in 1727 and began as an agricultural settlement. The waterways that stretch through Bow allowed the town to establish a series of mills that have since served as the heart of an area of town known affectionately as ''Bow Mills.'' Bow has also served as a historically significant stomping ground for many influential figures. Sergeant John Ordway, native to Bow, was part of the Lewis and Clark expedition and Andrew Jackson stopped in Bow on his 1833 New England Tour. Residents of this beautiful town are among the first in the nation to vote in primaries.

This progressive city has been able to maintain a family-oriented and relaxing environment for 275 years in spite of their close proximity to the two largest cities in New Hampshire. It is highly commendable that Bow has preserved a superbly low crime rate and given its residents a safe and secure town in which to live and raise their families. Bow is incomparable in so many ways, particularly the attention Bow gives to the public school system in their community. Bow's public schools are well maintained, well equipped with the latest technology to ensure cutting-edge education and skills training, and most importantly, provide an adequate number of teachers that can endow our children with guidance and direction. The student to teacher ratio is roughly 14 to 1. This is an astounding and praiseworthy circumstance and furnishes Bow's youth with the opportunity for one to one interaction in the classroom and an extended chance to explore each subject in greater depth.

Bow is truly one of the most unique and wonderful cities in New Hampshire and in the United States. It is said that Bow originally was given its name because of its literal positioning at the bow of the Merrimack River. I propose that perhaps Bow was given its name for its representational properties; the visual packaging of this town is beautifully decorated, however, what you discover inside the package is the true gift and reward.

Bow, New Hampshire, congratulations on your 275th anniversary. It is an honor to represent the citizens of Bow in the U.S. Senate.●

IN MEMORY OF RESERVIST ROBERT RANERI

● Mr. SMITH of New Hampshire. Mr. President, I rise today to honor the memory of a fallen soldier in the U.S. Military, Robert Raneri.

Robert Raneri was a captain and commander of the 94th Military Police Company in the Army Reserves and a highly respected and dedicated officer. Raneri's professionalism and dedication to the Army was thought by many to be unrivaled. In July of 2000, Captain Raneri led a unit of 600 soldiers in a mission to Bosnia. In the wake of a very politically and militarily charged conflict, Raneri returned nine months later with every one of the 600 soldiers alive and unscathed as he had promised upon their departure overseas. Those who worked with Robert knew him as a strong presence and as a man not afraid to take chances if it was in the best interest of the men he commanded and of the nation. His peers remember him as calm, deliberate, clear-headed, compassionate, tough, and exacting. These virtues combined created a fine leader, friend, and man in Mr. Robert Raneri.

Robert was to be married to Maj. Amy Huther a week after his June 26th passing, greatly looking forward to being a husband and a father someday. These dreams will cease to be realized for this exceptional man as a result of the unfortunate motorcycle accident that recently took his life.

Robert Raneri was a dedicated Army Reservist who spent his life serving the United States as a commanding officer to the 94th Military Police Company and his memory should be held in the highest respect. Robert's passing is a great loss not only for his family, but for the country and the U.S. Army.●

IN MEMORY OF ALBERT G. CAPPANNELLI

● Mr. SMITH of New Hampshire. Mr. President, I rise today in remembrance of a highly respected and valued member of the Manchester community and an esteemed public relations careerist, Mr. Albert G. Cappannelli.

Al began his work with public media as a radio news reporter after graduating from Boston University with a bachelor's degree in broadcast journalism. His fervor for the technique of media and journalism led Al to the arena of strategy consulting. As director of national media at High Point Communications, he developed tactics for clients throughout New Hampshire including the Department of Education as well as on the national circuit for companies including Anthem Blue Cross-Blue Shield, American Express Financial Services, and Maryland Public Service Commission. Colleagues described Albert as savvy and highly effective in his discipline.

In addition to Al's professional career, he established a well-deserved reputation as a community leader in Manchester. He volunteered his time and effort to a number of causes in the community spanning across interests with regard to both personal and social affairs. Al was an active member at St. Peter's in Auburn where he held a position on the parish council and was a parish facilitator for the Crown Ministries for the Diocese of Manchester. He was a huge advocate in matters surrounding education; volunteering his time with Weston Elementary School, Keene State College, McDonald Youth Leadership program, and as a member of the Greater Manchester Chamber of Commerce Education Committee.

Albert Cappannelli was the victim of an unfortunate and untimely passing as a result of liver cancer that had been diagnosed merely 2 weeks earlier. Albert is survived by his wife Jane of 16 years and his two children, Joshua and Helen.

Al spent his life and career serving public interest and revealed an uncompromising compassion and integrity throughout that endeavor. He was a fine man, respected colleague, and adored by all who knew him. I was proud to call him my friend, and honored to represent such a fine individual in the U.S. Senate.●

A TRIBUTE TO DEAN KAMEN

● Mr. SMITH of New Hampshire. Mr. President, I rise today to pay tribute to an innovator of the ages, an artist of medicine, and technological visionary, Mr. Dean Kamen.

As a prominent figure in the life and community of our State of New Hampshire we honor Mr. Kamen for his efforts and entrepreneurial spirit that have furthered the fields of science and technology in numerous ways with the advent of his inventions. The improvements in several medical procedures and enhancement of the administering of various drug treatments have vastly improved the lives of individuals who suffer from a range of illnesses. Mr. Kamen holds over 150 national and international patents and is renowned throughout the country as one of the greatest inventors of this age. Among his credits include the first wearable infusion pump, the first insulin pump for Diabetics, and the HomeChoice/TM/ dialysis machine.

Recently, Mr. Kamen was in New Hampshire to demonstrate to the Environment and Public Works Committee, his latest technological improvement, the Segway Human Transporter, an environmentally friendly and fuel-efficient mode of transportation for the 21st century. In attending this demonstration I was able to witness firsthand the incredible and impressive talent and vision of Mr. Kamen.

Dean Kamen accomplishments are well-recognized and his many awards include the Kilby Award for extraordinary contributions to society, the Heinz Award in Technology, and the National Medal of Technology given to him in 2000 by President Bill Clinton for inventions that have advanced medical care worldwide. In addition, Mr. Kamen was honored by the Juvenile Diabetes Research Foundation as ''2002 Person of the Year'' for work related to the research and advancement of diabetes treatment for youths.

Dean Kamen deserves to be recognized for his exceptional efforts at spreading the excitement of science and technology to the world at large. His advances for medical technology have been blanketed in the notion that technology can be of virtue and practical in our society, a proposition that is admirable and worthy of merit. Thank you, Dean, for all your efforts to aid others through the advancement

of medicine and technology. It is an honor to represent you in the U.S. Senate.●

THE 75TH ANNIVERSARY OF JENSEN'S RESIDENTIAL COMMUNITIES, INC.

● Mr. SMITH of New Hampshire. Mr. President, I rise today to pay tribute to the Jensen's Residential Communities, Inc., as they celebrate 75 years as an exceptional provider of affordable homes.

Today, I would like to give my congratulations to the Jensen family for their success in establishing and managing communities of premier manufactured homes. I would also like to extend my gratitude on behalf of New Hampshire and its local communities for providing such an excellent combined example of quality and economy.

The Jensen Residential Communities began in 1927 by Mr. Kristian Jensen Sr. as one of the pioneering manufactured home communities in New Hampshire. Since its inception, the housing communities have spread across to seven eastern states, totaling 27 developments. There are currently five Jensen Residential Communities in New Hampshire alone.

I want to congratulate the Jensen family once again for an admirable entrepreneurial endeavor and a first-rate product. Thank you for your continuous pledge to meet the needs of the American family. It is an honor to represent you in the US Senate.●

DAVID BIBBER IS RETIRING AFTER A LIFETIME OF PUBLIC SERVICE

● Mr. SMITH of New Hampshire. Mr. President, I rise today to commend and congratulate David Bibber who is retiring as chief of Dover's Fire and Rescue.

Davis Bibber has been chief of Dover, NH, Fire and Rescue team since 1978 and has recently decided his position as chief is in need of some ''new blood.'' Bibber was the new kid on the block when he began as a fireman at the Fairfax County fire department in 1962 at 18 years of age. David started as a volunteer and was permitted to live at the fire station while he finished school. After a few short years, David was granted a full-time job with the department. David's story is an inspirational example of the American dream; working his way up to the top.

On David's watch some major accomplishments have been achieved at Dover Fire and Rescue. Among them are the implementation of paramedic services, increased responsibility for emergency management services, greater enforcement of building codes, and an expansion in public education programs throughout the community pertaining to fire and safety. While David has been chief, Dover has also developed a central alarm system by combining the dispatch services for the police and fire department to lessen the response time for support.

Chief Bibber gives all the credit for his and the fire department's successes to his staff. He recognizes the hard work and dedication that each member of the team has offered in order to keep the city's rescue services running smoothly. David also recognizes the hard work that all city workers provide, respecting city counselors in particular for their pro bono duties and efforts to make the lives of Dover residents better.

Congratulations to Mr. David Bibber. I thank you, New Hampshire thanks you, and the city of Dover thanks you for serving the interests of the people with care and capability.●

TRIBUTE TO GEN. JOSEPH P. HOAR, U.S. MARINE CORPS, RETIRED

● Mr. LEVIN. Mr. President, I rise today to congratulate General Joe Hoar on the occasion of his retirement as Chairman of the Board of Directors of The Retired Officers Association, TROA.

Born in Boston, MA, General Hoar entered the Marine Corps as a Second Lieutenant in 1958, following his graduation from Tufts University. As an infantry officer, he commanded at all levels from platoon to regiment; he also commanded three Marine Corps Air Ground Task Forces. As a senior military officer, General Hoar became well-known to the members of the Armed Services Committee with his tours of duty as the Deputy Chief of Staff for Plans, Programs and Operations for the Marine Corps during the Gulf War, and, from 1991 to 1994, as the Commander in Chief, U.S. Central Command, the unified command that had the operational responsibilities for the Middle East, South Asia, and the Horn of Africa. He retired from active duty on September 1, 1994 after 37 years of commissioned service in the U.S. Marine Corps.

General Hoar's dedication to service and excellence has not diminished since leaving active duty. He served as a Trustee for the Center for Naval Analyses at Suffolk University in Boston, and as a Fellow of the World Economic Forum in Geneva, Switzerland. General Hoar was elected to TROA's board of directors in 1996. For the last two years, he served as TROA's Chairman of the Board, the position from which he is now retiring.

Through his stewardship, TROA continues to play a vital role as an advocate of legislative initiatives to maintain readiness and improve the quality of life for all members of the uniformed service community—active: reserve, and retired, plus their families and survivors.

General Hoar has been a strong supporter of the Senate's efforts to improve military readiness and quality-of-life through a competitive compensation package for active and reserve forces, improving health care for retired personnel and their families, and enhancing protections for the survivors of deceased service members. Under his leadership, TROA has been an invaluable source of information during the Senate's deliberations on a long list of compensation and benefits issues during this extraordinarily productive period.

General Joe Hoar has been a leader in every sense of the word in the U.S. Marine Corps, in TROA, and in the entire military retiree community. I know my colleagues join me in extending very best wishes to General Hoar for continued success in service to his Nation and the uniformed service members whom he has so capably led and served.●

IN HONOR OF NATIONAL CHEESECAKE DAY

● Mr. DURBIN: Mr. President, today is a very special day for all Americans, but it is especially near and dear to the hearts of many residents of my home State of Illinois, because today has been designated as National Cheesecake Day.

Some may be tempted to dismiss National Cheesecake Day as another meaningless holiday. To those unenlightened few, I extend my sympathies. For you have truly missed out on one of life's sweetest pleasures. You see, in Illinois, especially in the greater Chicago area, National Cheesecake Day can only mean one thing, Eli's Cheesecake.

When long-time restaurateur and Chicagoan Eli Schulman founded Eli's: The Place for Steak Restaurant, one of his marquee offerings was a superb cheesecake. It quickly became one of Chicago's favorite desserts. So popular, in fact, that Eli's began producing it for other restaurants and retail outlets across the country. Eli's Cheesecake Company has now been a Chicago icon in its own right for more than 20 years.

Since its 1980 debut at the first Taste of Chicago, Eli's Cheesecake has grown to become the largest specialty cheesecake company in the country. In both 1993 and 1997, Eli's Cheesecake was selected to participate in the presidential inaugural festivities, they have supplied desserts on Air Force One for Presidents Reagan to Clinton, and Eli's Cheesecake provided the cake for the First Lady's birthday bash in 1997.

How does a humble homemade Chicago dessert go from after-dinner obscurity to gracing the plates of Presidents and First Ladies?

Actually, there are two answers. The first is the taste. If you've ever had a bite of an Eli's cheesecake, you'd know that there is nothing like it anywhere in the world. Eli's has taken great care to continue making each cheesecake by hand—the same way the very first one was made. This ensures each bite will have the rich, creamy Eli's taste so many have come to love.

The second is the spirit of Eli Schulman himself.

In 1910, a young man named Eli Schulman was born on Chicago's West

Side. Although Eli's father owned a bakery on Roosevelt Road, times were hard for the Schulmans.

Eli was forced to leave school and embark on a series of jobs to support his family, doing everything from selling newspapers, to peddling seat cushions at ballparks, to managing a shoe store and selling women's dresses.

In 1940, Eli decided to open his own restaurant called the Ogden Huddle. Soon after World War II breaks out, two signs appear in the restaurant's window. The first offers a 25 percent discount to men in uniform. The second simply states ''If you are hungry and don't have any money, come in and we'll feed you free.'' This spirit of generosity was carried throughout Eli Schulman's life.

Following the war, in the 1940s and 50s Eli's business expands and his new restaurants become ''hot spots'' for both the Rush Street and Lake Shore Drive set. When in town, entertainers such as Barbara Streisand, pianist Bobby Short and comedian Sheky Green often can be found frequenting Eli's.

In 1966, Eli and his Wife Esther realized their dream of opening a white-tablecloth establishment, Eli's The Place for Steak, in what was then the luxury hotel The Carriage House. Eli's soon became the spot for celebrities and dignitaries to dine. Everyone from Frank Sinatra and Sammy Davis Jr. to Gayle Sayers of the Chicago Bears and comedian Henny Youngman, all began to make Eli's their place for steak.

In the late 1970s, following up on a suggestion from a customer about his dessert, Eli spent several weeks coming up with a recipe that pleases everyone. Eli's Cheesecake quickly became a marquee offering at Eli's the Place for Steak. In the next few years, this rich and creamy dessert became such a hit that Eli's began producing cheesecakes for other restaurants and retail outlets.

Although Eli Schulman passed away in 1988, a playground in Seneca Park, located across the street from Eli's the Place for Steak, has been dedicated to his memory. And Eli Schulman's spirit lives on in the company he started. His son, Marc Schulman and Marc's wife Maureen, are dedicated to providing their customers with products and services that live up to the name ''Chicago's Finest.''

Eli's Cheesecake now employs more than 200 associates, the company's growth has been dramatic, and its headquarters, Eli's Cheesecake World, is a 62,000 square-foot state-of-the-art bakery, visitor center, and cafe.

Today, the company makes more than 15,000 cheesecakes every day for sale to restaurants, supermarkets, and airlines. Eli's Cheesecakes are also available to the public via the company's thriving mail-order business and Web site.

In honor of this great day, I have brought a taste of Chicago to the U.S. Senate. Earlier today, I delivered a sample of Eli's Cheesecakes to both the Democratic and Republican Cloakrooms for my colleagues to enjoy.

As we go about the Nation's business today, I hope that each of my colleagues will take a moment to enjoy the treats in the cloakrooms and ponder the words of a respected American writer who once proclaimed that cheesecake was the truest democratic dessert, it is a mix of different ingredients that did not care much for the presence of an upper crust.●

HONORING ROSWELL, NEW MEXICO UPON BEING SELECTED AS A 2002 NATIONAL CIVIC LEAGUE ALL-AMERICA CITY

● Mr. DOMENICI. Mr. President, I rise to join the National Civic League in recognizing the city of Roswell, NM as a recipient of the 2002 All-America City award.

Roswell is one of the most fascinating cities in America. Perhaps Roswell's most notorious claim to fame is the 1947 ''Roswell Incident,'' in which an alleged space craft is said to have crashed nearby. It was in Roswell that Dr. Robert H. Goddard chose to launch the first rockets into space, propelling him into history as the father of space exploration. The New Mexico Military Institute, noted for such distinguished alums as Roger Staubach, Sam Donaldson, and Conrad Hilton, has been training tomorrow's future leaders in the Roswell area since 1891. However, Roswell has much more to offer than stories about extraterrestrials.

The city has been at the forefront of local civic programs aimed at improving community standards. The Nothing Other Than Excellence, NOTE, program emphasizes how music appreciation can benefit reading and math abilities. A low-income dental program, the Community Dental Initiative, has provided a creative way to provide access to affordable dental needs by combining a mobile dental clinic with a permanent clinic helping to reach under-served people. In addition, the city has taken up my initiative to get schools and communities involved in character education. They have developed a citywide program involving schools, parents, churches, and the government to promote Character Counts, a program that stresses the importance of trustworthiness, respect, responsibility, caring, citizenship, and fairness in young people's lives.

It is for their civic work that the National Civic League recognized Roswell as an All-America City. For the past 53 years, the National Civic League annually chooses 10 outstanding communities for their efforts to involve community members in innovative projects to address local challenges. I am pleased that Roswell has tried to create a better community through active public participation in civic activities.

Roswell's success is due to the active involvement of the community and their willingness to make a difference in each other's lives. All of Roswell can bask in the honor of being selected as an All-America City. This could not have been achieved without everyone's support. I commend you all on your well deserved recognition.●

MESSAGE FROM THE HOUSE

At 2:15 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. 5005. An act to establish the Department of Homeland Security, and for other purposes.

MEASURES PLACED ON THE CALENDAR

The following bill was read the first and second times by unanimous consent, and placed on the calendar:

H.R. 5005. An act to establish the Department of Homeland Security, and for other purposes.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, which were referred as indicated:

EC–8288. A communication from the Acting Director, Office of Regulatory Law, Board of Veterans' Appeals, Department of Veterans' Affairs, transmitting, pursuant to law, the report of a rule entitled ''Board of Veterans' Appeals: Rules of Practice—Attorney Fee Matters'' (RIN2900–AI98) received on July 26, 2002; to the Committee on Veterans' Affairs.

EC–8289. A communication from the General Counsel, Federal Emergency Management Agency, transmitting, pursuant to law, the report of a rule entitled ''Suspension of Community Eligibility'' (Doc. No. FEMA–7787) received on July 26, 2002; to the Committee on Banking, Housing, and Urban Affairs.

EC–8290. A communication from the Chairman, Federal Deposit Insurance Corporation, transmitting, pursuant to law, the Corporation's Annual Report for calendar year 2001; to the Committee on Banking, Housing, and Urban Affairs.

EC–8291. A communication from the Assistant Secretary of Defense, Force Management Policy, transmitting, pursuant to law, a report concerning the approval of the demonstration project plan for the U.S. Army Communications-Electronics Command (CECOM) Research, Development, and Engineering Community (RDEC); to the Committee on Armed Services.

EC–8292. A communication from the Chairman, Office of the General Counsel, Federal Election Commission, transmitting, pursuant to law, the report of a rule entitled ''Reorganization of Definition of Contribution and Expenditure'' received on July 26, 2002; to the Committee on Rules and Administration.

EC–8293. A communication from the Assistant General Counsel for Regulatory Law, Office of Procurement and Assistance Policy, Department of Energy, transmitting, pursuant to law, the report of a rule entitled

''Greening the Government Requirements in Contracting'' (AL–2002–05) received on July 26, 2002; to the Committee on Energy and Natural Resources.

EC–8294. A communication from the Assistant General Counsel for Regulatory Law, Office of Procurement and Assistance Policy, Department of Energy, transmitting, pursuant to law, the report of a rule entitled ''Processing Requests for Indemnification or Other Extraordinary Contractual Relief Under Pub. L. 85–804'' (AL–2002–04) received on July 26, 2002; to the Committee on Energy and Natural Resources.

EC–8295. A communication from the Director, Regulations Policy and Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Secondary Direct Food Additives Permitted for Direct Addition to Food for Human Consumption; Materials Used as Fixing Agents in the Immobilization of Enzyme Preparations'' (Doc. No. 89F–0452) received on July 26, 2002; to the Committee on Health, Education, Labor, and Pensions.

EC–8296. A communication from the Director, Regulations Policy and Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Digoxin Products for Oral Use; Revocation of Conditions for Marketing'' (RIN0910–AC12) received on July 26, 2002; to the Committee on Health, Education, Labor, and Pensions.

EC–8297. A communication from the Regulations Coordinator, Centers for Medicare and Medicaid Services, transmitting, pursuant to law, the report of a rule entitled ''Medicare and Medicaid Programs; Technical Change to Requirements for the Group Health Insurance Market; Non-Federal Governmental Plan Exempt from HIPAA Title I Requirements'' (RIN0938–AK00) received on July 25, 2002; to the Committee on Finance.

EC–8298. A communication from the Regulations Coordinator, Centers for Medicare and Medicaid Services, transmitting, pursuant to law, the report of a rule entitled ''Medicare Program; End-Stage Renal Disease-Removal of Waiver of Conditions for Coverage under a State of Emergency in Houston, Texas Area'' (RIN0938–AL39) received on July 25, 2002; to the Committee on Finance.

EC–8299. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Information Reporting Requirements for Certain Payments Made on Behalf of Another Person, Payments to Joint Payees, and Payments of Gross Proceeds from Sales Involving Investment Advisors'' (RIN1545–AW48; TD9010) received on July 26, 2002; to the Committee on Finance.

EC–8300. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Guidance Regarding the Active Trade or Business Requirement of Section 355(b)'' (Rev. Rul. 2002–49, 2002–32) received on July 26, 2002; to the Committee on Finance.

EC–8301. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Regulations Governing Practice Before the Internal Revenue Service'' (RIN1545–AY05; TD90114) received on July 26, 2002; to the Committee on Finance.

EC–8302. A communication from the Chief, Regulations Division, Bureau of Alcohol, Tobacco, and Firearms, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Addition of New Grape Variety Names for American Wines'' (RIN1512–AC29) received on July 26, 2002; to the Committee on Finance.

EC–8303. A communication from the Chairman, Medicare Payment Advisory Commission, transmitting, pursuant to law, the Commission's June 2002 Report Assessing Medicare Benefits; to the Committee on Finance.

EC–8304. A communication from the Deputy Associate Administrator, Office of Acquisition Policy, General Service Administration, Department of Defense, transmitting, pursuant to law, the report of a rule entitled ''Federal Acquisition Regulation; Federal Acquisition Circular 2001–07'' (FAC 2001–07) received on July 18, 2002; to the Committee on Governmental Affairs.

EC–8305. A communication from the Director, Federal Emergency Management Agency, transmitting, pursuant to law, the Inspector General's and Director's semiannual reports that address the Agency's audit and audit follow-up activities during the period October 1, 2001 through March 31, 2002; to the Committee on Governmental Affairs.

EC–8306. A communication from the Federal Co-Chairman, Appalachian Regional Commission, transmitting, pursuant to law, the report of the Office of the Inspector General for the period October 1, 2001 through March 31, 2002; to the Committee on Governmental Affairs.

EC–8307. A communication from the Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Closure of the Spring Commercial Red Snapper Fishery in the Gulf of Mexico Exclusive Economic Zone'' received on July 26, 2002; to the Committee on Commerce, Science, and Transportation.

EC–8308. A communication from the Director of the United States Office of Personnel Management, Office of Insurance Programs, Office of Personnel Management, transmitting, pursuant to law, the report of a rule entitled ''Suspension of CHAMPVA or TRICARE or TRICARE-for-Life Eligibles' Enrollment in the Federal Employees Health Benefits (FEHB) Program'' (RIN3206–AJ36) received on July 26, 2002; to the Committee on Governmental Affairs.

EC–8309. A communication from the Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of the Office of the Inspector General for the period October 1 , 2001 through March 31, 2002; to the Committee on Governmental Affairs.

EC–8310. A communication from the Inspector General, General Services Administration, transmitting, pursuant to law, the report of the Office of the Inspector General for the period October 1, 2001 through March 31, 2002; to the Committee on Governmental Affairs.

EC–8311. A communication from the Deputy Associate Administrator, Office of Acquisition Policy, National Aeronautics and Space Administration, General Services Administration, Department of Defense, transmitting, pursuant to law, the report of a rule entitled ''Federal Acquisition Regulation; Federal Acquisition Circular 2001–08'' (FAC 2001–08) received on July 26, 2002; to the Committee on Governmental Affairs.

EC–8312. A communication from the Administrator, Small Business Administration, transmitting, pursuant to law, the report of the Office of the Inspector General for the period October 1, 2001 through March 31, 2002; to the Committee on Governmental Affairs.

EC–8313. A communication from the Executive Officer, National Science Board, transmitting, pursuant to law, the Board's report under the Government in the Sunshine Act for calendar year 2001; to the Committee on Governmental Affairs.

EC–8314. A communication from the Secretary of Commerce, transmitting, pursuant to law, the Fiscal Year 2001 Annual Program Performance Report and the Fiscal Year 2003 Annual Performance Plan; to the Committee on Governmental Affairs.

EC–8315. A communication from the Inspector General Liaison, Selective Service System, transmitting the report of the Office of the Inspector General for the period October 1, 2001 through March 31, 2002; to the Committee on Governmental Affairs.

EC–8316. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $50,000,000 or more to Japan; to the Committee on Foreign Relations.

EC–8317. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles or defense services sold commercially under contract in the amount of $50,000,000 or more to Russia, Ukraine and Norway; to the Committee on Foreign Relations.

EC–8318. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $50,000,000 or more to Canada; to the Committee on Foreign Relations.

EC–8319. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to Pakistan; to the Committee on Foreign Relations.

EC–8320. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to Pakistan; to the Committee on Foreign Relations.

EC–8321. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to India; to the Committee on Foreign Relations.

EC–8322. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $50,000,000 or more to Turkey, Australia, Italy, Germany, Norway, and Canada; to the Committee on Foreign Relations.

EC–8323. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to Pakistan; to the Committee on Foreign Relations.

EC–8324. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to Pakistan; to the Committee on Foreign Relations.

EC–8325. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to

the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to Pakistan; to the Committee on Foreign Relations.

EC–8326. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $50,000,000 or more to Russia and Kazakhstan; to the Committee on Foreign Relations.

EC–8327. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to Pakistan; to the Committee on Foreign Relations.

EC–8328. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to Pakistan; to the Committee on Foreign Relations.

EC–8329. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to Pakistan; to the Committee on Foreign Relations.

EC–8330. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to Pakistan; to the Committee on Foreign Relations.

EC–8331. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to Pakistan; to the Committee on Foreign Relations.

EC–8332. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to Pakistan; to the Committee on Foreign Relations.

EC–8333. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to Pakistan; to the Committee on Foreign Relations.

EC–8334. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to India; to the Committee on Foreign Relations.

EC–8335. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $50,000,000 or more to Thailand and France; to the Committee on Foreign Relations.

EC–8336. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of technical data and defense services to India; to the Committee on Foreign Relations.

EC–8337. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles to India; to the Committee on Foreign Relations.

EC–8338. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $50,000,000 or more to the Netherlands; to the Committee on Foreign Relations.

EC–8339. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of technical data and defense services to India; to the Committee on Foreign Relations.

EC–8340. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of technical data and defense services to India; to the Committee on Foreign Relations.

EC–8341. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of technical data and defense services to India; to the Committee on Foreign Relations.

EC–8342. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of the certification of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $50,000,000 or more to Turkey; to the Committee on Foreign Relations.

EC–8343. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to law, a report concerning fees for passport services; to the Committee on Foreign Relations.

EC–8344. A communication from the President of the United States, transmitting, consistent with the War Powers Resolution, a report on the deployment of combat-equipped U.S. Armed Forces to Bosnia and Herzegovina and other states in the region in order to participate in and support the North Atlantic Treaty Organization (NATO)-led Stabilization Force (SFOR); to the Committee on Foreign Relations.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. BIDEN, from the Committee on Foreign Relations, with amendments:

S. 1777: A bill to authorize assistance for individuals with disabilities in foreign countries, including victims of landmines and other victims of civil strife and warfare, and for other purposes.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of committees were submitted:

By Mr. BIDEN for the Committee on Foreign Relations.

*James Howard Yellin, of Pennsylvania, 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 Burundi.

Nominee: James H. Yellin.

Post: Ambassador to Burundi.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Contributions, Amount, Date, Donee:

1. Self, none.

2. Spouse, not applicable.

3. Children and Spouses Names: not applicable.

4. Parents Names:

Herman A. Yellin, (deceased).

Liliian D. Yellin, (deceased).

5. Grandparents Names: (deceased).

6. Brothers and Spouses Names: not applicable.

7. Sisters and Spouses Names: not applicable.

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*Kristie Anne Kenney, of Maryland, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Ecuador.

Nominee: Kristie A. Kenney.

Post: Ambassador to Ecuador.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Contributions, Amount, Date, Donee:

1. Self, none.

2. Spouse, none.

3. Children and Spouses names:

We have no children.

4. Parents names:

Jeremiah J. Kenney, Jr and Elizabeth Kenney—no contributions.

5. Grandparents Names:

Jeremiah J. Kenney—deceased 1972; Selma J. Kenney—deceased 1985.

George Cornish—deceased 1945; Irma Cornish—deceased 1972.

6. Brothers and Spouses Names:

John Kenney and Lisanne Dickson (wife)—No contributions.

7. Sisters and Spouses Names:

I have no sisters.

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*Barbara Calandra Moore, of Maryland, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Nicaragua.

Nominee: Barbara Calandra Moore.

Post: U.S. Ambassador to Nicaragua.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Contributions, Amount, Date, Donee:

1. Self: none.

2. Spouse: Spencer B. Moore, none.

3. Children and Spouses Names: Nicholas A. Moore, none.

4. Parents Names: Mary G. Calandra, none.

5. Grandparents Names: deceased: Peter & Concetta Calandra, Frank & Ana Galza.

6. Brothers and Spouses Names: N/A.

7. Sisters and Spouses Names: Christine C. Varian, none; Edward S. Varian, none.

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*John William Blaney, of Virginia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Liberia.

Nominee: John W. Blaney III.

Post: Monrovia, Liberia.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Contributions, Amount, Date, Donee:

1. Self, John W. Blaney III, None.

2. Spouse, Robin Suppe-Blaney, None.

3. Children and Spouses Names: Marla Blaney, none; Vanessa Blaney, none.

4. Parents Names: John W. Blaney, Jr., (deceased); May E. Blaney, none.

5. Grandparents Names: John W. Blaney, (deceased); Ethel Davis Luke, (deceased).

6. Brothers and Spouses Names: Charlene Gerrish (sister), none; Hal Gerrish, none.

7. Sisters and Spouses names: N/A.

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*Martin George Brennan, of California, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of American to the Republic of Zambia.

Nominee: Martin George Brennan.

Post: Lusaka.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Contributions, amount, date, donee:

1. Self, none.

2. Spouse: Giovanna Lucia Brennan, none.

3. Children and Spouses Names: Sean Robert Brennan, none; Peter Francis Brennan, none; Elsabet Sophia Brennan, none.

Note: none of my children are married.

4. Parents Names: Robert Martin Brennan, (deceased); Carol Ida (Puccini) Brennan, none.

5. Grandparents: Names: George Mansueto Puccini, (deceased); Rose Puccini, (deceased): Note: father's parents deceased for over 35 years.

6. Brothers and Spouses Names: David Donovon Brennan, none; Jody Brennan (spouse), none.

7. Sisters and Spouses Names: Claire R. Brennan Cavero, none; Nevin Cavero (spouse), none; Moira C. Brennan, none (not married).

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*Vicki Huddleston, of Arizona, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of American to the Republic of Mali.

Nominee: Vicki Huddleston.

Post: Mali.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Contributions, amount, date, donee:

1. Self, Vicki Huddleston, none.

2. Spouse: Robert Huddleston, none.

3. Children and Spouses Names: Robert S. Huddleston, none; Alexandra Huddleston, none.

4. Parents Names: Howard S. Latham, none; Duane L. Latham, none.

5. Grandparents Names: Edward & Mary Dickinson (deceased); Marion & Pauline Latham (deceased).

6. Brothers and Spouses Names: Gary & Louise Latham, $100 to Alfredo Guiterrez (D–AZ); Steve Latham, Jeffrey Latham, none.

7. Sisters and Spouses Names: none.

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*Donald C. Johnson, of Texas, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Cape Verde.

Nominee: Donald Crandall Johnson.

Post: Cape Verde.

Contributions, Amount, Date, Donee.

1. Self, Donald Crandall Johnson, none.

2. Spouse, Nelda Sabillon Johnson, none.

3. Children and spouses: Robert E. Johnson, none; Stephen C. Johnson, none; Melodie Johnson, none.

4. Parents: Edson Johnson, Jr., $16.27, CY 2000, Democratic Party, and Sidney L. Johnson, none.

5. Grandparents: Deceased.

6. Brothers and spouses: Thomas C. Johnson, $25, CY 1999, Republican Party; Rosalinda Johnson, none; James C. Johnson and Julie Johnson, none; David C. Johnson and Bonfilla Johnson, none; Paul C. Johnson and Angie Johnson, none.

7. Sisters and spouses: Melinda B. Johnson, none; A.H. Najmi, none.

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*Jimmy Kolker, of Missouri, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Uganda.

Nominee: Jimmy Kolker.

Post: Ambassador to Uganda.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Contributions, Amount, Date, Donee.

1. Self, Jimmy Kolker, $650—1998, $500—1999, $500—2000, Rush Holt for Congress.

2. Spouse: Britt-Marie Forslund, none.

3. Children and spouses, Anne K. Kolker, none; Eva K. Kolter, none.

4. Parents: Leon Kolker, $25, 1998, Tom Daschle for Senate; Harriette Coret, none.

5. Grandparents: Deceased.

6. Brothers and spouses: Danny Kolker and Annette Fromm, none.

7. Sisters and spouses: none.

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*Gail Dennise Thomas Mathieu, of New Jersey, 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 Niger.

Nominee: Gail Dennise Mathieu.

Post: Chief of Mission.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Contributions, amount, date, donee:

1. Self: none.

2. Spouse: Erick Mathieu, none.

3. Children and spouses names: Yuri Kasim Mathieu, none.

4. Parents names: Herbert D. Thomas (deceased); Mildred Thomas (deceased).

5. Grandparents names: Mary Simmons (deceased); Emma Israel (deceased).

6. Brothers and spouses names: Nairobi Sailcat, none.

7. Sisters and spouses names: none.

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*Larry Leon Palmer, of Georgia, 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 Honduras.

Nominee: Larry L. Palmer.

Post: Ambassador to Honduras.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Contributions, donee, date, amount:

1. Self: None.

2. Spouse: Lucille Palmer, none.

3. Children and spouses names: Vincent Palmer, none.

4. Parents names: Rev. Roosevelt (deceased) & Mrs. Gladys Palmer, none.

5. Grandparents names: Augustus & Litha Young, Joseph & Inez Palmer (all deceased).

6. Brothers and spouses names: Rev. Roosevelt V. & Theresa Palmer, none. Charles W. and Iris Palmer (deceased).

7. Sisters and spouses names: Miriam Louise and Louis Golphin, none.

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*J. Anthony Holmes, of California, a Career Member of the Senior Foreign Service, Class of Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Burkina Faso.

Nominee: Joseph Anthony Holmes.

Post: Ouagadougou, Burkina Faso.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Contributions, Amount, Date, Donee:

1. Self: J. Anthony Holmes, none.

2. Spouse: Ingalill M. Holmes, none.

3. Children and Spouses Names: Carl-Axel Holmes, none; Eric A. Holmes, none.

4. Parents Names: Joseph A. Holmes, (deceased 1991); Mary Louise Holmes, (deceased 1978).

5. Grandparents Names: Clifford & Susan Holmes, (deceased 1972).

6. Brothers and Spouses Names: Christopher J. Holmes, none; Mark & Elizabeth Holmes, none; Paul & Joan Holmes, none.

7. Sisters and Spouses Names: none.

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*Aurelia E. Brazeal, of Georgia, a Career Member of the Senior Foreign Service, Class of Career Minister, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Federal Democratic Republic of Ethiopia.

Nominee: Aurelia E. Brazeal.

Post: Ambassador to Ethiopia.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Contributions, Amount, Date, Donee:

1. Self, none.

2. Spouse, N/A.

3. Children and Spouses Names: N/A.

4. Parents Names: Mrs. Ernestine E. Brazeal, none.

5. Grandparents Names: N/A.

6. Brothers and Spouses Names: N/A.

7. Sisters and Spouses Names: Ms. Ernestine W. Brazeal, none.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

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. JEFFORDS (for himself, Mr. BINGAMAN, Mrs. LINCOLN, and Mrs. MURRAY):

S. 2819. A bill to amend title XXI of the Social Security Act to permit qualifying States to use a portion of their unspent allotments under the State children's health insurance program to expand health coverage under that program or for expenditures under the medicaid program, and for other purposes; to the Committee on Finance.

By Mrs. CARNAHAN (for herself and Mr. LEAHY):

S. 2820. A bill to increase the priority dollar amount for unsecured claims, and for other purposes; to the Committee on the Judiciary.

By Mr. FRIST (for himself, Mr. BINGAMAN, Mr. DODD, Mr. STEVENS, Mrs. CLINTON, Mr. WARNER, Mrs. MURRAY, Mr. DEWINE, and Mr. LUGAR):

S. 2821. A bill to establish grants to provide health services for improved nutrition, increased physical activity, obesity prevention, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. WYDEN:

S. 2822. A bill to prevent publicly traded corporations from issuing stock options to top management in a manner that is detrimental to the long-term interests of shareholders; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. AKAKA (for himself and Mr. CRAIG):

S. 2823. A bill to amend the Organic Act of Guam for the purposes of clarifying the local judicial structure of Guam; to the Committee on Energy and Natural Resources.

By Mr. KERRY (for himself and Mr. KENNEDY):

S. 2824. A bill to amend the Internal Revenue Code of 1986 to provide for the treatment of single sum deferred compensation payments received by survivors of terrorist attack victims; to the Committee on Finance.

By Mr. DORGAN (for himself and Mr. WARNER):

S. 2825. A bill to amend the Internal Revenue Code of 1986 to allow a nonrefundable tax credit for contributions to congressional candidates; to the Committee on Finance.

By Mr. SCHUMER (for himself, Mr. CRAIG, Mr. KENNEDY, and Mr. MCCAIN):

S. 2826. A bill to improve the national instant criminal background check system, and for other purposes; to the Committee on the Judiciary.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. KERRY (for himself, Mr. JEFFORDS, Mrs. MURRAY, Mr. LIEBERMAN, Mr. AKAKA, Mr. DURBIN, Mrs. BOXER, Ms. CANTWELL, Mr. TORRICELLI, Mr. LEAHY, Mr. FEINGOLD, and Mr. BINGAMAN):

S. Res. 311. A resolution expressing the Sense of the Senate regarding the policy of the United States at the World Summit on Sustainable Development and related matters; to the Committee on Foreign Relations.

By Mrs. FEINSTEIN (for herself and Mr. LEAHY):

S. Con. Res. 133. A concurrent resolution expressing the sense of Congress that the United States should not use force against Iraq, outside of the existing Rules of Engagement, without specific statutory authorization or a declaration of war under Article I, Section 8, Clause 11 of the Constitution of the United States; to the Committee on Foreign Relations.

ADDITIONAL COSPONSORS

S. 654

At the request of Mr. TORRICELLI, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 654, a bill to amend the Internal Revenue Code of 1986 to restore, increase, and make permanent the exclusion from gross income for amounts received under qualified group legal services plans.

S. 1291

At the request of Mr. HATCH, the names of the Senator from New Mexico (Mr. BINGAMAN) and the Senator from Maryland (Mr. SARBANES) were added as cosponsors of S. 1291, a bill to amend the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 to permit States to determine State residency for higher education purposes and to authorize the cancellation of removal and adjustment of status of certain alien college-bound students who are long term United States residents.

S. 1339

At the request of Mr. CAMPBELL, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 1339, a bill to amend the Bring Them Home Alive Act of 2000 to provide an asylum program with regard to American Persian Gulf War POW/MIAs, and for other purposes.

S. 1394

At the request of Mr. ENSIGN, the name of the Senator from Nebraska (Mr. HAGEL) was added as a cosponsor of S. 1394, a bill to amend title XVIII of the Social Security Act to repeal the medicare outpatient rehabilitation therapy caps.

S. 1785

At the request of Mr. CLELAND, the names of the Senator from Maryland (Mr. SARBANES) and the Senator from Washington (Mrs. MURRAY) were added as cosponsors of S. 1785, a bill to urge the President to establish the White House Commission on National Military Appreciation Month, and for other purposes.

S. 1867

At the request of Mr. LIEBERMAN, the name of the Senator from North Carolina (Mr. EDWARDS) was added as a cosponsor of S. 1867, a bill to establish the National Commission on Terrorist Attacks Upon the United States, and for other purposes.

S. 1967

At the request of Mr. KERRY, the name of the Senator from New Jersey (Mr. CORZINE) was added as a cosponsor of S. 1967, a bill to amend title XVIII of the Social Security Act to improve outpatient vision services under part B of the medicare program.

S. 2013

At the request of Mr. HARKIN, the name of the Senator from Wisconsin (Mr. KOHL) was added as a cosponsor of S. 2013, a bill to clarify the authority of the Secretary of Agriculture to prescribe performance standards for the reduction of pathogens in meat, meat products, poultry, and poultry products processed by establishments receiving inspection services.

S. 2027

At the request of Mr. DURBIN, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 2027, a bill to implement effective measures to stop trade in conflict diamonds, and for other purposes.

S. 2057

At the request of Mrs. LINCOLN, the name of the Senator from Louisiana (Mr. BREAUX) was added as a cosponsor of S. 2057, a bill to amend title XVIII of the Social Security Act to permit expansion of medical residency training programs in geriatric medicine and to provide for reimbursement of care coordination and assessment services provided under the medicare program.

S. 2237

At the request of Mr. ROCKEFELLER, the name of the Senator from Arkansas (Mr. HUTCHINSON) was added as a cosponsor of S. 2237, a bill to amend title 38, United States Code, to enhance compensation for veterans with hearing loss, and for other purposes.

S. 2268

At the request of Mr. MILLER, the name of the Senator from Nebraska (Mr. NELSON) was added as a cosponsor of S. 2268, a bill to amend the Act establishing the Department of Commerce to protect manufacturers and sellers in the firearms and ammunition industry from restrictions on interstate or foreign commerce.

S. 2480

At the request of Mr. LEAHY, the names of the Senator from New Hampshire (Mr. SMITH) and the Senator from Nebraska (Mr. NELSON) were added as cosponsors of S. 2480, a bill to amend title 18, United States Code, to exempt qualified current and former law enforcement officers from state laws prohibiting the carrying of concealed handguns.

S. 2513

At the request of Mr. BIDEN, the names of the Senator from Idaho (Mr. CRAPO), the Senator from Virginia (Mr. WARNER), the Senator from Washington (Mrs. MURRAY) and the Senator

from Missouri (Mrs. CARNAHAN) were added as cosponsors of S. 2513, a bill to asses the extent of the backlog in DNA analysis of rape kit samples, and to improve investigation and prosecution of sexual assault cases with DNA evidence.

S. 2554

At the request of Mr. SMITH of New Hampshire, the name of the Senator from Colorado (Mr. ALLARD) was added as a cosponsor of S. 2554 , a bill to amend title 49, United States Code, to establish a program for Federal flight deck officers, and for other purposes.

S. 2562

At the request of Mr. REID, the name of the Senator from Hawaii (Mr. INOUYE) was added as a cosponsor of S. 2562, a bill to expand research regarding inflammatory bowel disease, and for other purposes.

S. 2576

At the request of Mr. BINGAMAN, the name of the Senator from New Mexico (Mr. DOMENICI) was added as a cosponsor of S. 2576, a bill to establish the Northern Rio Grande National Heritage Area in the State of New Mexico, and for other purposes.

S. 2606

At the request of Mrs. BOXER, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 2606, a bill to require the Secretary of Labor to establish a trade adjustment assistance program for certain service workers, and for other purposes.

S. 2626

At the request of Mr. KENNEDY, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 2626, a bill to protect the public health by providing the Food and Drug Administration with certain authority to regulate tobacco products.

S. 2653

At the request of Mr. SANTORUM, the name of the Senator from Kentucky (Mr. BUNNING) was added as a cosponsor of S. 2653, a bill to reduce the amount of paperwork for special education teachers, to make mediation mandatory for all legal disputes related to individualized education programs, and for other purposes.

S. 2663

At the request of Mr. BREAUX, the name of the Senator from Kansas (Mr. BROWNBACK) was added as a cosponsor of S. 2663, a bill to permit the designation of Israeli-Turkish qualifying industrial zones.

S. 2734

At the request of Mr. KERRY, the names of the Senator from New Jersey (Mr. TORRICELLI) and the Senator from Michigan (Mr. LEVIN) were added as cosponsors of S. 2734, a bill to provide emergency assistance to non-farm small business concerns that have suffered economic harm from the devastating effects of drought.

S. 2770

At the request of Mr. DODD, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 2770, a bill to amend the Federal Law Enforcement Pay Reform Act of 1990 to adjust the percentage differentials payable to Federal law enforcement officers in certain high-cost areas.

S. 2800

At the request of Mr. BAUCUS, the names of the Senator from North Dakota (Mr. DORGAN), the Senator from Nebraska (Mr. NELSON) and the Senator from Nevada (Mr. REID) were added as cosponsors of S. 2800 , a bill to provide emergency disaster assistance to agricultural producers.

S.J. RES. 41

At the request of Mr. SPECTER, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S.J. Res. 41, a joint resolution calling for Congress to consider and vote on a resolution for the use of force by the United States Armed Forces against Iraq before such force is deployed.

S. RES. 309

At the request of Mr. SMITH of Oregon, his name was added as a cosponsor of S. Res. 309, a resolution expressing the sense of the Senate that Bosnia and Herzegovina should be congratulated on the 10th anniversary of its recognition by the United States.

At the request of Mr. SARBANES, his name was added as a cosponsor of S. Res. 309, supra.

S. CON. RES. 107

At the request of Mr. CRAIG, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. Con. Res. 107, a concurrent resolution expressing the sense of Congress that Federal land management agencies should fully support the Western Governors Association ''Collaborative 10-year Strategy for Reducing Wildland Fire Risks to Communities and the Environment'', as signed August 2001, to reduce the overabundance of forest fuels that place national resources at high risk of catastrophic wildfire, and prepare a National prescribed Fire Strategy that minimizes risks of escape.

AMENDMENT NO. 4326

At the request of Mr. MCCONNELL, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of amendment No. 4326 proposed to S. 812, a bill to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. JEFFORDS (for himself Mr. BINGAMAN, Mrs. LINCOLN, and Mrs. MURRAY):

S. 2819. A bill to amend title XXI of the Social Security Act to permit qualifying States to use a portion of their unspent allotments under the State children's health insurance program to expand health coverage under that program or for expenditures under the Medicaid program, and for other purposes; to the Committee on Finance.

Mr. JEFFORDS. Mr. President, today I am pleased to introduce the SCHIP Budget Allocation Bill of 2002. This important legislation addresses the allocation of budgeted but unspent SCHIP funds that are currently out of the reach of States and are scheduled to be returned to the treasury at the end of fiscal year 2002 under BIPA provisions. With our economy in recession, the healthcare needs of the pediatric Medicaid and SCHIP populations have not been in greater jeopardy in recent memory. Our bill will address several important and essential issues. First, it will financially reward those States that are doing an outstanding job with their SCHIP and Medicaid pediatric populations. Second, it will provide financial incentives to those States that have not yet achieved SCHIP eligibility standards. Third, it will provide additional Medicaid revenue, through an enhancement of the Federal Medicaid Assistant Percentage, FMAP, to States experiencing budget shortfalls due to the current recession. And lastly, it will protect children's healthcare services during this period of Medicaid cutbacks on benefits and services.

SCHIP's first year of implementation was 1998. At that time program budgeting was not done based on an actuarial estimate of per capita program costs, but rather excessive funds were committed to insure adequate funding. What has evolved since 1998 is a surplus of budgeted funds whose allocation and fate has been determined by a complex State-by-State budgeting process that allows for cross subsidization between States and has resulted in large sums of unspent funds to accumulate. An unintended consequence of this intricate budgeting process is that it allows States with unspent allocated funds and States with unspent redistributed funds to lose access to these funds at the end of this fiscal year. In total, over forty States will lose access to allocated monies, only to see budgeted funds diverted back to the treasury; money that could be used to shore up the health care needs of children in Medicaid. In reviewing available options, we see the opportunity to merge the original goals of SCHIP, namely to provide for the health care needs of as many children as possible, while addressing the major budget problems currently being experienced by most States. Our bill would accomplish this by allowing unspent SCHIP monies to be used to enhance the FMAP for State Medicaid services for pediatric and pregnant women beneficiaries. Prior to initiating and introducing this bill, we evaluated the SCHIP budget, with CMS and CBO data, and found that the program had adequate residual funds to allow for these monies to be used by States to weather these difficult economic times without financially damaging the actuarially projected needs of SCHIP.

Our proposal has been reviewed in detail and endorsed by the American Academy of Pediatrics. This advocacy group shares our concern that unless decisive action is taken, access to health care for indigent children will suffer in our current economic climate. Today, please join with me and my colleagues, Senators BINGAMAN, LINCOLN, and MURRAY in supporting this bill. We can not and must not allow children's health care to suffer during these difficult economic times.

By Mrs. CARNAHAN (for herself and Mr. LEAHY):

S. 2820. A bill to increase the priority dollar amount for unsecured claims, and for other purposes; to the Committee on the Judiciary.

Mrs. CARNAHAN. Mr. President, on behalf of myself and Senator LEAHY, I am introducing legislation to protect the employees of corporations that declare bankruptcy. This bill will also put a stop to the outrageous practice of giving unearned bonuses to select individuals immediately before declaring bankruptcy. With the failures of Enron, and now WorldCom, Americans have seen how cruel bankruptcy can be for the employees who dedicated themselves to their companies. While some executives received extra pay just before the bankruptcy, workers were left holding the bag. Workers have faced mass layoffs. And in many cases, workers have been denied their rightful severance pay.

I understand that bankruptcy is intended to shield corporations from their creditors while they restructure their business. However, I do not believe that corporations truly need protection from their own workers. It seems to be the other way around. Workers need greater protection from corporations that accept their labor and then refuse to pay.

The legislation I am introducing today will allow employees, and former employees, to recover a greater share of the money that their company owes them. This bill also puts a stop to the indefensible practice of paying some executives large sums of money just before claiming that the company does not have the money to pay its average workers. Let me explain each of these provisions in detail.

First, this bill increases the priority claim amount for employee wages and benefits to $13,500. Under current law, employees are only entitled to receive $4,650 for wages and benefits that they are owed. If their employers owes them more, for severance or other obligations, the employees must fight with all the other unsecured creditors in the restructuring process. In light of the Enron bankruptcy, where employees were owed average severance packages of $35,000, it is clear that the current limit must be increased as a matter of fairness.

Let me be clear. This bill only affects employees who are owed money by their employer. Increasing the priority claim creates no new obligation for a company to pay severance or other compensation. It merely makes it possible for employees to recover more of what is rightfully owed to them. It is appropriate that employees are given a priority in recovering debts. Employees depend on their paychecks to buy food, pay the rent, and provide for their families. And unlike investors or creditors that can diversify their risks, workers cannot diversify their employment.

In the case of the Enron bankruptcy, the parties have agreed that employees are entitled to collect, up front, $13,500 to cover wages, accrued vacation, contributions to benefit plans, and promised severance. This figure reflects a reasonable settlement. It recognizes the expenses that workers face as they seek new employment.

This bill includes a second provision which is designed to restore funds to the bankrupt estate which were unjustly dispersed immediately prior to the bankruptcy. My legislation permits the bankruptcy court to recover excessive employee compensation paid in the 90 days preceding bankruptcy, if it determines that that compensation was out of the ordinary course or unjust enrichment. These funds would be recovered for the benefit of the estate and its creditors.

In the days leading up to its bankruptcy, Enron paid millions of dollars in so-called retention bonuses to executives. However, these executives actually had no obligation to stay with the company through its restructuring; indeed, most of them have since left. It is unacceptable for a company to pay millions to some employees, without any justification, and then weeks later claim that it cannot make basic severance payments to the vast majority of its workers. This amendment will ensure that bankruptcy courts have the authority to prevent such outcomes in the future.

These are common sense reforms that protect employees and creditors faced with a corporate bankruptcy. In the wake of Enron and WorldCom, Americans are learning some very difficult lessons about the failures of large corporations. We ought to heed these lessons and ensure that workers and investors are better protected in the future. I encourage my colleagues to support this legislation. And I ask unanimous consent that the text of the legislation be printed in the RECORD.

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

S. 2820

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. FAIR TREATMENT OF COMPENSATION IN BANKRUPTCY.

(a) INCREASED PRIORITY CLAIM AMOUNT FOR EMPLOYEE WAGES AND BENEFITS.—Section 507(a) of title 11, United States Code, is amended—

(1) in paragraph (3), by striking ''$4,000'' and inserting ''$13,500''; and

(2) in paragraph (4), by striking ''$4,000'' and inserting ''$13,500''.

(b) RECOVERY OF EXCESSIVE COMPENSATION.—Section 547 of title 11, United States Code, is amended by adding at the end the following:

''(h) The court, on motion of a party of interest, may avoid any transfer of compensation made to a present or former employee, officer, or member of the board of directors of the debtor on or within 90 days before the date of the filing of the petition that the court finds, after notice and a hearing, to be—

''(1) out of the ordinary course of business; or

''(2) unjust enrichment.''.

By Mr. WYDEN:

S. 2822. A bill to prevent publicly traded corporations from issuing stock options to top management in a manner that is detrimental to the long-term interests of shareholders; to the Committee on Banking, Housing, and Urban Affairs.

Mr. WYDEN. Mr. President, it seems like every morning, Americans wake up to another headline about the collapse of a big United States corporation. The failures have devastated the savings of millions of hardworking Americans, savings they were depending on for their retirement, or to pay for their kids' college education.

When the smoke clears and the fallout settles, the issue of stock options comes to the fore. Report after report details the massive fortunes amassed by the directors and top executives of so many of the companies that are at the center of the storm. So often, these executives were granted huge stock option packages, which they cashed out quickly for multimillion dollar payouts shortly before the company went over the brink.

The landmark legislation that the Senate passed unanimously last week, and which I strongly supported, will curb significant corporate abuses and accounting scandals, but it does not touch the issues surrounding stock options. It is time the Senate acted to do so. Therefore, today I am introducing the Prevention of Stock Option Abuse Act.

There is no question in my mind that some companies have abused stock options, using them as a vehicle for funneling large amounts of wealth to top executives. What's more, options have been granted in ways that fail to serve their intended purpose of aligning the interests of management with the long-term interests of the company. Instead, several of the massive option grants have created perverse incentives, enabling top executives to get fabulously rich by pumping up the company's short-term share price. The tactics they use to do so may jeopardize the company's long-term financial health, but by the time the long term impact is felt, the executives have already cashed out and left the firm.

When an executive develops a big personal stake in options, it can lead to a big conflict of interest. Too often, the company's long-term interests take a back seat to the executive's desire for personal reasons to boost the short-

term share price. When the betting is between massaging the numbers to ''manage'' quarterly profit projections and improving the quality of the business through such things as R&D investments, short-term profits, and the value of executive stock options, can be the odds-on favorite.

But the abuse of stock options in the executive suite should not be taken as an indictment of stock options in general. I remain convinced that stock option plans, as long as they are broad-based plans that extend to rank-and-file employees as well as CEOs, can play a very important role in our economy. They can enable corporations to attract and retain good workers and top talent. And they can improve motivation and productivity, by giving employees a strong personal interest in the long-term success of the corporation.

Therefore, the legislation I am introducing today aims to stop the abuses at the top while not gutting options that are so vital to rank-and-file workers. It focuses on restoring the link between the long-term interests of the company and those of senior management, and giving shareholders knowledge about and control over the stock options of corporate leaders.

Specifically, the bill would direct the Securities and Exchange Commission to issue rules, applicable to all publicly traded companies, in three main areas.

First, to increase shareholder influence and oversight with respect to grants of stock options, the bill calls for rules requiring shareholder approval of stock option plans. This would help prevent the all too common ''I'll-scratch-your-back-if-you-scratch-mine'' culture of clubby directors and top executives voting each other huge option packages with little or no shareholder input.

Second, the bill contains tough provisions to ensure that stock options will provide incentives for corporate officers and directors to act in the best long-term interests of their corporations, rather than incentives to stimulate short-term run-ups in the stock price. It would do this by establishing substantial vesting periods for options and holding periods for stock shares, so that top executives do not have the ability to quickly cash out and jump ship.

The holding period would be multi-tiered. Directors and officers would be allowed to sell up to one quarter of their shares six months after acquiring them, to permit a degree of diversification or to meet their current financial needs. But for the majority, they would be required to wait at least three years. And they would be required to hold on to some of their stock until at least six months after leaving the company.

Third, and finally, to improve the transparency of stock option grants to directors and officers, the bill calls for rules to provide better and more frequent information to shareholders and investors. Shareholders deserve more information than that contained in the average footnote. Specifically, the bill would require stock option information to be reported quarterly, not just annually, and broken out into a separate, easy-to-find section in each company's public SEC filings.

To date, there have been two paths offered to deal with the issue of stock options. Some think the problem is so severe that options should be pared back across the board and that Congress should dictate new accounting rules for them. Others say that business as usual should be the order of the day, and that no immediate action is necessary.

The bill that I have introduced today seeks to lay out a third path. It offers a way to ensure that broad-based stock options can continue to be a useful tool for deserving workers, shareholders and the economy as a whole, while still curbing abuses by those in the executive suites whose conduct is over the line. I don't claim that the bill is the complete solution in its present form, but I believe it offers a strong framework for a new approach, and I look forward to working with my colleagues and others to refine and improve it as it moves through the legislative process.

The job of cleaning up corporate corruption will not be complete until Congress acts to correct the abuse of stock options. I hope my colleagues will join me in this effort to put tough new rules in place that will retain broad-based stock options for workers and curb their abuse by top management.

By Mr. AKAKA (for himself and Mr. CRAIG):

S. 2823. A bill to amend the Organic Act of Guam for the purposes of clarifying the local judicial structure of Guam; to the Committee on Energy and Natural Resources.

Mr. AKAKA. Mr. President, I am pleased to introduce legislation with the senior Senator from Idaho, Mr. Craig, which amends the Organic Act of Guam to clarify Guam's judicial structure by ensuring that it is a unified and co-equal branch of the Government of Guam. The Organic Act establishes the executive and legislative branches of the Government of Guam. This legislation would simply include Guam's judicial branch in the Organic Act.

Similar legislation, H.R. 521, was introduced in the House of Representatives by Representative Robert Underwood of Guam. The Bush Administration has no objection to the enactment of H.R. 521. The Congressional Budget Office also estimated that the legislation would have no impact on the federal budget.

For those of us who have followed and worked on territorial issues for a long time, we do our best to balance the role of Congress when overriding federal interests are involved with the concerns expressed by territorial leaders and the general public. In this case, the establishment of an independent judicial branch on Guam is an overriding federal interest and is broadly supported by the people of Guam. This bill is supported by General Ben Blaz, former Guam Delegate to Congress, Guam Governor Carl Guiterrez, Justice Philip Carbullido, Acting Chief Justice of Guam's Supreme Court, the Guam Bar Association, Guam's legal community, the National Conference of Chief Justices, and the Guam Pacific Daily News.

I believe that today's legislation is necessary to ensure the integrity and independence of Guam's judicial system as co-equal with the executive and legislative branches of the Government of Guam. I look forward to working with my colleagues in the Senate on this important issue.

I ask unanimous consent that the text of the bill be printed in the Record.

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

S. 2823

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. JUDICIAL STRUCTURE OF GUAM.

(a) JUDICIAL AUTHORITY; COURTS.—Section 22(a) of the Organic Act of Guam (48 U.S.C. 1424(a)) is amended to read as follows:

''(a)(1) The judicial authority of Guam shall be vested in a court established by Congress designated as the 'District Court of Guam', and a judicial branch of Guam which branch shall constitute a unified judicial system and include an appellate court designated as the 'Supreme Court of Guam', a trial court designated as the 'Superior Court of Guam', and such other lower local courts as may have been or shall hereafter be established by the laws of Guam.

''(2) The Supreme Court of Guam may, by rules of such court, create divisions of the Superior Court of Guam and other local courts of Guam.

''(3) The courts of record for Guam shall be the District Court of Guam, the Supreme Court of Guam, the Superior Court of Guam (except the Traffic and Small Claims divisions of the Superior Court of Guam) and any other local courts or divisions of local courts that the Supreme Court of Guam shall designate.''.

(b) JURISDICTION AND POWERS OF LOCAL COURTS.—Section 22A of the Organic Act of Guam (48 U.S.C. 1424–1) is amended to read as follows:

''SEC. 22A. (a) The Supreme Court of Guam shall be the highest court of the judicial branch of Guam (excluding the District Court of Guam) and shall—

''(1) have original jurisdiction over proceedings necessary to protect its appellate jurisdiction and supervisory authority and such other original jurisdiction as the laws of Guam may provide;

''(2) have jurisdiction to hear appeals over any cause in Guam decided by the Superior Court of Guam or other courts established under the laws of Guam;

''(3) have jurisdiction to issue all orders and writs in aid of its appellate, supervisory, and original jurisdiction, including those orders necessary for the supervision of the judicial branch of Guam;

''(4) have supervisory jurisdiction over the Superior Court of Guam and all other courts of the judicial branch of Guam;

''(5) hear and determine appeals by a panel of three of the justices of the Supreme Court of Guam and a concurrence of two such justices shall be necessary to a decision of the Supreme Court of Guam on the merits of an appeal;

''(6) make and promulgate rules governing the administration of the judiciary and the practice and procedure in the courts of the judicial branch of Guam, including procedures for the determination of an appeal en banc; and

''(7) govern attorney and judicial ethics and the practice of law in Guam, including admission to practice law and the conduct and discipline of persons admitted to practice law.

''(b) The Chief Justice of the Supreme Court of Guam—

''(1) shall preside over the Supreme Court unless disqualified or unable to act;

''(2) shall be the administrative head of, and have general supervisory power over, all departments, divisions, and other instrumentalities of the judicial branch of Guam; and

''(3) may issue such administrative orders on behalf of the Supreme Court of Guam as necessary for the efficient administration of the judicial branch of Guam.

''(c) The Chief Justice of the Supreme Court of Guam, or a justice sitting in place of such Chief Justice, may make any appropriate order with respect to—

''(1) an appeal prior to the hearing and determination of that appeal on the merits; or

''(2) dismissal of an appeal for lack of jurisdiction or failure to take or prosecute the appeal in accordance with applicable laws or rules of procedure.

''(d) Except as granted to the Supreme Court of Guam or otherwise provided by this Act or any other Act of Congress, the Superior Court of Guam and all other local courts established by the laws of Guam shall have such original and appellate jurisdiction over all causes in Guam as the laws of Guam provide, except that such jurisdiction shall be subject to the exclusive or concurrent jurisdiction conferred on the District Court of Guam under section 22 of this Act.

''(e) The qualifications and duties of the justices and judges of the Supreme Court of Guam, the Superior Court of Guam, and all other local courts established by the laws of Guam shall be governed by the laws of Guam and the rules of such courts.''.

(c) TECHNICAL AMENDMENTS.—(1) Section 22C(a) of the Organic Act of Guam (48 U.S.C. 1424–3(a)) is amended by inserting ''which is known as the Supreme Court of Guam,'' after ''appellate court authorized by section 22A(a) of this Act,''.

(2) Section 22C(d) of the Organic Act of Guam (48 U.S.C. 1424–3(d)) is amended—

(A) by inserting '', which is known as the Supreme Court of Guam,'' after ''appellate court provided for in section 22A(a) of this Act''; and

(B) by striking ''taken to the appellate court'' and inserting ''taken to such appellate court''.

SEC. 2. APPEALS TO UNITED STATES SUPREME COURT.

Section 22B of the Organic Act of Guam (48 U.S.C. 1424–2) is amended by striking '': *Provided*, That'' and all that follows through the end and inserting a period.

By Mr. DORGAN (for himself and Mr. WARNER):

S. 2825. A bill to amend the Internal Revenue Code of 1986 to allow a nonrefundable tax credit for contributions to congressional candidates; to the Committee on Finance.

Mr. DORGAN. Mr. President, earlier this year we enacted a bold new campaign finance reform bill. After years of debate and delay, the Congress passed and the President signed this far-reaching legislation, known as McCain-Feingold. This new law eliminates the large ''soft money'' contributions from our campaign finance system and it expanded the role that some individuals can play by raising the individual campaign contribution limits.

But there is one critical area that the McCain-Feingold bill didn't address, one important problem that the new law doesn't solve: how to give low- and middle-income families an incentive to contribute to the candidate of their choice.

Today, I am introducing a bill with my colleague from Virginia, Senator WARNER, that will do just that. It will empower millions of working Americans to become engaged in our political system, by providing a tax credit to those who donate money to congressional candidates.

As campaigns become more and more expensive, the number of small contributors is actually decreasing. The current campaign finance system is becoming dominated by big dollar contributors. This is not healthy for our campaigns and it is not good for our democracy.

My bill would make middle income Americans more able to donate to candidates. Specifically, my bill would provide a maximum $400 tax credit to married couples earning up to $120,000 for their campaign contributions. For singles with income up to $60,000, the tax credit would apply to contributions up to $200. This credit will provide a dollar for dollar offset for contributions, an incentive that could encourage the vast majority of working families to consider contributions to the candidates of their choice.

This is not a new idea. This type of credit was a part of our tax system for more than a decade in the 1970s and 1980s. It has been a part of many campaign finance reform proposals over the years, proposals that have been introduced and supported by both Democrats and Republicans. And this policy proposal is the focus of a new study by the American Enterprise Institute, AEI, which concluded that this approach would help to elevate small donors from the supporting role that they now play. So, our proposal has been successful in the past, and it has had broad support from both parties over the past thirty years.

Participation in the political process is key to a strong democracy. This bill will help broaden participation and will provide an incentive for more Americans to be included in political campaigns. That is healthy for our form of government.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2825

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CREDIT FOR CONTRIBUTIONS TO CONGRESSIONAL CANDIDATES.

(a) GENERAL RULE.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is amended by inserting after section 25B the following new section:

''SEC. 25C. CONTRIBUTIONS TO CONGRESSIONAL CANDIDATES.

''(a) GENERAL RULE.—In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the total of contributions to candidates for the office of Senator or Representative in, or Delegate or Resident Commissioner to, the Congress.

''(b) MAXIMUM CREDIT.—The credit allowed by subsection (a) for a taxable year shall not exceed $200 ($400 in the case of a joint return).

''(c) VERIFICATION.—The credit allowed by subsection (a) shall be allowed, with respect to any contribution, only if such contribution is verified in such manner as the Secretary shall prescribe by regulations.

''(d) DEFINITIONS.—For purposes of this section—

''(1) CANDIDATE; CONTRIBUTION.—The terms 'candidate' and 'contribution' have the meanings given such terms in section 301 of the Federal Election Campaign Act of 1971.

''(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means any taxpayer whose adjusted gross income for the taxable year does not exceed $60,000 ($120,000 in the case of a joint return).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 642 of the Internal Revenue Code of 1986 (relating to special rules for credits and deductions of estates or trusts) is amended by adding at the end the following new subsection:

''(j) CREDIT FOR CERTAIN CONTRIBUTIONS NOT ALLOWED.—An estate or trust shall not be allowed the credit against tax provided by section 25C.''.

(2) The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 25B the following new item:

''Sec. 25C. Contributions to congressional candidates.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2002.

By Mr. SCHUMER (for himself, Mr. CRAIG, Mr. KENNEDY, and Mr. MCCAIN):

S. 2826. A bill to improve the national instant criminal background check system; and for other purposes; to the Committee on the Judiciary.

Mr. SCHUMER. Mr. President, we are an odd group of Senators, but not when it comes to making sure that guns are kept away from drug addicts, felons, illegal aliens and others.

Today, we're announcing an extremely important new bill that would plug up the gaping holes that are currently in the Justice Department's gun background check system.

This bill is needed to prevent brutal, senseless murders like the one that took place in a Long Island church a few months ago from ever happening again.

For those of you who may not know what happened, on March 8, 2002, Peter J. Troy walked into Britt's Firearms in Mineolan, NY and purchased a .22 caliber semi-automatic rifle. Four days later, he walked into a church in Lynbrook, NY, Our Lady of Peace, and shot and killed the Reverend Lawrence M. Penzes and Eileen Tosner.

Mr. Troy had a history of mental health problems, and had been admitted to Bellevue Hospital Center and Nassau University Medical Center on at least two occasions. In addition, Mr. Troy's mother had a restraining order issued against him in February 1998, which he violated on more than one occasion.

Yet despite his history of mental illness and violent behavior, Mr. Troy was approved to purchase the rifle by a Federal background check. In fact, there was no records on Peter J. Troy in the National Instant Criminal Background Check System, NICS, at all.

That never, ever should have happened. We knew Peter Troy was a violent man. We knew he was mentally ill. He had no business owning a gun, and he proved it, to the shock and horror of everyone in Long Island and to everyone else in this Nation.

Had the Federal system that checks all gun purchasers picked up on the fact that Peter Troy was both mentally ill and was subject to a restraining order, he never would have been sold a rifle and the murders may never had occurred.

All the signs were there and all the signs were ignored. That's why we need to tighten State reporting laws so that the violent and the mentally ill, people who aren't allowed to purchase guns, aren't able to purchase guns. Otherwise, this could happen again and again.

The Federal Gun Control Act bars people who have been committed to a mental institution or convicted of a felony from purchasing a firearm. That's not the problem.

The problem is that this kind of information is not always shared with the NICS system. The INS, for example, doesn't always share info about an illegal alien with the Justice Department or a State doesn't forward info about an involuntary commitment to the FBI.

So when the background check is performed, the information never appears, red flags aren't raised, and the gun purchase goes right through.

In other words, the Federal background check is only as good as the records that are in it.

How poor is our background check system? This year, Americans for Gun Safety released a report showing that over a 30-month period, 10,000 felons obtained a gun simply because faulty records made it impossible to complete a background check on time.

And their report warned that this 10,000 figure is only the tip of the iceberg. It doesn't include the thousands of illegal immigrants, domestic abusers, and the severely mentally ill who are not in the system at all and cannot be stopped by a background check no matter how much time is allowed.

It's catch as catch can, and we're not catching very much.

Under the bill we're introducing, if someone is trying to buy a gun, and if they are either: 1. under indictment; 2. been convicted of a crime punishable by more than a year; 3. is a fugitive from justice; 4. is a known drug addict; 5. if they've been committed to a mental institution; 6. is subject to a court order restraining them from domestic violence; or 7. been convicted of a domestic violence misdemeanor, the State will be legally required to let the FBI know.

It's a lot of information. There's no question about it. But most of this information is kept by the states. And most of it is automated. So for the majority of these categories, it's a matter of getting the information from point A, the State, to point B—the FBI. Unfortunately, most States, including New York, do not have good records on mental health, and that's going to take some more work.

The bill provides $375 million per year for three years, for States to get their records in order and to automate them to ensure that they get to the FBI quickly.

It also requires Federal agencies to share the records they keep with NICS. For example, the INS would be required to share its records on illegal aliens with NICS.

I want to thank my colleagues who are with me today, particularly Senator CRAIG, for recognizing that this is a public safety issue that needs urgent attention and not a ''gun control'' issue per se. Working together, we can get this done in the Senate with the same speed the House got it done.

Mr. CRAIG. Mr. President, I am pleased to join my colleagues in an unprecedented alliance today, introducing legislation to improve the National Instant Background Check System (NICS). While we have frequently demonstrated our differing views of second amendment issues, we stand together when it comes to enforcing laws against criminal gun violence, and that is the subject of our legislation.

The vast majority of gun owners in our country today understand that the right to keep and bear arms comes with a grave duty to use firearms responsibly and within the law.

The NICS system deals with the tiny but dangerous fraction of Americans who have lost their firearm rights because they are proven lawbreakers, convicted felons—or because they do not have the capacity to understand their responsibilities as firearm users. Our federal laws prohibit these individuals from possessing or acquiring firearms, and the NICS system is made up of the records of these ''prohibited persons.'' This is the list against which prospective gun purchasers are checked when the law requires a background check. State and local agencies still play a big role, conducting checks on almost half the applications based on their own records.

We want the system to be fast, so that it does not unduly burden individuals in the exercise of their second amendment rights. That means the records need to be automated, so we don't have the kind of delays that happen when local law enforcement has to manually check written records.

It is equally critical to all of us that the system be accurate. Accuracy means we need to be able to remove a record if it is no longer relevant—for example, if it's a record of an indictment on charges that were later dropped. It also means we need all relevant records—records pertaining not only to convicted felons, but also those who are adjudicated mentally incompetent and drug abusers, and all other categories prohibited by federal law from possessing firearms.

Accurate, automated records means truly instant checks, fewer delays for law-abiding gun purchases, and better use as a tool to prevent violent criminals from obtaining firearms.

U.S. taxpayers have spend hundreds of millions of dollars in less than a decade, helping to improve all States' criminal history records for law enforcement purposes. It is time to focus our national strategy on getting the job completed, to the benefit of not just the gun-purchasing public but all Americans concerned about the safety of their communities.

Our bill sets out the objectives needed to complete the NICS system, and it provides incentives and strategies for accomplishing those objectives. We have been working in tandem with like-minded members in the other body, and the bill we introduce today reflects the changes made by the House Judiciary Committee in the original proposal. Among other things, this bill specifies the records still needed from federal agencies to fill in the gaps, and requires the removal of records that are no longer relevant. It provides inventive for States to improve their systems through grants and waivers of current matching fund requirements. It calls on DOJ and the mental health community to develop privacy protocols so that mental health records can be properly added to the system.

I am also pleased that the bill incorporates a provision of great importance to law-abiding gun owners, making permanent the prohibition against charging a federal fee for background checks. Congress has supported this prohibition repeatedly, acknowledging that any such check is being done for law enforcement purposes and not as a service or convenience to gun purchasers. It makes good sense to codify that prohibition, once and for all.

In sum, this is an important and timely measure. I appreciate the work that the cosponsors have done to get us to this point, and I urge all our colleagues to support the bill's enactment.

Mr. MCCAIN. Mr. President, along with Senators SCHUMER, CRAIG, and KENNEDY, I rise today to introduce the ''Our Lady of Peace Act'' that has the strong support of major organizations across the political spectrum.

This legislation fixes a huge hole in our system—a hole that delays legitimate firearms purchases and allows criminals and other prohibited buyers to obtain guns. The hole is the faulty records in the National Instant Criminal Background Check System, NICS. Based on a report released by Americans for Gun Safety Foundation in January 2002, Congress has learned that millions of records are missing from the NICS database. Over a 30-month period, 10,000 criminals obtained a firearm despite a background check because the records couldn't be checked properly within the 3 days allowed by federal law. In addition, thousands of other prohibited buyers will never be stopped because very few restraining orders, drug abuse or mental disability records are kept at all. This report makes it clear that if we are to be serious about stopping criminals, wife-beaters and illegal aliens from slipping through a background check, we had better fix this broken system.

Better records mean more accurate background checks—checks which stop prohibited buyers while allowing legitimate buyers to be approved. And better records put the ''instant'' back into instant check, because delays occur when records have to be searched manually. In fact, the only reason why criminal background checks sometime take several days is because records have to be checked by hand instead of computer.

The figure is astonishing. There are over 30 million missing records.

For felony records, the typical state has automated only 58 percent of its felony conviction records. The FBI estimates that out of 39 million felony arrest records, 16 million of them lack final disposition information. Without final disposition records, background checks must rely on time consuming manual searches of courthouse files to approve or deny firearms purchases.

On the issue of mental health, 33 States keep no mental health disqualifying records and no state supplies mental health disqualifying records to NICS. The General Accounting Office, GAO, estimates that 2.7 million mental illness records should be in the NICS databases, but less than 100,000 records are available, nearly all from VA mental hospitals. States have supplied only 41 mental health records to NICS. Combined with the federal records, the GAO estimates that only 8.6 percent of the records of those disqualified from buying a firearm for mental health reasons are accessible on the NICS database.

In the case of drug abusers, the GAO estimates that only 3 percent of the 14 million records of drug abusers are automated, not including felons and wanted fugitives. States have supplied only 97 of those records to NICS which the GAO estimates as representing less than 0.1 percent of the total records of those with drug records that would deny them a firearm.

On the issue of domestic violence, 20 States lack a database for either domestic violence misdemeanants or temporary restraining orders or both, 42 percent of all NICS denials based on restraining orders come from one State—Kentucky—which does the best job of automating TRO's from the bench. The Department of Justice estimates that nearly 2 million restraining order records are missing from the database.

In the case of illegal aliens/non-immigrant status records, the GAO estimates that over 2 million illegal alien records are absent from the NICS database. Through 2001, NICS had no records of non-immigrants in the United States making it impossible to stop visitors to the U.S. on tourist or student visas from purchasing firearms.

The benefits of better records are simple and important. They lead to accurate and instant background checks. Better records mean we would be able to stop far more prohibited buyers from obtaining a gun than we do now. When a restraining order, drug abuse or mental health record is missing, nothing in the NICS system indicates a reason to delay the sale and search records. NICS simply approves the transaction usually within 3 minutes.

Poor records are why and this legislation will fix the system. This bill requires Federal agencies such as the Immigration and Naturalization Service, INS, and the VA to provide all records of those disqualified from purchasing a firearm to NICS. For INS, it would mean sending millions of records of those here on tourist visas, student visas, and all other non-immigrant visas to NICS. Each State would be allowed to receive a waiver for up to 5 years of the 10 percent matching requirement for the National Criminal History Improvement Grants, NCHIP, when that state automates and makes available to NICS at least 95 percent of records of those disqualified from purchasing a firearm. This bill also requires states to automate and send to NICS all disqualifying records under Federal and State law, including domestic violence misdemeanors, restraining orders, criminal conviction misdemeanors, drug abuse and other relevant records to NICS.

We also provides grants of $250 million per year for 3 years to States to improve background check records, automate systems, enhance states capacities to perform background checks, supply mental health records and domestic violence records to NICS. We also give grants of $125 million per year for 3 years to States to assess their systems for rapidly getting criminal conviction, domestic violence records and other records from the courtroom into the NICS database and for improving those systems so as to eliminate the lag time between conviction and entry into NICS.

Better records mean instant checks: 72 percent of background checks are approved and completed within minutes, but 5 percent take days to complete for one reason only faulty records force law enforcement into time consuming searches to locate final disposition records for felony and domestic violence convictions. It is our hope that this legislation will finally make our records system complete and totally stop prohibited buyers from gaining access to firearms while allowing legitimate buyers to be approved.

STATEMENTS ON SUBMITTED RESOLUTIONS

SENATE RESOLUTION 311—EXPRESSING THE SENSE OF THE SENATE REGARDING THE POLICY OF THE UNITED STATES AT THE WORLD SUMMIT ON SUSTAINABLE DEVELOPMENT AND RELATED MATTERS

Mr. KERRY (for himself, Mr. JEFFORDS, Mrs. MURRAY, Mr. LIEBERMAN, Mr. AKAKA, Mr. DURBIN, Mrs. BOXER, Ms. CANTWELL, Mr. TORRICELLI, Mr. LEAHY, Mr. FEINGOLD, and Mr. BINGAMAN) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 311

Whereas the Senate recalls the Stockholm Declaration of the United Nations Conference on the Human Environment of 1972, the Rio Declaration on Environment and Development of the United Nations Conference on Environment and Development of 1992, and Agenda 21—which provided the framework for action for achieving sustainable development;

Whereas the pillars of sustainable development—economic development, social development and environmental protection—are interdependent and mutually reinforcing components, and many countries continue to face overwhelming social, environmental and economic challenges;

Whereas global environmental degradation is both affected by and a significant cause of, social and economic problems such as pervasive poverty, unsustainable production and consumption patterns, poor ecosystem management and land use, and the burden of debt;

Whereas, despite the many successful and continuing efforts of the international community, the environment and the natural resource base that supports life on Earth continue to deteriorate at an alarming rate;

Whereas the Senate recognizes the importance of the World Summit on Sustainable Development as a review of progress achieved in implementing the commitments made at the United Nations Conference on Environment and Development, and as an opportunity for the international community to strengthen international cooperation and implement its commitments to achieve sustainable development;

Whereas the Senate recognizes further that the World Summit on Sustainable Development is intended to be a summit of heads of state;

Whereas the United States delegation was represented by the President at the United Nations Conference on Environment and Development of 1992;

Whereas the Senate recognizes further the importance of the United States of America

as a world leader in effectively addressing issues related to the 3 pillars of sustainable development: Now, therefore, be it

Resolved, That it is the sense of the Senate that—

(1) having the President lead the United States delegation would send a strong signal of United States support for the goals of sustainable development;

(2) the United States should at the World Summit on Sustainable Development—

(A) reaffirm its support for the implementation of commitments entered into by the United States and the international community at the United Nations Conference on Environment and Development;

(B) support increased international cooperation to implement the provisions of Agenda 21 and to address the challenges of sustainable development in the twenty-first century, including new specific targets and commitments, in particular with respect to the protection of the oceans and freshwater, combating deforestation, implementation of the United Nations Convention to Combat Desertification, protection of the atmosphere including global climate change, preservation of biological diversity, and reducing the use of persistent bioaccumulative toxic pollutants;

(C) reaffirm the importance of integrating environmental and social considerations into economic decision making, including trade and investment agreements;

(D) support measures to improve compliance with and enforcement of international environmental commitments;

(E) support measures to improve the economic, social, and environmental well-being of develop countries, including the mobilization of domestic and international resources and development assistance beyond current levels;

(F) support the Global Environment Facility, which provides critical financial assistance for environmental improvements in the developing world, at a level which will allow it to adequately fund ongoing and important new priorities;

(G) support good governance within each country and at the international level as essential for sustainable development, including sound environmental, social and economic policies, democratic and transparent institutions responsive to the needs of the people, public access to information, the rule of law, anti-corruption measures, gender equality and an enabling environment for investment;

(H) support efforts to meaningfully improve the institutional structure for implementing the framework created by Agenda 21 and the Rio Declaration on Environment and Development, as well as a more coherent and coordinated approach among international environmental instruments;

(I) remain firmly opposed to commercial whaling and to all efforts to reopen international trade in whale meat or to downlist any whale population in the Convention on International Trade in Endangered Species; and

(J) support measures to increase the use of renewable sources of energy throughout the world—for example, encourage export credit agencies to foster more projects to develop renewable energy resources;

(3) both at the world Summit on Sustainable Development and in other appropriate fora, the United States should re-engage in, provide leadership to, and urgently pursue the negotiation of binding international agreements to address global climate change consistent with—

(A) United States commitments under Article 2 of the United Nations Framework Convention on Climate Change to ''achieve . . . stabilization of greenhouse gas concentrations at a level that avoids dangerous anthropogenic interference with the climate system . . . within a timeframe sufficient to allow ecosystems to adapt naturally to climate change . . .'';

(B) the findings of the Third Assessment Report of the Intergovernmental Panel on Climate Change, which the Administration should support in its international negotiations; and

(C) the Sense of Congress on Climate Change approved by the Senate as part of the National Energy Policy Act of 2002;

(4) both at the World Summit on Sustainable Development and in other appropriate fora, the United States should support, provide leadership and urgently pursue the negotiation of binding international agreements for the protection of the marine environment, aimed at—

(A) reducing over-capacity of the global fishing fleet to environmentally and economically sustainable levels;

(B) reducing bycatch, and protecting endangered migratory species, such as sea turtles, marine mammals and sea birds;

(C) addressing the international aspects of marine debris;

(D) combating the degradation and destruction of coral reefs; and

(E) reducing land-based pollution such as sewage and other nutrients; and

(5) the President should identify priority international environmental agreements that the United States has signed during and following the United Nations Conference on Environment and Development that the Administration will present to the Senate for ratification.

Mr. KERRY. Mr. President, I rise today to submit a Senate resolution with my good friend and the chairman of the Environment and Public Works Committee, Mr. JEFFORDS of Vermont. We are pleased to be joined by Senators BOXER, LIEBERMAN, AKAKA, MURRAY, DURBIN, CANTWELL, TORRICELLI, FEINGOLD, LEAHY, and BINGAMAN in submitting this resolution.

The World Summit on Sustainable Development, WSSD, will take place August 26–September 4, 2002 in Johannesburg, South Africa. The WSSD will bring together tens of thousands of participants, including governments, environmentalists and business leaders. The WSSD is timed as the tenth anniversary of the groundbreaking United Nations Conference on Environment and Development, UNCED, held in Rio de Janiero in 1992. The overall goal of the WSSD is to assess the progress of countries in implementing the commitments made at Rio and to reinvigorate the global commitment to sustainable development.

Among the core accomplishments of the Rio conference were ''Agenda 21,'' which provides a comprehensive framework for achieving sustainable development, including chapters on protecting the atmosphere and the oceans, and the Rio Declaration which sets forth principles such as the need for a precautionary approach in environmental protection. Also at Rio, several important international conventions were opened for signature: the United Nations Framework Convention on Climate Change, UNFCC, and the Convention on Biological Diversity, CBD, both of which were ultimately signed by the United States, with the UNFCC also ratified by the U.S. Senate.

I cannot emphasize how critical this world summit is. As a planet we need to find a way forward, with countries large and small, rich and poor working together, to agree on steps that protect the environment yet allow our economies to grow sustainable. This resolution that I am offering today urges the administration to make this summit a priority, and to support the goals of sustainable development. This includes supporting specific, concrete targets and timetables for implementing the broad goals of Agenda 21, and a host of other common sense issues that should be addressed at the WSSD. The United States must be a leader in demonstrating its commitments to these goals, and in showing the world that economic growth can occur consistent with improved environmental quality. The resolution also calls on the United States to take a leading role both at the Summit as well as in other appropriate venues in negotiating binding international agreements to address the very real threat of global climate change, as well as agreements to address critical oceans and fisheries issues facing the world today.

This summit is a real opportunity for our Nation. It is my hope that the Bush Administration will recognize it as such and work with the international community to develop a host of measures that will make this planet a better place to live.

Mr. JEFFORDS. Mr. President, I rise today with my colleague and friend Sen. JOHN KERRY and ten other Senators to submit a Sense of the Senate Resolution concerning United States policy at the World Summit on Sustainable Development, WSSD, an international conference to be held in Johannesburg, South Africa from August 24–September 4, 2002. The Kerry-Jeffords Resolution calls on the United States to reaffirm its current environmental and development commitments under and since the 1992 United Nations Conference on Environment and Development held in Rio de Janeiro, Brazil, otherwise known as the Earth Summit.

The Kerry-Jeffords Resolution also urges the United States to take its sustainable development commitments further through the full implementation of ratified treaties such as the United Nations Framework Convention on Climate Change and the United Nations Convention to Combat Desertification, two treaties of great importance to me. Implementation of these and other treaties should include commitment to real targets and timetables. At a recent joint hearing between the Environment and Public Works and Foreign Relations Committees, we learned that the United States has not maintained the spirit or the letter of its commitment under the Framework Convention. Other provisions in the Resolution call on the United States to be actively engaged in international negotiations that address

the protection of oceans and freshwater, combating deforestation, preservation of biological diversity, increasing the use of renewable energy sources, and reducing the use of persistent toxic pollutants.

The Resolution makes it clear that Presidential leadership of the United States delegation at the WSSD would send a strong signal of our Nation's support for the goals of sustainable development. President Bush's participation at Johannesburg would help rebuild alliances weakened by the Administration's diminished involvement in international climate change negotiations. His participation would also strengthen relationships that are becoming increasingly important in a world where any nation can face serious threats to its national security and its environmental and human security. This Summit is an important opportunity to demonstrate that we will not act unilaterally when our actions can permanently and negatively affect the global commons.

SENATE CONCURRENT RESOLUTION 133—EXPRESSING THE SENSE OF CONGRESS THAT THE UNITED STATES SHOULD NOT USE FORCE AGAINST IRAQ, OUTSIDE OF THE EXISTING RULES OF ENGAGEMENT, WITHOUT SPECIFIC STATUTORY AUTHORIZATION OR A DECLARATION OF WAR UNDER ARTICLE I, SECTION 8, CLAUSE 11 OF THE CONSTITUTION OF THE UNITED STATES

Mrs. FEINSTEIN (for herself and Mr. LEAHY) submitted the following concurrent resolution; which was referred to the Committee on Foreign Relations:

Expressing the sense of Congress that the United States should not use force against Iraq, outside of the existing Rules of Engagement, without specific statutory authorization or a declaration of war under Article I, Section 8, Clause 11 of the Constitution of the United States.

Whereas, in accordance with United Nations Security Council Resolution 687 (1991), Iraq—

(1) agreed to destroy, remove, or render harmless all chemical and biological weapons and stocks of agents and all related subsystems and components and all research, development, support, and manufacturing facilities related thereto;

(2) agreed to destroy, remove, or render harmless all ballistic missiles with a range greater than 150 kilometers, and related major parts and production facilities;

(3) agreed not to acquire or develop any nuclear weapons, nuclear-weapons-usable material, nuclear-related subsystems or components, or nuclear-related research, development, support, or manufacturing facilities; and

(4) agreed to permit immediate on-site inspection of Iraq's biological, chemical, and missile capabilities, and assist the International Atomic Energy Agency in carrying out the destruction, removal, or rendering harmless of all nuclear-related items and in developing a plan for ongoing monitoring and verification of Iraq's compliance;

Whereas the regime of Saddam Hussein consistently refused to comply with United Nations Special Commission weapons inspectors in Iraq between 1991 and 1998 by denying them access to crucial sites and documents;

Whereas on October 31, 1998, Iraq banned the United Nations weapons inspectors despite its agreement and obligation to comply with United Nations Security Council Resolution 687 (1991);

Whereas Congress declared in Public Law 105–235 that ''the Government of Iraq is in material and unacceptable breach of its international obligations, and therefore the President is urged to take appropriate action, in accordance with the Constitution and relevant laws of the United States, to bring Iraq into compliance with its international obligations'';

Whereas, in his State of the Union Address on January 29, 2002, the President of the United States stated that the ''Iraqi regime has plotted to develop anthrax, and nerve gas, and nuclear weapons for over a decade'';

Whereas it is believed that Iraq continues in its efforts to develop weapons of mass destruction, in violation of United Nations Security Council Resolution 687 (1991) and subsequent resolutions, and that the regime of Saddam Hussein has used weapons of mass destruction against its own people;

Whereas the development of weapons of mass destruction by Iraq is a threat to the United States, and its friends and allies in the Middle East;

Whereas Public Law 107–40 authorizes the President to use United States Armed Forces against ''those nations, organizations or persons he determines planned, authorized, committed, or aided the terrorist attacks that occurred on September 11, 2001, or harbored such organizations or persons in order to prevent any future acts on international terrorism against the United States by such nations, organizations, or persons'';

Whereas no such evidence has been forthcoming linking Iraq to the September 11, 2001 attacks; and

Whereas Article I, Section 8, Clause 11 of the Constitution of the United States confers upon Congress the sole power to declare war: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That (a) it is the sense of Congress that—

(1) the United States and the United Nations Security Council should insist on a complete program of inspection and monitoring to prevent the development of weapons of mass destruction in Iraq;

(2) Iraq should allow the United Nations weapons inspectors ''immediate, unconditional, and unrestricted access to any and all areas, facilities, equipment, records and means of transportation which they wish to inspect'' as required by United Nations Security Council Resolution 707 of August 15, 1991, and United Nations Security Council Resolution 1284 of December 17, 1999; and

(3) the United States should not use force against Iraq without specific statutory authorization or a declaration of war under Article I, Section 8, Clause 11 of the Constitution of the United States, except as provided in subsection (b).

(b) Subsection (a)(3) does not apply to any use of force in compliance with the existing Rules of Engagement (ROE) used by coalition forces to exercise the right of self-defense or under the National Security Act of 1947.

Mrs. FEINSTEIN. Mr. President, on behalf of Senator LEAHY and myself, I rise today to submit a concurrent resolution. This resolution is aimed to deal with a great deal of the speculation we read about in the public press as to whether there is an intent of the administration for use of force against Iraq.

We all know that use of force requires a specific statutory authorization or declaration of war under article I, section 8, clause 11 of the Constitution of the United States. I believe the issue is not a question of whether or not Iraq is a rogue state. It is. It is also not a question of whether Saddam Hussein is a brutal dictator. He is.

The question, however, is what is the best policy for the United States and how to address these issues, and if we are to use force, that we do so only after full debate and consideration of all of the options and with a united Government and with the specific statutory authorization of the Congress.

Under the Constitution, only the Congress can declare war, and I offer this resolution because of the growing sense, both within the United States and abroad, that the Bush administration is poised to launch a major military offensive against the Nation of Iraq.

Thus far, the administration has submitted no evidence of any Iraqi connection to 9/11 to this Congress, and the resolution authorizing the use of force against al-Qaida is specifically worded so that hard evidence of such a connection is needed to justify military action.

Conclusive proof that Saddam Hussein is, indeed, harboring weapons of mass destruction, that he is providing shelter for al-Qaida terrorist cells, or that he is in any way linked to the attacks of September 11 would quickly galvanize support for military action. As of now, however, no such evidence has been substantiated.

At this time, moreover, I know of no formal support for a full-scale military action from any other nation. I know of no formal grant to fly over or landing rights which would be granted by any nation in connection with any invasion plan.

As far as I know at this point, the United States would be alone, unilaterally taking action. To take action without support from our allies or the United Nations would clearly identify the United States as an aggressor and may well prompt a series of potentially catastrophic actions.

Both Turkey and Jordan, two of our most loyal and longstanding allies in the region, have been open about their concern about United States unilateral action at this time, making clear their opposition. They have also pinpointed that the present crisis between the Israelis and the Palestinians should be the world's primary focus in the Middle East.

Until the Israeli-Palestinian conflict is stabilized, until more than a semblance of security and stability has returned to Israel and Palestine, a massive invasion against Iraq could expose the Israeli people to possible missile strikes from Baghdad.

We should also remain focused and stay the course in our war on terror.

The government of Hamid Karzai in Afghanistan is increasingly unstable. There are serious questions and concerns about security throughout Afghanistan. The warlords are restless and asserting power, and previously dissipated Taliban elements are returning to Afghanistan. The situation remains volatile.

The stabilization of Afghanistan, its successful transition to a democratic government, and its restoration of its war-torn economy should remain a top priority for all of us. I believe it would be a tragic mistake if the United States turns its attention and effort from Afghanistan before the new Afghan Government is stabilized and security in the country is improved.

I, for one, strongly believe that Iraq should promptly agree to the return of the United Nations weapons inspectors it expelled in 1998. If the government of Saddam Hussein has nothing to hide, something it continues to claim, then now is the time to prove it to the entire world.

Iraq's refusal to cooperate is tacit admission of deception and of the pursuit and stockpiling of chemical, biological, and, yes, admission that the rumors of his pressing ahead to develop nuclear warheads are, in fact, true.

Last week, at a meeting in Vienna, United Nations Secretary General Kofi Annan told an Iraqi delegation in no uncertain terms that the Iraqi Government must allow U.N. inspectors back in or there was no point to continue discussions and negotiations.

There was no response from the Iraqi delegation, who simply left Vienna and returned to Baghdad. I understand that Saddam Hussein is a brutal dictator who during a 34-year reign of terror has systematically eliminated all internal opposition, even including members of his own family. He has ruthlessly persecuted Iraq's Kurdish minority. He has used chemical weapons against the Kurds and his own people. He has initiated a decade-long war against Iran, at the cost of nearly 2 million casualties. He has financially supported Palestinian terrorists and he has invaded Kuwait, prompting the United States to launch Operation Desert Storm.

In the history of our Nation, we have never attacked another country, except in response to an attack on our own shores, our people or our national interests. Until and unless the administration is prepared to come forward to offer its rationale, to submit its evidence to the American people, and to allow Congress to vote to authorize the use of force, an attack on Iraq, I believe, is both unwise and ill timed.

Unwise because it would certainly encourage an unprecedented response by Saddam Hussein, most likely targeted against Israel. Unwise because until the administration has thought through the who, the what, and the how of the regime that will take power in Iraq after Saddam Hussein is disposed of, any military action may well have unintended and undesirable consequences.

One cannot overemphasize how important the nature of the next Iraqi regime is to the future of the Middle East. It will require that the United States engage in nation building, something this administration has been reluctant to do. Call it what you will, but in the wake of toppling Saddam Hussein our commitment to Iraq must not be brief or perfunctory. This, I believe, is ill timed because of the unfinished business in Afghanistan, the continuing threat of al-Qaida, and the fact that at least two-thirds of the al-Qaida leadership, including Osama bin Laden, remain at large.

The war against terror has not yet been won. We should stay the course. So before rushing precipitously forward in an attack on Iraq, I urge the Bush administration to work with allies and the United Nations to develop a multilateral approach to compel Iraq to live up to its obligations under Security Council Resolution 687.

Should Iraq be unwilling to live up to its obligations and the President determines that there is just cause for military action against Iraq, I urge him to come before this Congress, to come before the American people, to make his case and let us in turn discharge our constitutional duty to debate and vote on the authorization of the use of force. The many thousands of our sons and daughters who will bear the brunt of such an operation, some of whom will surely pay the highest price, deserve no less.

I ask unanimous consent that the concurrent resolution be printed in the RECORD.

AMENDMENTS SUBMITTED AND PROPOSED

SA 4327. Mr. WELLSTONE submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table.

SA 4328. Mr. BINGAMAN submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4329. Mr. DURBIN (for himself, Mr. DEWINE, Mr. DORGAN, Mr. LEVIN, and Mr. JOHNSON) submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4330. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4331. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4332. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4333. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4334. Mr. NICKLES submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4335. Mr. NICKLES submitted an amendment intended to be proposed to amendment SA 4299 proposed by Mr. REID (for Mr. DORGAN (for himself, Mr. WELLSTONE, Mr. JEFFORDS, Ms. STABENOW, Ms. COLLINS, Mr. LEVIN, Mr. JOHNSON, Mr. MILLER, Mr. DURBIN, Mr. FEINGOLD, and Mr. HARKIN)) to the bill (S. 812) supra; which was ordered to lie on the table.

SA 4336. Mr. NICKLES submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4337. Mr. NICKLES submitted an amendment intended to be proposed to amendment SA 4299 proposed by Mr. REID (for Mr. DORGAN (for himself, Mr. WELLSTONE, MR. JEFFORDS, Ms. STABENOW, Ms. COLLINS, Mr. LEVIN, Mr. JOHNSON, Mr. MILLER, Mr. DURBIN, Mr. FEINGOLD, and Mr. HARKIN)) to the bill (S. 812) supra; which was ordered to lie on the table.

SA 4338. Mr. NICKLES submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4339. Mr. NICKLES submitted an amendment intended to be proposed to amendment SA 4299 proposed by Mr. REID (for Mr. DORGAN (for himself, Mr. WELLSTONE, Mr. JEFFORDS, Ms. STABENOW, Ms. COLLINS, Mr. LEVIN, Mr. JOHNSON, Mr. MILLER, Mr. DURBIN, Mr. FEINGOLD, and Mr. HARKIN)) to the bill (S. 812) supra; which was ordered to lie on the table.

SA 4340. Mr. LEAHY submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4341. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4342. Mr. FRIST submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4343. Mr. FRIST submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4344. Mr. FRIST submitted an amendment intended to be proposed to amendment SA 4299 proposed by Mr. REID (for Mr. DORGAN (for himself, Mr. WELLSTONE, Mr. JEFFORDS, Ms. STABENOW, Ms. COLLINS, Mr. LEVIN, Mr. JOHNSON, Mr. MILLER, Mr. DURBIN, Mr. FEINGOLD, and Mr. HARKIN)) to the bill (S. 812) supra; which was ordered to lie on the table.

SA 4345. Mr. GRAHAM (for himself, Mr. SMITH of Oregon, Mr. MILLER, Mrs. LINCOLN, Mr. BINGAMAN, Mr. KENNEDY, and Ms. STABENOW) proposed an amendment to amendment SA 4299 proposed by Mr. REID (for Mr. DORGAN (for himself, Mr. WELLSTONE, Mr. JEFFORDS, Ms. STABENOW, Ms. COLLINS, Mr. LEVIN, Mr. JOHNSON, Mr. MILLER, Mr. DURBIN, Mr. FEINGOLD, and Mr. HARKIN)) to the bill (S. 812) supra.

SA 4346. Ms. LANDRIEU submitted an amendment intended to be proposed by her to the bill H.R. 5010, making appropriations for the Department of Defense for the fiscal year ending September 30, 2003, and for other purposes; which was ordered to lie on the table.

SA 4347. Ms. LANDRIEU submitted an amendment intended to be proposed by her to the bill H.R. 5010, supra; which was ordered to lie on the table.

SA 4348. Ms. LANDRIEU submitted an amendment intended to be proposed by her to the bill H.R. 5010, supra; which was ordered to lie on the table.

SA 4349. Mr. HUTCHINSON submitted an amendment intended to be proposed to amendment SA 4345 proposed by Mr. GRAHAM (for himself, Mr. SMITH of Oregon, Mr. MILLER, Mrs. LINCOLN, Mr. BINGAMAN, Mr. KENNEDY, and Ms. STABENOW) to the amendment

SA 4299 proposed by Mr. REID (for Mr. DORGAN (for himself, Mr. WELLSTONE, Mr. JEFFORDS, Ms. STABENOW, Ms. COLLINS, Mr. LEVIN, Mr. JOHNSON, Mr. MILLER, Mr. DURBIN, Mr. FEINGOLD, and Mr. HARKIN)) to the bill (S. 812) to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 4327. Mr. WELLSTONE submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. STATE PRESCRIPTION DRUG DISCOUNT.

(a) FINDINGS.—Congress makes the following findings:

(1) More than 70,000,000 Americans, including more than 18,000,000 Medicare beneficiaries, are uninsured or underinsured for prescription drug coverage.

(2) High prescription drug prices are denying uninsured and underinsured Americans access to medically necessary care, thereby threatening their health and safety. Many of these Americans require repeated doctor or medical clinic appointments, becoming sicker because they cannot afford to take the drugs prescribed for them. Many are admitted to or treated at hospitals because they cannot afford the drugs prescribed for them that could have prevented the need for hospitalization. Many enter expensive institutional care settings because they cannot afford the prescription drugs that could have supported them outside of an institution. In each of these circumstances, uninsured and underinsured residents too often become medicaid recipients because of their inability to afford prescription drugs.

(3) Pursuant to the Social Security Act, State medicaid programs receive discounts in the form of rebates for outpatient prescription drugs. On average, these rebates provide discounts of more than 40 percent off retail prices.

(4) In 49 States, individual Americans do not have access to medicaid rebates. But in 1 State, since June 1, 2001, over 100,000 Americans have received discounts from those rebates through the ''Healthy Maine'' program. This program, established as a demonstration project pursuant to a waiver from the Secretary of Health and Human Services has proven to work. Americans need that program replicated in every State, immediately.

(5) The Federal and State governments are the only agents that, as a practical matter, can play an effective role as a market participant on behalf of Americans who are uninsured or underinsured.

(b) STATE PRESCRIPTION DISCOUNT PROGRAM.—

(1) IN GENERAL.—Section 1927(a) of the Social Security Act (42 U.S.C. 1396r–8(a)) is amended by adding at the end the following:

''(7) REQUIREMENTS RELATING TO AGREEMENTS FOR DRUGS PROCURED BY INDIVIDUALS THROUGH STATE PRESCRIPTION DRUG DISCOUNT PROGRAMS.—

''(A) IN GENERAL.—A manufacturer meets the requirements of this paragraph if the manufacturer enters into an agreement with the State to make rebate payments for drugs covered by a State prescription drug discount program in the same amounts as are paid by the manufacturer to the State for such drugs under a rebate agreement described in subsection (b).

''(B) STATE PRESCRIPTION DRUG DISCOUNT PROGRAM DEFINED.—

''(i) IN GENERAL.—In this paragraph, the term 'State prescription drug discount program' means a State program under which, with respect to a rebate period, not less than the amount equal to 95 percent of all the rebates paid to the State under agreements entered into under subparagraph (A) during such period is provided to eligible State residents in the form of discounted prices for the purchase of outpatient prescription drugs.

''(ii) ELIGIBLE STATE RESIDENT.—For purposes of clause (i), the term 'eligible State resident' means an individual who is a State resident and—

''(I) who is eligible for benefits under title XVIII; or

''(II) whose income does not exceed 300 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(iii) ADDITIONAL SUBSIDIES.—Nothing in this subparagraph shall be construed as—

''(I) requiring a State to expend State funds to carry out a State prescription drug discount program; or

''(II) prohibiting a State from electing to contribute State funds to a State prescription drug discount program to provide greater subsidies to eligible State residents for outpatient prescription drugs covered under the program.

''(C) NO OFFSET AGAINST MEDICAL ASSISTANCE.—Amounts received by a State under an agreement entered into under subparagraph (A) in any quarter shall not be considered to be a reduction in the amount expended under the State plan in the quarter for medical assistance for purposes of section 1903(a)(1).''.

(2) CONFORMING AMENDMENT.—The first sentence of section 1927(a)(1) of the Social Security Act (42 U.S.C. 1396r–8(a)(1)) is amended, by striking ''and paragraph (6)'' and inserting '', paragraph (6), and paragraph (7)''.

(c) ENHANCED REBATES FOR STATE MEDICAID PROGRAMS.—Section 1927(b)(1)(B) of the Social Security Act (42 U.S.C. 1396r–8(b)(1)(B) is amended—

(1) by striking ''Amounts'' and inserting the following:

''(i) IN GENERAL.—Except as provided in clause (ii) and subsection (a)(7)(C), amounts''; and

(2) by adding at the end the following:

''(ii) ENHANCED REBATE.—In the case of a State that has a State prescription drug discount program described in subsection (a)(7) and that has entered into a rebate agreement described in paragraph (1) or (4) of subsection (a) that provides a greater rebate for a covered outpatient drug than the rebate that would be paid for the covered outpatient drug under subsection (c), then, notwithstanding clause (i), only the amount equal to ½ of the difference between the amount received by the State in any quarter under such a rebate agreement and the amount of the rebate that would be paid under subsection (c) for such covered outpatient drug shall be considered to be a reduction in the amount expended under the State plan in the quarter for medical assistance for purposes of section 1903(a)(1).''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2004.

SA 4328. Mr. BINGAMAN submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the end, add the following:

SEC. ___. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS ESTABLISHED FOR PURPOSES OF THE MEDICAID DRUG REBATE PROGRAM.

Section 1927(c)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(ii)) is amended—

(1) in subclause (II), by striking ''and'' at the end;

(2) in subclause (Ill), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(IV) with respect to a covered entity described in section 340B(a)(4)(L) of the Public Health Service Act, shall, in addition to any prices excluded under clause (i)(I), exclude any price charged on or after the date of enactment of this subparagraph, for any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, inpatient hospital services (and for which payment may be made under this title as part of payment for and not as direct reimbursement for the drug).''.

SA 4329. Mr. DURBIN (for himself, Mr. DEWINE, Mr. DORGAN, Mr. LEVIN, and Mr. JOHNSON) submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the end, add the following:

SEC. ___. COMPREHENSIVE COVERAGE OF IMMUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)), as amended by section 113(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–473), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by striking '', to an individual who receives'' and all that follows before the semicolon at the end and inserting ''to an individual who has received an organ transplant''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to drugs furnished on or after the date of enactment of this Act.

SEC. ___. PROVISION OF APPROPRIATE COVERAGE OF IMMUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PROGRAM FOR ORGAN TRANSPLANT RECIPIENTS.

(a) CONTINUED ENTITLEMENT TO IMMUNOSUPPRESSIVE DRUGS.—

(1) KIDNEY TRANSPLANT RECIPIENTS.—Section 226A(b)(2) of the Social Security Act (42 U.S.C. 426–1(b)(2)) is amended by inserting ''(except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))'' after ''shall end''.

(2) OTHER TRANSPLANT RECIPIENTS.—The flush matter following paragraph (2)(C)(ii)(II) of section 226(b) of the Social Security Act (42 U.S.C. 426(b)) is amended by striking ''of this subsection)'' and inserting ''of this subsection and except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))''.

(3) APPLICATION.—Section 1836 of the Social Security Act (42 U.S.C. 1395o) is amended—

(A) by striking ''Every individual who'' and inserting ''(a) IN GENERAL.—Every individual who''; and

(B) by adding at the end the following new subsection:

''(b) SPECIAL RULES APPLICABLE TO INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

''(1) IN GENERAL.—In the case of an individual whose eligibility for benefits under this title has ended except for the coverage of immunosuppressive drugs by reason of section 226(b) or 226A(b)(2), the following rules shall apply:

''(A) The individual shall be deemed to be enrolled under this part for purposes of receiving coverage of such drugs.

''(B) The individual shall be responsible for the full amount of the premium under section 1839 in order to receive such coverage.

''(C) The provision of such drugs shall be subject to the application of—

''(i) the deductible under section 1833(b); and

''(ii) the coinsurance amount applicable for such drugs (as determined under this part).

''(D) If the individual is an inpatient of a hospital or other entity, the individual is entitled to receive coverage of such drugs under this part.

''(2) ESTABLISHMENT OF PROCEDURES IN ORDER TO IMPLEMENT COVERAGE.—The Secretary shall establish procedures for—

''(A) identifying beneficiaries that are entitled to coverage of immunosuppressive drugs by reason of section 226(b) or 226A(b)(2); and

''(B) distinguishing such beneficiaries from beneficiaries that are enrolled under this part for the complete package of benefits under this part.''.

(4) TECHNICAL AMENDMENT.—Subsection (c) of section 226A of the Social Security Act (42 U.S.C. 426–1), as added by section 201(a)(3)(D)(ii) of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1497), is redesignated as subsection (d).

(b) EXTENSION OF SECONDARY PAYER REQUIREMENTS FOR ESRD BENEFICIARIES.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following new sentence: ''With regard to immunosuppressive drugs furnished on or after the date of enactment of this sentence, this subparagraph shall be applied without regard to any time limitation.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to drugs furnished on or after the date of enactment of this Act.

SEC. ___. PLANS REQUIRED TO MAINTAIN COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

(a) APPLICATION TO CERTAIN HEALTH INSURANCE COVERAGE.—

(1) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following:

''SEC. 2707. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

''A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide coverage of immunosuppressive drugs that is at least as comprehensive as the coverage provided by such plan or issuer on the day before the date of enactment of this section, and such requirement shall be deemed to be incorporated into this section.''.

(2) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2707)'' after ''requirements of such subparts''.

(b) APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following new section:

''SEC. 714. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

''A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide coverage of immunosuppressive drugs that is at least as comprehensive as the coverage provided by such plan or issuer on the day before the date of enactment of this sentence, and such requirement shall be deemed to be incorporated into this section.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(B) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Coverage of immunosuppressive drugs.''.

(c) APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Coverage of immunosuppressive drugs.'';

and

(2) by inserting after section 9812 the following:

''SEC. 9813. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

''A group health plan shall provide coverage of immunosuppressive drugs that is at least as comprehensive as the coverage provided by such plan on the day before the date of enactment of this sentence, and such requirement shall be deemed to be incorporated into this section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning on or after January 1, 2003.

SA 4330. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

Beginning on page 27, strike line 15 and all that follows through page 28, line 18 and insert the following:

''(E) NO CLAIM FOR PATENT INFRINGEMENT.—An owner of a patent with respect to''.

SA 4331. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

Beginning on page 27, strike line 15 and all that follows through page 28, line 16, and insert the following:

''(E) CORRECTION OR DELETION OF PATENT INFORMATION.—

''(i) IN GENERAL.—A person that has filed an application under subsection (b)(2) or (j) for a drug may submit to arbitration a claim to require the holder of the application to amend the application—

''(I) to correct patent information filed under subparagraph (A); or

''(II) to delete the patent information in its entirety for the reason that—

''(aa) the patent does not claim the drug for which the application was approved; or

''(bb) the patent does not claim an approved method of using the drug.

''(ii) AMERICAN ARBITRATION ASSOCIATION.—Arbitration under clause (i) shall be administered by the American Arbitration Association, in accordance with the Commercial Arbitration Rules.

''(iii) DECISION.—

''(I) TIMING.—Not later than 180 days after the date on which an arbitrator receives a written request for arbitration under this subparagraph, the arbitrator shall render a decision with respect to the claim.

''(II) LIMITATION.—In rendering a decision under subclause (I), the arbitrator shall not—

''(aa) order the correction of patent information filed under subparagraph (B); or

''(bb) award monetary damages.

''(III) BINDING EFFECT.—A decision rendered under subclause (I)—

''(aa) shall be final and binding; and

''(bb) may be entered in any court having jurisdiction over the claim.

SA 4332. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

Beginning on page 28, strike line 17 and all that follows through page 39, line 18, and insert the following:

(2) TRANSITION PROVISION.—Each holder of an application for approval of a new drug under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) that has been approved before the date of enactment of this Act shall amend the application to include the patent information required under the amendment made by paragraph (1) not later than the date that is 30 days after the date of enactment of this Act (unless the Secretary of Health and Human Services extends the date because of extraordinary or unusual circumstances).

(b) FILING WITH AN APPLICATION.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subsection (b)(2)—

(A) in subparagraph (A), by striking ''and'' at the end;

(B) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(C) with respect to a patent that claims both the drug and a method of using the drug or claims more than 1 method of using the drug for which the application is filed—

''(i) a certification under subparagraph (A)(iv) on a claim-by-claim basis; and

''(ii) a statement under subparagraph (B) regarding the method of use claim.''; and

(2) in subsection (j)(2)(A), by inserting after clause (viii) the following:

''With respect to a patent that claims both the drug and a method of using the drug or claims more than 1 method of using the drug for which the application is filed, the application shall contain a certification under clause (vii)(IV) on a claim-by-claim basis and a statement under clause (viii) regarding the method of use claim.''.

SEC. 4. LIMITATION OF 30-MONTH STAY TO CERTAIN PATENTS.

(a) ABBREVIATED NEW DRUG APPLICATIONS.—Section 505(j)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)) is amended—

(1) in subparagraph (B)—

(A) in clause (iii)—

(i) by striking ''(iii) If the applicant made a certification described in subclause (IV) of paragraph (2)(A)(vii),'' and inserting the following:

''(iii) SUBCLAUSE (IV) CERTIFICATION WITH RESPECT TO CERTAIN PATENTS.—If the applicant made a certification described in paragraph (2)(A)(vii)(IV) with respect to a patent (other than a patent that claims a process for manufacturing the listed drug) for which patent information was filed with the Secretary under subsection (c)(2)(A),''; and

(ii) by adding at the end the following: ''The 30-month period provided under the second sentence of this clause shall not apply to a certification under paragraph (2)(A)(vii)(IV) made with respect to a patent for which patent information was filed with the Secretary under subsection (c)(2)(B).'';

(B) by redesignating clause (iv) as clause (v); and

(C) by inserting after clause (iii) the following:

''(iv) SUBCLAUSE (IV) CERTIFICATION WITH RESPECT TO OTHER PATENTS.—

''(I) IN GENERAL.—If the applicant made a certification described in paragraph (2)(A)(vii)(IV) with respect to a patent not described in clause (iii) for which patent information was published by the Secretary under subsection (c)(2)(D), the approval shall be made effective on the date that is 45 days after the date on which the notice provided under paragraph (2)(B) was received, unless a civil action for infringement of the patent, accompanied by a motion for preliminary injunction to enjoin the applicant from engaging in the commercial manufacture or sale of the drug, was filed on or before the date that is 45 days after the date on which the notice was received, in which case the approval shall be made effective—

''(aa) on the date of a court action declining to grant a preliminary injunction; or

''(bb) if the court has granted a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug—

''(AA) on issuance by a court of a determination that the patent is invalid or is not infringed;

''(BB) on issuance by a court of an order revoking the preliminary injunction or permitting the applicant to engage in the commercial manufacture or sale of the drug; or

''(CC) on the date specified in a court order under section 271(e)(4)(A) of title 35, United States Code, if the court determines that the patent is infringed.

''(II) COOPERATION.—Each of the parties shall reasonably cooperate in expediting a civil action under subclause (I).

''(III) EXPEDITED NOTIFICATION.—If the notice under paragraph (2)(B) contains an address for the receipt of expedited notification of a civil action under subclause (I), the plaintiff shall, on the date on which the complaint is filed, simultaneously cause a notification of the civil action to be delivered to that address by the next business day.''; and

(2) by inserting after subparagraph (B) the following:

''(C) FAILURE TO BRING INFRINGEMENT ACTION.—If, in connection with an application under this subsection, the applicant provides an owner of a patent notice under paragraph (2)(B) with respect to the patent, and the owner of the patent fails to bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice is received, the owner of the patent shall be barred from bringing a civil action for infringement of the patent against the applicant with respect to the application.''.

(b) OTHER APPLICATIONS.—Section 505(c)) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)) (as amended by section 9(a)(3)(A)(iii)) is amended—

(1) in paragraph (3)—

(A) in subparagraph (C)—

(i) by striking ''(C) If the applicant made a certification described in clause (iv) of subsection (b)(2)(A),'' and inserting the following:

''(C) CLAUSE (iv) CERTIFICATION WITH RESPECT TO CERTAIN PATENTS.—If the applicant made a certification described in subsection (b)(2)(A)(iv) with respect to a patent (other than a patent that claims a process for manufacturing the listed drug) for which patent information was filed with the Secretary under paragraph (2)(A),''; and

(ii) by adding at the end the following: ''The 30-month period provided under the second sentence of this subparagraph shall not apply to a certification under subsection (b)(2)(A)(iv) made with respect to a patent for which patent information was filed with the Secretary under paragraph (2)(B).''; and

(B) by inserting after subparagraph (C) the following:

''(D) CLAUSE (iv) CERTIFICATION WITH RESPECT TO OTHER PATENTS.—

''(i) IN GENERAL.—If the applicant made a certification described in subsection (b)(2)(A)(iv) with respect to a patent not described in subparagraph (C) for which patent information was published by the Secretary under paragraph (2)(D), the approval shall be made effective on the date that is 45 days after the date on which the notice provided under subsection (b)(3) was received, unless a civil action for infringement of the patent, accompanied by a motion for preliminary injunction to enjoin the applicant from engaging in the commercial manufacture or sale of the drug, was filed on or before the date that is 45 days after the date on which the notice was received, in which case the approval shall be made effective—

''(I) on the date of a court action declining to grant a preliminary injunction; or

''(II) if the court has granted a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug—

''(aa) on issuance by a court of a determination that the patent is invalid or is not infringed;

''(bb) on issuance by a court of an order revoking the preliminary injunction or permitting the applicant to engage in the commercial manufacture or sale of the drug; or

''(cc) on the date specified in a court order under section 271(e)(4)(A) of title 35, United States Code, if the court determines that the patent is infringed.

''(ii) COOPERATION.—Each of the parties shall reasonably cooperate in expediting a civil action under clause (i).

''(iii) EXPEDITED NOTIFICATION.—If the notice under subsection (b)(3) contains an address for the receipt of expedited notification of a civil action under clause (i), the plaintiff shall, on the date on which the complaint is filed, simultaneously cause a notification of the civil action to be delivered to that address by the next business day.''; and

(2) by inserting after paragraph (3) the following:

''(4) FAILURE TO BRING INFRINGEMENT ACTION.—If, in connection with an application under subsection (b)(2), the applicant provides an owner of a patent notice under subsection (b)(3) with respect to the patent, and the owner of the patent fails to bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice is received, the owner of the patent shall be barred from bringing a civil action for infringement of the patent against the applicant with respect to the application.''.

SA 4333. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

Beginning on page 31, strike line 12 and all that follows through page 40 and insert the following:

SEC. 4. 30-MONTH STAY.

(a) ABBREVIATED NEW DRUG APPLICATIONS.—Section 505(j)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)) is amended—

(1) in subparagraph (B)(iii)—

(A) by striking ''(iii) If the applicant'' and inserting the following:

''(iii) SUBCLAUSE (IV) CERTIFICATION.—If the applicant''; and

(B) by adding at the end the following: ''The 30-month period provided under this clause shall not apply to a certification under paragraph (2)(A)(vii)(IV) made with respect to a patent for which patent information was filed with the Secretary after the filing of the application under this subsection that contains the certification.''; and

(2) by inserting after subparagraph (B) the following:

''(C) FAILURE TO BRING INFRINGEMENT ACTION.—If, in connection with an application under this subsection, the applicant provides an owner of a patent notice under paragraph (2)(B) with respect to the patent, and the owner of the patent fails to bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice is received, the owner of the patent shall be barred from bringing a civil action for infringement of the patent in connection with the development, manufacture, use, offer to sell, or sale of the drug for which the application was filed or approved under this subsection.''.

(b) OTHER APPLICATIONS.—Section 505(c)) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)) is amended—

(1) in paragraph (3)(C)—

(A) by striking ''(C) If the applicant'' and inserting the following:

''(C) CLAUSE (iv) CERTIFICATION.—If the applicant''; and

(B) by adding at the end the following: ''The 30-month period provided under this subparagraph shall not apply to a certification under subsection (b)(2)(A)(iv) made with respect to a patent for which patent information was filed with the Secretary after the filing of the application described in subsection (b)(2) that contains the certification.''; and

(2) by inserting after paragraph (3) the following:

''(4) FAILURE TO BRING INFRINGEMENT ACTION.—If, in connection with an application under subsection (b)(2), the applicant provides an owner of a patent notice under subsection (b)(3) with respect to the patent, and the owner of the patent fails to bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice is received, the owner of the patent shall be barred from bringing a civil action for infringement of the patent in connection with the development, manufacture, use, offer to sell, or sale of the drug for which the application was filed or approved under subsection (b)(2).''.

SA 4334. Mr. NICKLES submitted an amendment intended to be proposed by

him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, add the following:

SEC. ___. NONAPPLICATION OF STATE AUTHORITY TO ENTER INTO DRUG REBATE AGREEMENTS IF THE AGREEMENTS WOULD RESULT IN INCREASED MEDICAID DRUG COSTS.

Notwithstanding any other provision of this Act, section 1927 of the Social Security Act (42 U.S.C. 1396r–8) shall be applied without regard to subsection (l) (as added by this Act) if the Secretary of Health and Human Services determines that the application of that subsection would result in an increase in expenditures under the medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for covered outpatient drugs (as defined in section 1927(k)(2) of that Act (42 U.S.C. 1396r–8(k)(2)).

SA 4335. Mr. NICKLES submitted an amendment intended to be proposed to amendment SA 4299 proposed by Mr. REID (for Mr. DORGAN (for himself, Mr. WELLSTONE, Mr. JEFFORDS, Ms. STABENOW, Ms. COLLINS, Mr. LEVIN, Mr. JOHNSTON, Mr. MILLER, Mr. DURBIN, Mr. FEINGOLD, and Mr. HARKIN)) to the bill (S. 812) to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, add the following:

SEC. ___. NONAPPLICATION OF STATE AUTHORITY TO ENTER INTO DRUG REBATE AGREEMENTS IF THE AGREEMENTS WOULD RESULT IN INCREASED MEDICAID DRUG COSTS.

Notwithstanding any other provision of this Act, section 1927 of the Social Security Act (42 U.S.C. 1396r–8) shall be applied without regard to subsection (l) (as added by this Act) if the Secretary of Health and Human Services determines that the application of that subsection would result in an increase in expenditures under the medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for covered outpatient drugs (as defined in section 1927(k)(2) of that Act (42 U.S.C. 1396r–8(k)(2)).

SA 4336. Mr. NICKLES submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, add the following:

SEC. ___. SCOPE OF APPLICATION OF TEMPORARY INCREASE IN FMAP.

Section ___(a)(5) of this Act (relating to the scope of application of the temporary increase in the State Federal medical assistance percentage) is amended—

(1) by striking the period at the end of subparagraph (B) and inserting ''; or''; and

(2) by adding at the end the following:

''(C) payments that are in excess of the aggregate upper payment limits applicable to the medicaid program, as determined under part 447 of title 42 of the Code of Federal Regulations, (or that would be considered to be in excess of such limits if a transition period described in section 447.272(e) or 447.321(e) of title 42 of the Code of Federal Regulations) did not apply to the payments).''.

SA 4337. Mr. NICKLES submitted an amendment intended to be proposed to amendment SA 4299 proposed by Mr. REID (for Mr. DORGAN (for himself, Mr. WELLSTONE, Mr. JEFFORDS, Ms. STABENOW, Ms. COLLINS, Mr. LEVIN, Mr. JOHNSON, Mr. MILLER, Mr. DURBIN, Mr. FEINGOLD, and Mr. HARKIN)) to the bill (S. 812) to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, add the following:

''(C) payments that are in excess of the aggregate upper payment limits applicable to the medicaid program, as determined under part 447 of title 42 of the Code of Federal Regulations, (or that would be considered to be in excess of such limits if a transition period described in section 447.272(e) or 447.321(e) of title 42 of the Code of Federal Regulations) did not apply to the payments).''.

SA 4338. Mr. NICKLES submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, add the following:

SEC. ___. CLARIFICATION OF STATE AUTHORITY RELATING TO MEDICAID DRUG REBATE AGREEMENTS.

Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended by adding at the end the following:

''(l) RULE OF CONSTRUCTION.—

''(1) IN GENERAL.—With respect to individuals described in paragraph (2) who are enrolled in a State prescription drug program described in paragraph (3), nothing in this section shall be construed as prohibiting a State from—

''(A) directly entering into rebate agreements (on the State's own initiative or under a section 1115 waiver approved by the Secretary before, on, or after the date of enactment of this subsection) that are similar to a rebate agreement described in subsection (b) with a manufacturer for purposes of ensuring the affordability of outpatient prescription drugs in order to provide access to such drugs by such individuals; or

''(B) making prior authorization (that satisfies the requirements of subsection (d) and that does not violate any requirements of this title that are designed to ensure access to medically necessary prescribed drugs for individuals enrolled in the State program under this title) a condition of not participating in such a similar rebate agreement.

''(2) INDIVIDUALS DESCRIBED.—For purposes of paragraph (1), individuals described in this paragraph are individuals—

''(A) whose family income does not exceed 200 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; and

''(B) who are not otherwise eligible for medical assistance under this title.

''(3) STATE PRESCRIPTION DRUG PROGRAM DESCRIBED.—For purposes of paragraph (1), a State prescription drug program described in this paragraph is a State program that was in effect as of July 1, 2002, and under which State appropriated funds substantially paid for the cost of outpatient prescription drugs for individuals described in paragraph (1) who were enrolled in the program.''.

SA 4339. Mr. NICKLES submitted an amendment intended to be proposed to amendment SA 4299 proposed by Mr. REID (for Mr. DORGAN (for himself, Mr. WELLSTONE, Mr. JEFFORDS, Ms. STABENOW, Ms. COLLINS, Mr. LEVIN, Mr. JOHNSON, Mr. MILLER, Mr. DURBIN, Mr. FEINGOLD, and Mr. HARKIN) to the bill (S. 812) to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, add the following:

SEC. ___. CLARIFICATION OF STATE AUTHORITY RELATING TO MEDICAID DRUG REBATE AGREEMENTS.

Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended by adding at the end the following:

''(l) RULE OF CONSTRUCTION.—

''(1) IN GENERAL.—With respect to individuals described in paragraph (2) who are enrolled in a State prescription drug program described in paragraph (3), nothing in this section shall be construed as prohibiting a State from—

''(A) directly entering into rebate agreements (on the State's own initiative or under a section 1115 waiver approved by the Secretary before, on, or after the date of enactment of this subsection) that are similar to a rebate agreement described in subsection (b) with a manufacturer for purposes of ensuring the affordability of outpatient prescription drugs in order to provide access to such drugs by such individuals; or

''(B) making prior authorization (that satisfies the requirements of subsection (d) and that does not violate any requirements of this title that are designed to ensure access to medically necessary prescribed drugs for individuals enrolled in the State program under this title) a condition of not participating in such a similar rebate agreement.

''(2) INDIVIDUALS DESCRIBED.—For purposes of paragraph (1), individuals described in this paragraph are individuals—

''(A) whose family income does not exceed 200 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; and

''(B) who are not otherwise eligible for medical assistance under this title.

''(3) STATE PRESCRIPTION DRUG PROGRAM DESCRIBED.—For purposes of paragraph (1), a State prescription drug program described in this paragraph is a State program that was in effect as of July 1, 2002, and under which State appropriated funds substantially paid for the cost of outpatient prescription drugs for individuals described in paragraph (1) who were enrolled in the program.''.

SA 4340. Mr. LEAHY submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the end insert the following:

TITLE ____—DRUG COMPETITION ACT OF 2002

SEC. ____01. SHORT TITLE.

This title may be cited as the ''Drug Competition Act of 2002''.

SEC. ____02. FINDINGS.

Congress finds that—

(1) prescription drug prices are increasing at an alarming rate and are a major worry of many senior citizens and American families;

(2) there is a potential for companies with patent rights regarding brand-name drugs and companies which could manufacture generic versions of such drugs to enter into financial deals that could tend to restrain trade and greatly reduce competition and increase prescription drug expenditures for American citizens; and

(3) enhancing competition among these companies can significantly reduce prescription drug expenditures for Americans.

SEC. ____03. PURPOSES.

The purposes of this title are—

(1) to provide timely notice to the Department of Justice and the Federal Trade Commission regarding agreements between companies with patent rights regarding branded drugs and companies which could manufacture generic versions of such drugs; and

(2) by providing timely notice, to enhance the effectiveness and efficiency of the enforcement of the antitrust and competition laws of the United States.

SEC. ____04. DEFINITIONS.

In this title:

(1) ANDA.—The term ''ANDA'' means an Abbreviated New Drug Application, as defined under section 201(aa) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(aa)).

(2) ASSISTANT ATTORNEY GENERAL.—The term ''Assistant Attorney General'' means the Assistant Attorney General in charge of the Antitrust Division of the Department of Justice.

(3) BRAND NAME DRUG.—The term ''brand name drug'' means a drug approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)).

(4) BRAND NAME DRUG COMPANY.—The term ''brand name drug company'' means the party that received Food and Drug Administration approval to market a brand name drug pursuant to an NDA, where that drug is the subject of an ANDA, or a party owning or controlling enforcement of any patent listed in the Approved Drug Products With Therapeutic Equivalence Evaluations of the Food and Drug Administration for that drug, under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)).

(5) COMMISSION.—The term ''Commission'' means the Federal Trade Commission.

(6) GENERIC DRUG.—The term ''generic drug'' is a product that the Food and Drug Administration has approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

(7) GENERIC DRUG APPLICANT.—The term ''generic drug applicant'' means a person who has filed or received approval for an ANDA under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

(8) NDA.—The term ''NDA'' means a New Drug Application, as defined under section 505(b) et seq. of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b) et seq.)

SEC. ____05. NOTIFICATION OF AGREEMENTS.

(a) IN GENERAL.—

(1) REQUIREMENT.—A generic drug applicant that has submitted an ANDA containing a certification under section 505(j)(2)(vii)(IV) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(2)(vii)(IV)) and a brand name drug company that enter into an agreement described in paragraph (2), prior to the generic drug that is the subject of the application entering the market, shall each file the agreement as required by subsection (b).

(2) DEFINITION.—An agreement described in this paragraph is an agreement regarding—

(A) the manufacture, marketing or sale of the brand name drug that is the subject of the generic drug applicant's ANDA;

(B) the manufacture, marketing or sale of the generic drug that is the subject of the generic drug applicant's ANDA; or

(C) the 180-day period referred to in section 505(j)(5)(B)(iv) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)(B)(iv)) as it applies to such ANDA or to any other ANDA based on the same brand name drug.

(b) FILING.—

(1) AGREEMENT.—The generic drug applicant and the brand name drug company entering into an agreement described in subsection (a)(2) shall file with the Assistant Attorney General and the Commission the text of any such agreement, except that the generic drug applicant and the brand-name drug company shall not be required to file an agreement that solely concerns—

(A) purchase orders for raw material supplies;

(B) equipment and facility contracts; or

(C) employment or consulting contracts.

(2) OTHER AGREEMENTS.—The generic drug applicant and the brand name drug company entering into an agreement described in subsection (a)(2) shall file with the Assistant Attorney General and the Commission the text of any other agreements not described in subsection (a)(2) between the generic drug applicant and the brand name drug company which are contingent upon, provide a contingent condition for, or are otherwise related to an agreement which must be filed under this title.

(3) DESCRIPTION.—In the event that any agreement required to be filed by paragraph (1) or (2) has not been reduced to text, both the generic drug applicant and the brand name drug company shall file written descriptions of the non-textual agreement or agreements that must be filed sufficient to reveal all of the terms of the agreement or agreements.

SEC. ____6. FILING DEADLINES.

Any filing required under section ____05 shall be filed with the Assistant Attorney General and the Commission not later than 10 business days after the date the agreements are executed.

SEC. ____07. DISCLOSURE EXEMPTION.

Any information or documentary material filed with the Assistant Attorney General or the Commission pursuant to this title shall be exempt from disclosure under section 552 of title 5, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this section is intended to prevent disclosure to either body of Congress or to any duly authorized committee or subcommittee of the Congress.

SEC. ____08. ENFORCEMENT.

(a) CIVIL PENALTY.—Any brand name drug company or generic drug applicant which fails to comply with any provision of this title shall be liable for a civil penalty of not more than $11,000, for each day during which such entity is in violation of this title. Such penalty may be recovered in a civil action brought by the United States, or brought by the Commission in accordance with the procedures established in section 16(a)(1) of the Federal Trade Commission Act (15 U.S.C. 56(a)).

(b) COMPLIANCE AND EQUITABLE RELIEF.—If any brand name drug company or generic drug applicant fails to comply with any provision of this title, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General or the Commission. Equitable relief under this subsection may include an order by the district court which renders unenforceable, by the brand name drug company or generic drug applicant failing to file, any agreement that was not filed as required by this title for the period of time during which the agreement was not filed by the company or applicant as required by this title.

SEC. ____09. RULEMAKING.

The Commission, with the concurrence of the Assistant Attorney General and by rule in accordance with section 553 of title 5 United States Code, consistent with the purposes of this title—

(1) may define the terms used in this title;

(2) may exempt classes of persons or agreements from the requirements of this title; and

(3) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this title.

SEC. ____10. SAVINGS CLAUSE.

Any action taken by the Assistant Attorney General or the Commission, or any failure of the Assistant Attorney General or the Commission to take action, under this title shall not bar any proceeding or any action with respect to any agreement between a brand name drug company and a generic drug applicant at any time under any other provision of law, nor shall any filing under this title constitute or create a presumption of any violation of any antitrust or competition laws.

SEC. ____11. EFFECTIVE DATE.

This title shall—

(1) take effect 30 days after the date of enactment of this title; and

(2) shall apply to agreements described in section ____05 that are entered into 30 days after the date of enactment of this title.

SA 4341. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 812 to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the end, add the following:

TITLE ____—MEDICARE AMBULANCE PAYMENT REFORM

SEC. ____01. AMBULANCE PAYMENT RATES.

(a) PAYMENT RATES.—

(1) IN GENERAL.—Section 1834(l)(3) of the Social Security Act (42 U.S.C. 1395m(l)(3)) is amended to read as follows:

''(3) PAYMENT RATES.—In the case of any ambulance service furnished under this part in 2003 or any subsequent year, the Secretary shall set the payment rates under the fee schedule for such service at amounts equal to the payment rate under the fee schedule for that service furnished during the previous year, increased by the percentage increase in the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year.''.

(2) CONFORMING AMENDMENT.—Section 221(c) of the Medicare, medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–487), as enacted into law by section 1(a)(6) of Public Law 106–554, is repealed.

(3) TECHNICAL AMENDMENT.—

(A) IN GENERAL.—Paragraph (8) of section 1834(l) of the Social Security Act (42 U.S.C.

1395m(l)), as added by section 221(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–487), as enacted into law by section 1(a)(6) of Public Law 106–554, is redesignated as paragraph (9).

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect as if included in the enactment of such section 221(a).

(b) USE OF MEDICAL CONDITIONS FOR CODING AMBULANCE SERVICES.—Section 1834(l)(7) of the Social Security Act (42 U.S.C. 1395m(l)(7)) is amended to read as follows:

''(7) CODING SYSTEM.—

''(A) IN GENERAL.—The Secretary shall, in accordance with section 1173(c)(1)(B), establish a system or systems for the coding of claims for ambulance services for which payment is made under this subsection, including a code set specifying the medical condition of the individual who is transported and the level of service that is appropriate for the transportation of an individual with that medical condition.

''(B) MEDICAL CONDITIONS.—The code set established under subparagraph (A) shall—

''(i) take into account the list of medical conditions developed in the course of the negotiated rulemaking process conducted under paragraph (1); and

''(ii) notwithstanding any other provision of law, be adopted as a standard code set under section 1173(c).''.

SEC. ___02. PRUDENT LAYPERSON STANDARD FOR EMERGENCY AMBULANCE SERVICES UNDER MEDICARE AND MEDICAID.

(a) AMBULANCE SERVICES FOR MEDICARE FEE-FOR-SERVICE BENEFICIARIES.—Section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) is amended by inserting before the semicolon at the end the following: '', except that such regulations shall not fail to treat ambulance services as medical and other health services solely because the ultimate diagnosis of the individual receiving the ambulance services results in the conclusion that ambulance services were not necessary, as long as the request for ambulance services is made after the sudden onset of a medical condition that would be classified as an emergency medical condition (as defined in section 1852(d)(3)(B)).''.

(b) AMBULANCE SERVICES FOR MEDICARE+CHOICE ENROLLEES.—Section 1852(d)(3)(A) of the Social Security Act (42 U.S.C. 1395w–22(d)(3)(A)) is amended by inserting ''(including the services described in section 1861(s)(7))'' after ''outpatient services'' in the matter preceding clause (i).

(c) AMBULANCE SERVICES IN MEDICAID MANAGED CARE PLANS.—Section 1932(b)(2)(B) of the Social Security Act (42 U.S.C. 1396u–2(b)(2)(B)) is amended by inserting ''(including the services described in section 1861(s)(7) (if covered by the State plan))'' after ''outpatient services'' in the matter preceding clause (i).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services provided on and after the date of enactment of the Act.

SA 4342. Mr. FRIST submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

Strike section 7.

SA 4343. Mr. FRIST submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ___—IMPROVED VACCINE AFFORDABILITY AND AVAILABILITY

SEC. ___01. SHORT TITLE.

This title may be cited as the ''Improved Vaccine Affordability and Availability Act''.

Subtitle A—State Vaccine Grants

SEC. ___11. AVAILABILITY OF INFLUENZA VACCINE.

Section 317(j) of the Public Health Service Act (42 U.S.C. 247b(j)) is amended by adding at the end the following:

''(3)(A) For the purpose of carrying out activities relating to influenza vaccine under the immunization program under this subsection, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2003 and 2004. Such authorization shall be in addition to amounts available under paragraphs (1) and (2) for such purpose.

''(B) The authorization of appropriations established in subparagraph (A) shall not be effective for a fiscal year unless the total amount appropriated under paragraphs (1) and (2) for the fiscal year is not less than such total for fiscal year 2000.

''(C) The purposes for which amounts appropriated under subparagraph (A) are available to the Secretary include providing for improved State and local infrastructure for influenza immunizations under this subsection in accordance with the following:

''(i) Increasing influenza immunization rates in populations considered by the Secretary to be at high risk for influenza-related complications and in their contacts.

''(ii) Recommending that health care providers actively target influenza vaccine that is available in September, October, and November to individuals who are at increased risk for influenza-related complications and to their contacts.

''(iii) Providing for the continued availability of influenza immunizations through December of such year, and for additional periods to the extent that influenza vaccine remains available.

''(iv) Encouraging States, as appropriate, to develop contingency plans (including plans for public and professional educational activities) for maximizing influenza immunizations for high-risk populations in the event of a delay or shortage of influenza vaccine.

''(D) The Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives, and the Committee on Health, Education, Labor, and Pensions of the Senate, periodic reports describing the activities of the Secretary under this subsection regarding influenza vaccine. The first such report shall be submitted not later than June 6, 2003, the second report shall be submitted not later than June 6, 2004, and subsequent reports shall be submitted biennially thereafter.''.

SEC. ___12. PROGRAM FOR INCREASING IMMUNIZATION RATES FOR ADULTS AND ADOLESCENTS; COLLECTION OF ADDITIONAL IMMUNIZATION DATA.

(a) ACTIVITIES OF CENTERS FOR DISEASE CONTROL AND PREVENTION.—Section 317(j) of the Public Health Service Act (42 U.S.C. 247b(j)), as amended by section ___11, is further amended by adding at the end the following:

''(4)(A) For the purpose of carrying out activities to increase immunization rates for adults and adolescents through the immunization program under this subsection, and for the purpose of carrying out subsection (k)(2), there are authorized to be appropriated $50,000,000 for fiscal year 2003, and such sums as may be necessary for each of the fiscal years 2004 through 2006. Such authorization is in addition to amounts available under paragraphs (1), (2), and (3) for such purposes.

''(B) In expending amounts appropriated under subparagraph (A), the Secretary shall give priority to adults and adolescents who are medically underserved and are at risk for vaccine-preventable diseases, including as appropriate populations identified through projects under subsection (k)(2)(E).

''(C) The purposes for which amounts appropriated under subparagraph (A) are available include (with respect to immunizations for adults and adolescents) the payment of the costs of storing vaccines, outreach activities to inform individuals of the availability of the immunizations, and other program expenses necessary for the establishment or operation of immunization programs carried out or supported by States or other public entities pursuant to this subsection.

''(5) The Secretary shall annually submit to Congress a report that—

''(A) evaluates the extent to which the immunization system in the United States has been effective in providing for adequate immunization rates for adults and adolescents, taking into account the applicable year 2010 health objectives established by the Secretary regarding the health status of the people of the United States; and

''(B) describes any issues identified by the Secretary that may affect such rates.

''(6) In carrying out this subsection and paragraphs (1) and (2) of subsection (k), the Secretary shall consider recommendations regarding immunizations that are made in reports issued by the Institute of Medicine.''.

(b) RESEARCH, DEMONSTRATIONS, AND EDUCATION.—Section 317(k) of the Public Health Service Act (42 U.S.C. 247b(k)) is amended—

(1) by redesignating paragraphs (2) through (4) as paragraphs (3) through (5), respectively; and

(2) by inserting after paragraph (1) the following:

''(2) The Secretary, directly and through grants under paragraph (1), shall provide for a program of research, demonstration projects, and education in accordance with the following:

''(A) The Secretary shall coordinate with public and private entities (including nonprofit private entities), and develop and disseminate guidelines, toward the goal of ensuring that immunizations are routinely offered to adults and adolescents by public and private health care providers.

''(B) The Secretary shall cooperate with public and private entities to obtain information for the annual evaluations required in subsection (j)(5)(A).

''(C) The Secretary shall (relative to fiscal year 2001) increase the extent to which the Secretary collects data on the incidence, prevalence, and circumstances of diseases and adverse events that are experienced by adults and adolescents and may be associated with immunizations, including collecting data in cooperation with commercial laboratories.

''(D) The Secretary shall ensure that the entities with which the Secretary cooperates for purposes of subparagraphs (A) through (C) include managed care organizations, community-based organizations that provide health services, and other health care providers.

''(E) The Secretary shall provide for projects to identify racial and ethnic minority groups and other health disparity populations for which immunization rates for adults and adolescents are below such rates for the general population, and to determine the factors underlying such disparities.''.

SEC. ___13. IMMUNIZATION AWARENESS.

(a) DEVELOPMENT OF INFORMATION CONCERNING MENINGITIS.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Director of the Centers for Disease Control and Prevention, shall develop and make available to entities described in paragraph (2) information concerning bacterial meningitis and the availability and effectiveness of vaccinations for populations targeted by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary of Health and Human Services, acting through the Centers for Disease Control and Prevention).

(2) ENTITIES.—An entity is described in this paragraph if the entity—

(A) is—

(i) a college or university; or

(ii) any other facility with a setting similar to a dormitory that houses age-appropriate populations for whom the Advisory Committee on Immunization Practices recommends such a vaccination; and

(B) is determined appropriate by the Secretary of Health and Human Services.

(b) DEVELOPMENT OF INFORMATION CONCERNING HEPATITIS.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Director of the Centers for Disease Control and Prevention, shall develop and make available to entities described in paragraph (2) information concerning hepatitis A and B and the availability and effectiveness of vaccinations with respect to such diseases.

(2) ENTITIES.—An entity is described in this paragraph if the entity—

(A) is—

(i) a health care clinic that serves individuals diagnosed as being infected with HIV or as having other sexually transmitted diseases;

(ii) an organization or business that counsels individuals about international travel or who arranges for such travel;

(iii) a police, fire or emergency medical services organization that responds to natural or man-made disasters or emergencies;

(iv) a prison or other detention facility;

(v) a college or university; or

(vi) a public health authority or children's health service provider in areas of intermediate or high endemicity for hepatitis A as defined by the Centers for Disease Control and Prevention; and

(B) is determined appropriate by the Secretary of Health and Human Services.

SEC. ___14. SUPPLY OF VACCINES.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall prioritize, acquire, and maintain a supply of such prioritized vaccines sufficient to provide vaccinations throughout a 6-month period.

(b) PROCEEDS.—Any proceeds received by the Secretary of Health and Human Services from the sale of vaccines contained in the supply described in subsection (a), shall be available to the Secretary for the purpose of purchasing additional vaccines for the supply. Such proceeds shall remain available until expended.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the purpose of carrying out subsection (a) such sums as may be necessary for each of fiscal years 2003 through 2008.

Subtitle B—Vaccine Injury Compensation Program

SEC. ___21. ADMINISTRATIVE REVISION OF VACCINE INJURY TABLE.

Section 2114 of the Public Health Service Act (42 U.S.C. 300aa–14) is amended—

(1) in subsection (c), by striking paragraph (1) and inserting the following:

''(1) The Secretary may promulgate regulations to modify in accordance with paragraph (3) the Vaccine Injury Table. In promulgating such regulations, the Secretary shall provide for notice and for at least 60 days opportunity for public comment.''; and

(2) in subsection (d), by striking ''90 days'' and inserting ''60 days''.

SEC. ___22. EQUITABLE RELIEF.

Section 2111(a)(2)(A) of the Public Health Service Act (42 U.S.C. 300aa–11(a)(2)(A)) is amended by striking ''No person'' and all that follows through ''and—'' and inserting the following: ''No person may bring or maintain a civil action against a vaccine administrator or manufacturer in a State or Federal court for damages arising from, or equitable relief relating to, a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988 and no such court may award damages or equitable relief for any such vaccine-related injury or death, unless the person proves past or present physical injury and a timely petition has been filed, in accordance with section 2116 for compensation under the Program for such injury or death and—''.

SEC. ___23. PARENT OR OTHER THIRD PARTY PETITIONS FOR COMPENSATION.

(a) LIMITATIONS ON DERIVATIVE PETITIONS.—Section 2111(a)(2) of the Public Health Service Act (42 U.S.C. 300aa–11(a)(2)) is amended—

(1) in subparagraph (B), by inserting ''or (B)'' after ''subparagraph (A)'';

(2) by redesignating subparagraph (B) as subparagraph (C); and

(3) by inserting after subparagraph (A) the following:

''(B)(i) No parent, legal guardian, or spouse (referred to in this title as a parent or other third party) may bring or maintain a civil action against a vaccine administrator or manufacturer in a Federal or State court for damages or equitable relief relating to a vaccine-related injury or death, including damages for loss of consortium, society, companionship, or services, loss of earnings, medical or other expenses, and emotional distress, and no court may award damages or equitable relief in such an action, unless—

''(I) the person who sustained the underlying vaccine-related injury or death upon which such parent's or other third party's claim is premised has, in accordance with section 2112, been awarded compensation in a final judgment of the United States Court of Federal Claims and such judgment is subject to no further appeal or review;

''(II) such parent or other third party timely filed a derivative petition, in accordance with section 2116; and

''(III)(aa) the United States Court of Federal Claims has issued judgment under section 2112 on the derivative petition, and such parent or other third party elects under section 2121(a) to file a civil action; or

''(bb) such parent or other third party elects to withdraw such derivative petition under section 2121(b) or such petition is considered withdrawn under such section.

''(ii) Any civil action brought in accordance with this subparagraph shall be subject to the standards and procedures set forth in sections 2122 and 2123, regardless of whether the action arises directly from a vaccine-related injury or death associated with the administration of a vaccine. In a case in which the person who sustained the underlying vaccine-related injury or death upon which such parent's or other third party's civil action is premised elects under section 2121(a) to receive the compensation awarded, such parent or other third party may not bring a civil action for damages or equitable relief, and no court may award damages or equitable relief, for any injury or loss of the type set forth in section 2115(a) or that might in any way overlap with or otherwise duplicate compensation of the type available under section 2115(a).''.

(b) ELIGIBLE PERSONS.—Section 2111(a)(9) of the Public Health Service Act (42 U.S.C. 300aa–11(a)(9)) is amended by striking the period and inserting ''and to a parent or other third party to the extent such parent or other third party seeks damages or equitable relief relating to a vaccine-related injury or death sustained by a person who is qualified to file a petition for compensation under the Program.''.

(c) PETITIONERS.—Section 2111(b) of the Public Health Service Act (42 U.S.C. 300aa–11(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), by striking ''(B)'' and inserting ''(C)'';

(B) by redesignating subparagraph (B) as subparagraph (C); and

(C) by inserting after subparagraph (A) the following:

''(B) Except as provided in subparagraph (C), any parent or other third party with respect to a person—

''(i) who has sustained a vaccine-related injury or death;

''(ii) who has filed a petition for compensation under the Program (or whose legal representative has filed such a petition as authorized in subparagraph (A)); and

''(iii) who has, in accordance with section 2112, been awarded compensation in a final judgment of the United States Court of Federal Claims that is subject to no further appeal or review;

may, if such parent or other third party meets the requirements of subsection (d), file a derivative petition under this section.''; and

(2) in paragraph (2)—

(A) by inserting ''by or on behalf of the person who sustained the vaccine-related injury or death'' after ''filed''; and

(B) by adding at the end the following: ''A parent or other third party may file only 1 derivative petition with respect to each administration of a vaccine.''.

(d) DERIVATIVE PETITION CONTENTS.—Section 2111 of the Public Health Service Act (42 U.S.C. 300aa–11) is amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c) the following:

''(d) DERIVATIVE PETITIONS.—

''(1) If the parent or other third party with respect to the person who sustained the vaccine-related injury or death seeks compensation under the Program, such parent or other third party shall file a timely derivative petition for compensation under the Program in accordance with this section.

''(2) Such a derivative petition shall contain—

''(A) except for records that are unavailable as described in subsection (c)(3), an affidavit, and supporting documentation, demonstrating that—

''(i) such person was, in accordance with section 2112, previously awarded compensation for the underlying vaccine-related injury or death upon which such parent's or other third party's derivative petition is premised in a final judgment of the United States Court of Federal Claims and such judgment is subject to no further appeal or review;

''(ii) the derivative petition was filed not later than 60 days after the date on which such judgment became final and subject to no further appeal or review;

''(iii) such parent or other third party suffered a loss compensable under section 2115(b) as a result of the vaccine-related injury or death sustained by such person; and

''(iv) such parent or other third party has not previously collected an award or settlement of a civil action for damages for such loss; and

''(B) records establishing such parent's or other third party's relationship to the person who sustained the vaccine-related injury or death.''.

(e) DETERMINATION OF ELIGIBILITY FOR COMPENSATION.—Section 2113(a)(1) of the Public Health Service Act (42 U.S.C. 300aa–13(a)(1)) is amended—

(1) in subparagraph (A), by inserting ''or, as applicable, section 2111(d)'' before the comma; and

(2) in subparagraph (B), by inserting ''or, as applicable, that the injury or loss described in the derivative petition is due to factors unrelated to the vaccine-related injury or death'' after ''the petition''.

(f) COMPENSATION.—Section 2115 of the Public Health Service Act (42 U.S.C. 300aa–15) is amended—

(1) by redesignating subsections (b) through (j) as subsections (c) through (k), respectively;

(2) by inserting after subsection (a) the following:

''(b) DERIVATIVE PETITIONS.—Compensation awarded under the Program to a parent or other third party who files a derivative petition under section 2111 for a loss sustained as a result of a vaccine-related injury or death sustained by the injured party shall include compensation, if any, for loss of consortium, society, companionship, or services, in an amount not to exceed the lesser of $250,000 or the total amount of compensation awarded to the person who sustained the underlying vaccine-related injury or death.'';

(3) in subsection (e)(2), as so redesignated by paragraph (1)—

(A) by striking ''(2) and (3)'' and inserting ''(2), (3), and (4)''; and

(B) by inserting ''and subsection (b),'' after ''(a),'';

(4) in subsection (g), as so redesignated by paragraph (1), in paragraph (4)(B), by striking ''subsection (j)'' and inserting ''subsection (k)'';

(5) in subsection (j), as so redesignated by paragraph (1)—

(A) in paragraph (1), by striking ''subsection (j)'' and inserting ''subsection (k)''; and

(B) in paragraph (2), by inserting '', or to a parent or other third party with respect to a person who sustained a vaccine-related injury or death,'' after ''death''; and

(6) in subsection (k), as so redesignated by paragraph (1), by striking ''subsection (f)(4)(B)'' and inserting ''subsection (g)(4)(B)''.

SEC. ___24. JURISDICTION TO DISMISS ACTIONS IMPROPERLY BROUGHT.

Section 2111(a)(3) of the Public Health Service Act (42 U.S.C. 300aa–11(a)(3)) is amended by adding at the end the following: ''If any civil action which is barred under subparagraph (A) or (B) of paragraph (2) is filed or maintained in a State court, or any vaccine administrator or manufacturer is made a party to any civil action brought in State court (other than a civil action which may be brought under paragraph (2)) for damages or equitable relief for a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988, the civil action may be removed by the defendant or defendants to the United States Court of Federal Claims, which shall have jurisdiction over such civil action, and which shall dismiss such action. The notice required by section 1446 of title 28, United States Code, shall be filed with the United States Court of Federal Claims, and that court shall proceed in accordance with sections 1446 through 1451 of title 28, United States Code.''.

SEC. ___25. APPLICATION.

Section 2111(a)(9) of the Public Health Service Act (42 U.S.C. 300aa–11(a)(9)) is amended by striking ''This'' and inserting ''Except as provided in paragraph (2), this''.

SEC. ___26. CLARIFICATION OF WHEN INJURY IS CAUSED BY FACTOR UNRELATED TO ADMINISTRATION OF VACCINE.

Section 2113(a)(2)(B) of the Public Health Service Act (42 U.S.C. 300aa–13(a)(2)(B)) is amended—

(1) by inserting ''structural lesions, genetic disorders,'' after ''and related anoxia),'';

(2) by inserting ''(without regard to whether the cause of the infection, toxin, trauma, structural lesion, genetic disorder, or metabolic disturbance is known)'' after ''metabolic disturbances''; and

(3) by striking ''but'' and inserting ''and''.

SEC. ___27. INCREASE IN AWARD IN THE CASE OF A VACCINE-RELATED DEATH AND FOR PAIN AND SUFFERING.

Section 2115(a) of the Public Health Service Act (42 U.S.C. 300aa–15(a)) is amended—

(1) in paragraph (2), by striking ''$250,000'' and inserting ''$350,000''; and

(2) in paragraph (4), by striking ''$250,000'' and inserting ''$350,000''.

SEC. ___28. BASIS FOR CALCULATING PROJECTED LOST EARNINGS.

Section 2115(a)(3)(B) of the Public Health Service Act (42 U.S.C. 300aa–15(a)(3)(B)) is amended by striking ''loss of earnings'' and all that follows and inserting the following: ''loss of earnings determined on the basis of the annual estimate of the average (mean) gross weekly earnings of wage and salary workers age 18 and over (excluding the incorporated self-employed) in the private nonfarm sector (which includes all industries other than agricultural production crops and livestock), as calculated annually by the Bureau of Labor Statistics from the quarter sample data of the Current Population Survey, or as calculated by such similar method as the Secretary may prescribe by regulation, less appropriate taxes and the average cost of a health insurance policy, as determined by the Secretary.''.

SEC. ___29. ALLOWING COMPENSATION FOR FAMILY COUNSELING EXPENSES AND EXPENSES OF ESTABLISHING GUARDIANSHIP.

(a) FAMILY COUNSELING EXPENSES IN POST-1988 CASES.—Section 2115(a) of the Public Health Service Act (42 U.S.C. 300aa–15(a)) is amended by adding at the end to following:

''(5) Actual unreimbursable expenses that have been or will be incurred for family counseling as is determined to be reasonably necessary and that result from the vaccine-related injury from which the petitioner seeks compensation.''.

(b) EXPENSES OF ESTABLISHING GUARDIANSHIPS IN POST-1988 CASES.—Section 2115(a) of the Public Health Service Act (42 U.S.C. 300aa–15(a)), as amended by subsection (a), is further amended by adding at the end the following:

''(6) Actual unreimbursable expenses that have been, or will be reasonably incurred to establish and maintain a guardianship or conservatorship for an individual who has suffered a vaccine-related injury, including attorney fees and other costs incurred in a proceeding to establish and maintain such guardianship or conservatorship.''.

(c) CONFORMING AMENDMENT FOR CASES FROM 1988 AND EARLIER.—Section 2115 of the Public Health Service Act (42 U.S.C. 300aa–15) is amended in subsection (c), as so redesignated by section ___23(f)—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking ''(e)'' and inserting ''(f))'';

(3) by redesignating paragraph (3) as paragraph (5); and

(4) by inserting after paragraph (2), the following:

''(3) family counseling expenses (as provided for in paragraph (5) of subsection (a));

''(4) expenses of establishing guardianships (as provided for in paragraph (6) of subsection (a)); and''.

SEC. ___30. ALLOWING PAYMENT OF INTERIM COSTS.

Section 2115 of the Public Health Service Act (42 U.S.C. 300aa–15) is amended in subsection (f), as so redesignated by section ___23(f), by adding at the end the following:

''(4) A special master or court may make an interim award of costs if—

''(A) the case involves a vaccine administered on or after October 1, 1988;

''(B) the special master or court has determined whether or not the petitioner is entitled to compensation under the Program;

''(C) the award is limited to other costs (within the meaning of paragraph (1)(B)) incurred in the proceeding; and

''(D) the petitioner provides documentation verifying the expenditure of the amount for which compensation is sought.''.

SEC. ___31. PROCEDURE FOR PAYING ATTORNEYS' FEES.

Section 2115 of the Public Health Service Act (42 U.S.C. 300aa–15), is amended in subsection (f), as so redesignated by section ___23(f) and amended by section ___30, by adding at the end the following:

''(5) When a special master or court awards attorney fees or costs under paragraph (1) or (4), it may order that such fees or costs be payable solely to the petitioner's attorney if—

''(A) the petitioner expressly consents; or

''(B) the special master or court determines, after affording to the Secretary and to all interested persons the opportunity to submit relevant information, that—

''(i) the petitioner cannot be located or refuses to respond to a request by the special master or court for information, and there is no practical alternative means to ensure that the attorney will be reimbursed for such fees or costs expeditiously; or

''(ii) there are otherwise exceptional circumstances and good cause for paying such fees or costs solely to the petitioner's attorney.''.

SEC. ___32. EXTENSION OF STATUTE OF LIMITATIONS.

(a) GENERAL RULE.—Section 2116(a) of the Public Health Service Act (42 U.S.C. 300aa–16(a)) is amended—

(1) in paragraph (2) by striking ''36 months'' and inserting ''6 years''; and

(2) in paragraph (3), by striking ''48 months'' and inserting ''6 years''.

(b) CLAIMS BASED ON REVISIONS TO TABLE.—Section 2116 of the Public Health Service Act (42 U.S.C. 300aa–16) is amended by striking subsection (b) and inserting the following:

''(b) EFFECT OF REVISED TABLE.—If at any time the Vaccine Injury Table is revised and the effect of such revision is to make an individual eligible for compensation under the program, where, before such revision, such individual was not eligible for compensation under the program, or to significantly increase the likelihood that an individual will be able to obtain compensation under the program, such person may, and shall before filing a civil action for equitable relief or monetary damages, notwithstanding section 2111(b)(2), file a petition for such compensation if—

''(1) the vaccine-related death or injury with respect to which the petition is filed occurred not more than 8 years before the effective date of the revision of the table; and

''(2) either—

''(A) the petition satisfies the conditions described in subsection (a); or

''(B) the date of the occurrence of the first symptom or manifestation of onset of the injury occurred more than 4 years before the petition is filed, and the petition is filed not more than 2 years after the effective date of the revision of the table.''.

(c) DERIVATIVE PETITIONS.—Section 2116 of the Public Health Service Act (42 U.S.C. 300aa–16) is amended by adding at the end the following:

''(d) DERIVATIVE PETITIONS.—No derivative petition may be filed for compensation under the Program later than 60 days after the date on which the United States Court of Federal Claims has entered final judgment and the time for all further appeal or review has expired on the underlying claim of the person who sustained the vaccine-related injury or death upon which the derivative petition is premised.''.

(d) TIMELY RESOLUTIONS OF CLAIMS.—

(1) SPECIAL MASTER DECISION.—Section 2112(d)(3)(A) of the Public Health Service Act (42 U.S.C. 300aa–12(d)(3)(A)) is amended by adding at the end the following: ''For purposes of this subparagraph, the petition shall be deemed to be filed on the date on which all petition contents and supporting documents required under section 2111(c) and, when applicable, section 2111(d) and the Vaccine Rules of the United States Court of Federal Claims, such as an affidavit and supporting documentation, are served on the Secretary and filed with the clerk of the United States Court of Federal Claims.''.

(2) COURT OF FEDERAL CLAIMS DECISION.—Section 2121(b) of the Public Health Service Act (42 U.S.C. 300aa–21(b)) is amended by adding at the end the following: ''For purposes of this subsection, the petition shall be deemed to be filed on the date on which all petition contents and supporting documents required under section 2111(c) and, when applicable, section 2111(d) and the Vaccine Rules of the United States Court of Federal Claims, such as an affidavit and supporting documentation, are served on the Secretary and filed with the clerk of the United States Court of Federal Claims.''.

SEC. ___33. ADVISORY COMMISSION ON CHILDHOOD VACCINES.

(a) SELECTION OF PERSONS INJURED BY VACCINES AS PUBLIC MEMBERS.—Section 2119(a)(1)(B) of the Public Health Service Act (42 U.S.C. 300aa–19(a)(1)(B)) is amended by striking ''of whom'' and all that follows and inserting the following: ''of whom 1 shall be the legal representative of a child who has suffered a vaccine-related injury or death, and at least 1 other shall be either the legal representative of a child who has suffered a vaccine-related injury or death or an individual who has personally suffered a vaccine-related injury.''.

(b) MANDATORY MEETING SCHEDULE ELIMINATED.—Section 2119(c) of the Public Health Service Act (42 U.S.C. 300aa–19(c)) is amended by striking ''not less often than four times per year and''.

SEC. ___34. CLARIFICATION OF STANDARDS OF RESPONSIBILITY.

(a) GENERAL RULE.—Section 2122(a) of the Public Health Service Act (42 U.S.C. 300aa–22(a)) is amended by striking ''and (e) State law shall apply to a civil action brought for damages'' and inserting ''(d), and (f) State law shall apply to a civil action brought for damages or equitable relief''; and

(b) UNAVOIDABLE ADVERSE SIDE EFFECTS.—Section 2122(b)(1) of the Public Health Service Act (42 U.S.C. 300aa–22(b)(1)) is amended by inserting ''or equitable relief'' after ''for damages''.

(c) DIRECT WARNINGS.—Section 2122(c) of the Public Health Service Act (42 U.S.C. 300aa–22(c)) is amended by inserting ''or equitable relief'' after ''for damages''.

(d) CONSTRUCTION.—Section 2122(d) of the Public Health Service Act (42 U.S.C. 300aa–22(d)) is amended—

(1) by inserting ''or equitable relief'' after ''for damages''; and

(2) by inserting ''or relief'' after ''which damages''.

(e) PAST OR PRESENT PHYSICAL INJURY.—Section 2122 of the Public Health Service Act (42 U.S.C. 300aa–22) is amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c) the following:

''(d) PAST OR PRESENT PHYSICAL INJURY.—No vaccine manufacturer or vaccine administrator shall be liable in a civil action brought after October 1, 1988, for equitable or monetary relief absent proof of past or present physical injury from the administration of a vaccine, nor shall any vaccine manufacturer or vaccine administrator be liable in any such civil action for claims of medical monitoring, or increased risk of harm.''.

SEC. ___35. CLARIFICATION OF DEFINITION OF MANUFACTURER.

Section 2133(3) of the Public Health Service Act (42 U.S.C. 300aa–33(3)) is amended—

(1) in the first sentence, by striking ''under its label any vaccine set forth in the Vaccine Injury Table'' and inserting ''any vaccine set forth in the Vaccine Injury table, including any component or ingredient of any such vaccine''; and

(2) in the second sentence, by inserting ''including any component or ingredient of any such vaccine'' before the period.

SEC. ___36. CLARIFICATION OF DEFINITION OF VACCINE-RELATED INJURY OR DEATH.

Section 2133(5) of the Public Health Service Act (42 U.S.C. 300aa–33(5)) is amended by adding at the end the following: ''For purposes of the preceding sentence, an adulterant or contaminant shall not include any component or ingredient listed in a vaccine's product license application or product label.''.

SEC. ___37. CLARIFICATION OF DEFINITION OF VACCINE.

Section 2133 of the Public Health Service Act (42 U.S.C. 300aa–33) is amended by adding at the end the following:

''(7) The term 'vaccine' means any preparation or suspension, including a preparation or suspension containing an attenuated or inactive microorganism or subunit thereof or toxin, developed or administered to produce or enhance the body's immune response to a disease or diseases and includes all components and ingredients listed in the vaccines's product license application and product label.''.

SEC. ___38. AMENDMENTS TO VACCINE INJURY COMPENSATION TRUST FUND.

(a) EXPANSION OF COMPENSATED LOSS.—Section 9510(c)(1)(A) of the Internal Revenue Code of 1986 is amended by inserting '', or related loss,'' after ''death''.

(b) INCREASE IN LIMIT ON ADMINISTRATIVE EXPENSES.—Subparagraph (B) of section 9510(c)(1) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''(but not in excess of the base amount of $9,500,000 for any fiscal year)''; and

(2) by striking the period and inserting '', provided that such administrative costs shall not exceed the greater of—

''(i) the base amount of $9,500,000,

''(ii) 125 percent of the base amount for any fiscal year in which the total number of claims pending under such subtitle exceeds 150 percent of the average number of claims pending in the preceding 5 years,

''(iii) 175 percent of the base amount for any fiscal year in which the total number of claims pending under such subtitle exceeds 200 percent of the average number of claims pending in the preceding 5 years,

''(iv) 225 percent of the base amount for any fiscal year in which the total number of claims pending under such subtitle exceeds 250 percent of the average number of claims pending in the preceding 5 years, or

''(v) 275 percent of the base amount for any fiscal year in which the total number of claims pending under such subtitle exceeds 300 percent of the average number of claims pending in the preceding 5 years.''.

(c) CONFORMING AMENDMENT.—Section 9510(c)(1)(A) of the Internal Revenue Code of 1986 is amended by striking ''October 18, 2000'' and inserting ''the date of enactment of the Improved Vaccine Affordability and Availability Act''.

SEC. ___39. ONGOING REVIEW OF CHILDHOOD VACCINE DATA.

Part C of title XXI of the Public Health Service Act (42 U.S.C. 300a–25 et seq.) is amended by adding at the end the following:

''SEC. 2129. ONGOING REVIEW OF CHILDHOOD VACCINE DATA.

''(a) IN GENERAL.—Not later than 6 months after the date of enactment of this section, the Secretary shall enter into a contract with the Institute of Medicine of the National Academy of Science under which the Institute shall conduct an ongoing, comprehensive review of new scientific data on childhood vaccines (according to priorities agreed upon from time to time by the Secretary and the Institute of Medicine).

''(b) REPORTS.—Not later than 3 years after the date on which the contract is entered into under subsection (a), the Institute of Medicine shall submit to the Secretary a report on the findings of studies conducted, including findings as to any adverse events associated with childhood vaccines, including conclusions concerning causation of adverse events by such vaccines, and other appropriate recommendations, based on such findings and conclusions.

''(c) FAILURE TO ENTER INTO CONTRACT.—If the Secretary and the Institute of Medicine are unable to enter into the contract described in subsection (a), the Secretary shall enter into a contract with another qualified nongovernmental scientific organization for the purposes described in subsections (a) and (b).

''(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2003, 2004, 2005 and 2006.''.

SEC. ___40. PENDING ACTIONS.

The amendments made by this title shall apply to all actions or proceedings pending on or after the date of enactment of this Act, unless a court of competent jurisdiction has entered judgment (regardless of whether the time for appeal has expired) in such action or proceeding disposing of the entire action or proceeding.

SEC. ___41. REPORT.

Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Advisory Commission on Childhood Vaccines shall report to the Secretary of Health and Human Services regarding the status of the Vaccine Injury Compensation Trust Fund, and shall make recommendations to the Secretary regarding the allocation of funds from the Vaccine Injury Compensation Trust Fund.

SA 4344. Mr. FRIST submitted an amendment intended to be proposed to amendment SA 4299 proposed by Mr. REID (for Mr. DORGAN (for himself, Mr. WELLSTONE, Mr. JEFFORDS, Ms. STABENOW, Ms. COLLINS, Mr. LEVIN, Mr.

JOHNSON, Mr. MILLER, Mr. DURBIN, Mr. FEINGOLD, and Mr. HARKIN)) to the bill (S. 812) to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—IMPROVED VACCINE AFFORDABILITY AND AVAILABILITY

SEC. ___01. SHORT TITLE.

This title may be cited as the ''Improved Vaccine Affordability and Availability Act''.

Subtitle A—State Vaccine Grants

SEC. ___11. AVAILABILITY OF INFLUENZA VACCINE.

Section 317(j) of the Public Health Service Act (42 U.S.C. 247b(j)) is amended by adding at the end the following:

''(3)(A) For the purpose of carrying out activities relating to influenza vaccine under the immunization program under this subsection, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2003 and 2004. Such authorization shall be in addition to amounts available under paragraphs (1) and (2) for such purpose.

''(B) The authorization of appropriations established in subparagraph (A) shall not be effective for a fiscal year unless the total amount appropriated under paragraphs (1) and (2) for the fiscal year is not less than such total for fiscal year 2000.

''(C) The purposes for which amounts appropriated under subparagraph (A) are available to the Secretary include providing for improved State and local infrastructure for influenza immunizations under this subsection in accordance with the following:

''(i) Increasing influenza immunization rates in populations considered by the Secretary to be at high risk for influenza-related complications and in their contacts.

''(ii) Recommending that health care providers actively target influenza vaccine that is available in September, October, and November to individuals who are at increased risk for influenza-related complications and to their contacts.

''(iii) Providing for the continued availability of influenza immunizations through December of such year, and for additional periods to the extent that influenza vaccine remains available.

''(iv) Encouraging States, as appropriate, to develop contingency plans (including plans for public and professional educational activities) for maximizing influenza immunizations for high-risk populations in the event of a delay or shortage of influenza vaccine.

''(D) The Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives, and the Committee on Health, Education, Labor, and Pensions of the Senate, periodic reports describing the activities of the Secretary under this subsection regarding influenza vaccine. The first such report shall be submitted not later than June 6, 2003, the second report shall be submitted not later than June 6, 2004, and subsequent reports shall be submitted biennially thereafter.''.

SEC. ___12. PROGRAM FOR INCREASING IMMUNIZATION RATES FOR ADULTS AND ADOLESCENTS; COLLECTION OF ADDITIONAL IMMUNIZATION DATA.

(a) ACTIVITIES OF CENTERS FOR DISEASE CONTROL AND PREVENTION.—Section 317(j) of the Public Health Service Act (42 U.S.C. 247b(j)), as amended by section ___11, is further amended by adding at the end the following:

''(4)(A) For the purpose of carrying out activities to increase immunization rates for adults and adolescents through the immunization program under this subsection, and for the purpose of carrying out subsection (k)(2), there are authorized to be appropriated $50,000,000 for fiscal year 2003, and such sums as may be necessary for each of the fiscal years 2004 through 2006. Such authorization is in addition to amounts available under paragraphs (1), (2), and (3) for such purposes.

''(B) In expending amounts appropriated under subparagraph (A), the Secretary shall give priority to adults and adolescents who are medically underserved and are at risk for vaccine-preventable diseases, including as appropriate populations identified through projects under subsection (k)(2)(E).

''(C) The purposes for which amounts appropriated under subparagraph (A) are available include (with respect to immunizations for adults and adolescents) the payment of the costs of storing vaccines, outreach activities to inform individuals of the availability of the immunizations, and other program expenses necessary for the establishment or operation of immunization programs carried out or supported by States or other public entities pursuant to this subsection.

''(5) The Secretary shall annually submit to Congress a report that—

''(A) evaluates the extent to which the immunization system in the United States has been effective in providing for adequate immunization rates for adults and adolescents, taking into account the applicable year 2010 health objectives established by the Secretary regarding the health status of the people of the United States; and

''(B) describes any issues identified by the Secretary that may affect such rates.

''(6) In carrying out this subsection and paragraphs (1) and (2) of subsection (k), the Secretary shall consider recommendations regarding immunizations that are made in reports issued by the Institute of Medicine.''.

(b) RESEARCH, DEMONSTRATIONS, AND EDUCATION.—Section 317(k) of the Public Health Service Act (42 U.S.C. 247b(k)) is amended—

(1) by redesignating paragraphs (2) through (4) as paragraphs (3) through (5), respectively; and

(2) by inserting after paragraph (1) the following:

''(2) The Secretary, directly and through grants under paragraph (1), shall provide for a program of research, demonstration projects, and education in accordance with the following:

''(A) The Secretary shall coordinate with public and private entities (including nonprofit private entities), and develop and disseminate guidelines, toward the goal of ensuring that immunizations are routinely offered to adults and adolescents by public and private health care providers.

''(B) The Secretary shall cooperate with public and private entities to obtain information for the annual evaluations required in subsection (j)(5)(A).

''(C) The Secretary shall (relative to fiscal year 2001) increase the extent to which the Secretary collects data on the incidence, prevalence, and circumstances of diseases and adverse events that are experienced by adults and adolescents and may be associated with immunizations, including collecting data in cooperation with commercial laboratories.

''(D) The Secretary shall ensure that the entities with which the Secretary cooperates for purposes of subparagraphs (A) through (C) include managed care organizations, community-based organizations that provide health services, and other health care providers.

''(E) The Secretary shall provide for projects to identify racial and ethnic minority groups and other health disparity populations for which immunization rates for adults and adolescents are below such rates for the general population, and to determine the factors underlying such disparities.''.

SEC. ___13. IMMUNIZATION AWARENESS.

(a) DEVELOPMENT OF INFORMATION CONCERNING MENINGITIS.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Director of the Centers for Disease Control and Prevention, shall develop and make available to entities described in paragraph (2) information concerning bacterial meningitis and the availability and effectiveness of vaccinations for populations targeted by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary of Health and Human Services, acting through the Centers for Disease Control and Prevention).

(2) ENTITIES.—An entity is described in this paragraph if the entity—

(A) is—

(i) a college or university; or

(ii) any other facility with a setting similar to a dormitory that houses age-appropriate populations for whom the Advisory Committee on Immunization Practices recommends such a vaccination; and

(B) is determined appropriate by the Secretary of Health and Human Services.

(b) DEVELOPMENT OF INFORMATION CONCERNING HEPATITIS.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Director of the Centers for Disease Control and Prevention, shall develop and make available to entities described in paragraph (2) information concerning hepatitis A and B and the availability and effectiveness of vaccinations with respect to such diseases.

(2) ENTITIES.—An entity is described in this paragraph if the entity—

(A) is—

(i) a health care clinic that serves individuals diagnosed as being infected with HIV or as having other sexually transmitted diseases;

(ii) an organization or business that counsels individuals about international travel or who arranges for such travel;

(iii) a police, fire or emergency medical services organization that responds to natural or man-made disasters or emergencies;

(iv) a prison or other detention facility;

(v) a college or university; or

(vi) a public health authority or children's health service provider in areas of intermediate or high endemicity for hepatitis A as defined by the Centers for Disease Control and Prevention; and

(B) is determined appropriate by the Secretary of Health and Human Services.

SEC. ___14. SUPPLY OF VACCINES.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall prioritize, acquire, and maintain a supply of such prioritized vaccines sufficient to provide vaccinations throughout a 6-month period.

(b) PROCEEDS.—Any proceeds received by the Secretary of Health and Human Services from the sale of vaccines contained in the supply described in subsection (a), shall be available to the Secretary for the purpose of purchasing additional vaccines for the supply. Such proceeds shall remain available until expended.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the purpose of carrying out subsection (a) such sums as may be necessary for each of fiscal years 2003 through 2008.

Subtitle B—Vaccine Injury Compensation Program

SEC. ___21. ADMINISTRATIVE REVISION OF VACCINE INJURY TABLE.

Section 2114 of the Public Health Service Act (42 U.S.C. 300aa–14) is amended—

(1) in subsection (c), by striking paragraph (1) and inserting the following:

''(1) The Secretary may promulgate regulations to modify in accordance with paragraph (3) the Vaccine Injury Table. In promulgating such regulations, the Secretary shall provide for notice and for at least 60 days opportunity for public comment.''; and

(2) in subsection (d), by striking ''90 days'' and inserting ''60 days''.

SEC. ___22. EQUITABLE RELIEF.

Section 2111(a)(2)(A) of the Public Health Service Act (42 U.S.C. 300aa–11(a)(2)(A)) is amended by striking ''No person'' and all that follows through ''and—'' and inserting the following: ''No person may bring or maintain a civil action against a vaccine administrator or manufacturer in a State or Federal court for damages arising from, or equitable relief relating to, a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988 and no such court may award damages or equitable relief for any such vaccine-related injury or death, unless the person proves past or present physical injury and a timely petition has been filed, in accordance with section 2116 for compensation under the Program for such injury or death and—''.

SEC. ___23. PARENT OR OTHER THIRD PARTY PETITIONS FOR COMPENSATION.

(a) LIMITATIONS ON DERIVATIVE PETITIONS.—Section 2111(a)(2) of the Public Health Service Act (42 U.S.C. 300aa–11(a)(2)) is amended—

(1) in subparagraph (B), by inserting ''or (B)'' after ''subparagraph (A)'';

(2) by redesignating subparagraph (B) as subparagraph (C); and

(3) by inserting after subparagraph (A) the following:

''(B)(i) No parent, legal guardian, or spouse (referred to in this title as a parent or other third party) may bring or maintain a civil action against a vaccine administrator or manufacturer in a Federal or State court for damages or equitable relief relating to a vaccine-related injury or death, including damages for loss of consortium, society, companionship, or services, loss of earnings, medical or other expenses, and emotional distress, and no court may award damages or equitable relief in such an action, unless—

''(I) the person who sustained the underlying vaccine-related injury or death upon which such parent's or other third party's claim is premised has, in accordance with section 2112, been awarded compensation in a final judgment of the United States Court of Federal Claims and such judgment is subject to no further appeal or review;

''(II) such parent or other third party timely filed a derivative petition, in accordance with section 2116; and

''(III)(aa) the United States Court of Federal Claims has issued judgment under section 2112 on the derivative petition, and such parent or other third party elects under section 2121(a) to file a civil action; or

''(bb) such parent or other third party elects to withdraw such derivative petition under section 2121(b) or such petition is considered withdrawn under such section.

''(ii) Any civil action brought in accordance with this subparagraph shall be subject to the standards and procedures set forth in sections 2122 and 2123, regardless of whether the action arises directly from a vaccine-related injury or death associated with the administration of a vaccine. In a case in which the person who sustained the underlying vaccine-related injury or death upon which such parent's or other third party's civil action is premised elects under section 2121(a) to receive the compensation awarded, such parent or other third party may not bring a civil action for damages or equitable relief, and no court may award damages or equitable relief, for any injury or loss of the type set forth in section 2115(a) or that might in any way overlap with or otherwise duplicate compensation of the type available under section 2115(a).''.

(b) ELIGIBLE PERSONS.—Section 2111(a)(9) of the Public Health Service Act (42 U.S.C. 300aa–11(a)(9)) is amended by striking the period and inserting ''and to a parent or other third party to the extent such parent or other third party seeks damages or equitable relief relating to a vaccine-related injury or death sustained by a person who is qualified to file a petition for compensation under the Program.''.

(c) PETITIONERS.—Section 2111(b) of the Public Health Service Act (42 U.S.C. 300aa–11(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), by striking ''(B)'' and inserting ''(C)'';

(B) by redesignating subparagraph (B) as subparagraph (C); and

(C) by inserting after subparagraph (A) the following:

''(B) Except as provided in subparagraph (C), any parent or other third party with respect to a person—

''(i) who has sustained a vaccine-related injury or death;

''(ii) who has filed a petition for compensation under the Program (or whose legal representative has filed such a petition as authorized in subparagraph (A)); and

''(iii) who has, in accordance with section 2112, been awarded compensation in a final judgment of the United States Court of Federal Claims that is subject to no further appeal or review;

may, if such parent or other third party meets the requirements of subsection (d), file a derivative petition under this section.''; and

(2) in paragraph (2)—

(A) by inserting ''by or on behalf of the person who sustained the vaccine-related injury or death'' after ''filed''; and

(B) by adding at the end the following: ''A parent or other third party may file only 1 derivative petition with respect to each administration of a vaccine.''.

(d) DERIVATIVE PETITION CONTENTS.—Section 2111 of the Public Health Service Act (42 U.S.C. 300aa–11) is amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c) the following:

''(d) DERIVATIVE PETITIONS.—

''(1) If the parent or other third party with respect to the person who sustained the vaccine-related injury or death seeks compensation under the Program, such parent or other third party shall file a timely derivative petition for compensation under the Program in accordance with this section.

''(2) Such a derivative petition shall contain—

''(A) except for records that are unavailable as described in subsection (c)(3), an affidavit, and supporting documentation, demonstrating that—

''(i) such person was, in accordance with section 2112, previously awarded compensation for the underlying vaccine-related injury or death upon which such parent's or other third party's derivative petition is premised in a final judgment of the United States Court of Federal Claims and such judgment is subject to no further appeal or review;

''(ii) the derivative petition was filed not later than 60 days after the date on which such judgment became final and subject to no further appeal or review;

''(iii) such parent or other third party suffered a loss compensable under section 2115(b) as a result of the vaccine-related injury or death sustained by such person; and

''(iv) such parent or other third party has not previously collected an award or settlement of a civil action for damages for such loss; and

''(B) records establishing such parent's or other third party's relationship to the person who sustained the vaccine-related injury or death.''.

(e) DETERMINATION OF ELIGIBILITY FOR COMPENSATION.—Section 2113(a)(1) of the Public Health Service Act (42 U.S.C. 300aa–13(a)(1)) is amended—

(1) in subparagraph (A), by inserting ''or, as applicable, section 2111(d)'' before the comma; and

(2) in subparagraph (B), by inserting ''or, as applicable, that the injury or loss described in the derivative petition is due to factors unrelated to the vaccine-related injury or death'' after ''the petition''.

(f) COMPENSATION.—Section 2115 of the Public Health Service Act (42 U.S.C. 300aa–15) is amended—

(1) by redesignating subsections (b) through (j) as subsections (c) through (k), respectively;

(2) by inserting after subsection (a) the following:

''(b) DERIVATIVE PETITIONS.—Compensation awarded under the Program to a parent or other third party who files a derivative petition under section 2111 for a loss sustained as a result of a vaccine-related injury or death sustained by the injured party shall include compensation, if any, for loss of consortium, society, companionship, or services, in an amount not to exceed the lesser of $250,000 or the total amount of compensation awarded to the person who sustained the underlying vaccine-related injury or death.'';

(3) in subsection (e)(2), as so redesignated by paragraph (1)—

(A) by striking ''(2) and (3)'' and inserting ''(2), (3), and (4)''; and

(B) by inserting ''and subsection (b),'' after ''(a),'';

(4) in subsection (g), as so redesignated by paragraph (1), in paragraph (4)(B), by striking ''subsection (j)'' and inserting ''subsection (k)'';

(5) in subsection (j), as so redesignated by paragraph (1)—

(A) in paragraph (1), by striking ''subsection (j)'' and inserting ''subsection (k)''; and

(B) in paragraph (2), by inserting '', or to a parent or other third party with respect to a person who sustained a vaccine-related injury or death,'' after ''death''; and

(6) in subsection (k), as so redesignated by paragraph (1), by striking ''subsection (f)(4)(B)'' and inserting ''subsection (g)(4)(B)''.

SEC. ___24. JURISDICTION TO DISMISS ACTIONS IMPROPERLY BROUGHT.

Section 2111(a)(3) of the Public Health Service Act (42 U.S.C. 300aa–11(a)(3)) is amended by adding at the end the following: ''If any civil action which is barred under subparagraph (A) or (B) of paragraph (2) is filed or maintained in a State court, or any vaccine administrator or manufacturer is made a party to any civil action brought in State court (other than a civil action which may be brought under paragraph (2)) for damages or equitable relief for a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988, the civil action may be removed by the defendant or defendants to the United States

Court of Federal Claims, which shall have jurisdiction over such civil action, and which shall dismiss such action. The notice required by section 1446 of title 28, United States Code, shall be filed with the United States Court of Federal Claims, and that court shall proceed in accordance with sections 1446 through 1451 of title 28, United States Code.''.

SEC. ___25. APPLICATION.

Section 2111(a)(9) of the Public Health Service Act (42 U.S.C. 300aa–11(a)(9)) is amended by striking ''This'' and inserting ''Except as provided in paragraph (2), this''.

SEC. ___26. CLARIFICATION OF WHEN INJURY IS CAUSED BY FACTOR UNRELATED TO ADMINISTRATION OF VACCINE.

Section 2113(a)(2)(B) of the Public Health Service Act (42 U.S.C. 300aa–13(a)(2)(B)) is amended—

(1) by inserting ''structural lesions, genetic disorders,'' after ''and related anoxia),'';

(2) by inserting ''(without regard to whether the cause of the infection, toxin, trauma, structural lesion, genetic disorder, or metabolic disturbance is known)'' after ''metabolic disturbances''; and

(3) by striking ''but'' and inserting ''and''.

SEC. ___27. INCREASE IN AWARD IN THE CASE OF A VACCINE-RELATED DEATH AND FOR PAIN AND SUFFERING.

Section 2115(a) of the Public Health Service Act (42 U.S.C. 300aa–15(a)) is amended—

(1) in paragraph (2), by striking ''$250,000'' and inserting ''$350,000''; and

(2) in paragraph (4), by striking ''$250,000'' and inserting ''$350,000''.

SEC. ___28. BASIS FOR CALCULATING PROJECTED LOST EARNINGS.

Section 2115(a)(3)(B) of the Public Health Service Act (42 U.S.C. 300aa–15(a)(3)(B)) is amended by striking ''loss of earnings'' and all that follows and inserting the following: ''loss of earnings determined on the basis of the annual estimate of the average (mean) gross weekly earnings of wage and salary workers age 18 and over (excluding the incorporated self-employed) in the private nonfarm sector (which includes all industries other than agricultural production crops and livestock), as calculated annually by the Bureau of Labor Statistics from the quarter sample data of the Current Population Survey, or as calculated by such similar method as the Secretary may prescribe by regulation, less appropriate taxes and the average cost of a health insurance policy, as determined by the Secretary.''.

SEC. ___29. ALLOWING COMPENSATION FOR FAMILY COUNSELING EXPENSES AND EXPENSES OF ESTABLISHING GUARDIANSHIP.

(a) FAMILY COUNSELING EXPENSES IN POST-1988 CASES.—Section 2115(a) of the Public Health Service Act (42 U.S.C. 300aa–15(a)) is amended by adding at the end to following:

''(5) Actual unreimbursable expenses that have been or will be incurred for family counseling as is determined to be reasonably necessary and that result from the vaccine-related injury from which the petitioner seeks compensation.''.

(b) EXPENSES OF ESTABLISHING GUARDIANSHIPS IN POST-1988 CASES.—Section 2115(a) of the Public Health Service Act (42 U.S.C. 300aa–15(a)), as amended by subsection (a), is further amended by adding at the end the following:

''(6) Actual unreimbursable expenses that have been, or will be reasonably incurred to establish and maintain a guardianship or conservatorship for an individual who has suffered a vaccine-related injury, including attorney fees and other costs incurred in a proceeding to establish and maintain such guardianship or conservatorship.''.

(c) CONFORMING AMENDMENT FOR CASES FROM 1988 AND EARLIER.—Section 2115 of the Public Health Service Act (42 U.S.C. 300aa–15) is amended in subsection (c), as so redesignated by section ___23(f)—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking ''(e)'' and inserting ''(f))'';

(3) by redesignating paragraph (3) as paragraph (5); and

(4) by inserting after paragraph (2), the following:

''(3) family counseling expenses (as provided for in paragraph (5) of subsection (a));

''(4) expenses of establishing guardianships (as provided for in paragraph (6) of subsection (a)); and''.

SEC. ___30. ALLOWING PAYMENT OF INTERIM COSTS.

Section 2115 of the Public Health Service Act (42 U.S.C. 300aa–15) is amended in subsection (f), as so redesignated by section ___23(f), by adding at the end the following:

''(4) A special master or court may make an interim award of costs if—

''(A) the case involves a vaccine administered on or after October 1, 1988;

''(B) the special master or court has determined whether or not the petitioner is entitled to compensation under the Program;

''(C) the award is limited to other costs (within the meaning of paragraph (1)(B)) incurred in the proceeding; and

''(D) the petitioner provides documentation verifying the expenditure of the amount for which compensation is sought.''.

SEC. ___31. PROCEDURE FOR PAYING ATTORNEYS' FEES.

Section 2115 of the Public Health Service Act (42 U.S.C. 300aa–15), is amended in subsection (f), as so redesignated by section ___23(f) and amended by section ___30, by adding at the end the following:

''(5) When a special master or court awards attorney fees or costs under paragraph (1) or (4), it may order that such fees or costs be payable solely to the petitioner's attorney if—

''(A) the petitioner expressly consents; or

''(B) the special master or court determines, after affording to the Secretary and to all interested persons the opportunity to submit relevant information, that—

''(i) the petitioner cannot be located or refuses to respond to a request by the special master or court for information, and there is no practical alternative means to ensure that the attorney will be reimbursed for such fees or costs expeditiously; or

''(ii) there are otherwise exceptional circumstances and good cause for paying such fees or costs solely to the petitioner's attorney.''.

SEC. ___32. EXTENSION OF STATUTE OF LIMITATIONS.

(a) GENERAL RULE.—Section 2116(a) of the Public Health Service Act (42 U.S.C. 300aa–16(a)) is amended—

(1) in paragraph (2) by striking ''36 months'' and inserting ''6 years''; and

(2) in paragraph (3), by striking ''48 months'' and inserting ''6 years''.

(b) CLAIMS BASED ON REVISIONS TO TABLE.—Section 2116 of the Public Health Service Act (42 U.S.C. 300aa–16) is amended by striking subsection (b) and inserting the following:

''(b) EFFECT OF REVISED TABLE.—If at any time the Vaccine Injury Table is revised and the effect of such revision is to make an individual eligible for compensation under the program, where, before such revision, such individual was not eligible for compensation under the program, or to significantly increase the likelihood that an individual will be able to obtain compensation under the program, such person may, and shall before filing a civil action for equitable relief or monetary damages, notwithstanding section 2111(b)(2), file a petition for such compensation if—

''(1) the vaccine-related death or injury with respect to which the petition is filed occurred not more than 8 years before the effective date of the revision of the table; and

''(2) either—

''(A) the petition satisfies the conditions described in subsection (a); or

''(B) the date of the occurrence of the first symptom or manifestation of onset of the injury occurred more than 4 years before the petition is filed, and the petition is filed not more than 2 years after the effective date of the revision of the table.''.

(c) DERIVATIVE PETITIONS.—Section 2116 of the Public Health Service Act (42 U.S.C. 300aa–16) is amended by adding at the end the following:

''(d) DERIVATIVE PETITIONS.—No derivative petition may be filed for compensation under the Program later than 60 days after the date on which the United States Court of Federal Claims has entered final judgment and the time for all further appeal or review has expired on the underlying claim of the person who sustained the vaccine-related injury or death upon which the derivative petition is premised.''.

(d) TIMELY RESOLUTIONS OF CLAIMS.—

(1) SPECIAL MASTER DECISION.—Section 2112(d)(3)(A) of the Public Health Service Act (42 U.S.C. 300aa–12(d)(3)(A)) is amended by adding at the end the following: ''For purposes of this subparagraph, the petition shall be deemed to be filed on the date on which all petition contents and supporting documents required under section 2111(c) and, when applicable, section 2111(d) and the Vaccine Rules of the United States Court of Federal Claims, such as an affidavit and supporting documentation, are served on the Secretary and filed with the clerk of the United States Court of Federal Claims.''.

(2) COURT OF FEDERAL CLAIMS DECISION.—Section 2121(b) of the Public Health Service Act (42 U.S.C. 300aa–21(b)) is amended by adding at the end the following: ''For purposes of this subsection, the petition shall be deemed to be filed on the date on which all petition contents and supporting documents required under section 2111(c) and, when applicable, section 2111(d) and the Vaccine Rules of the United States Court of Federal Claims, such as an affidavit and supporting documentation, are served on the Secretary and filed with the clerk of the United States Court of Federal Claims.''.

SEC. ___33. ADVISORY COMMISSION ON CHILDHOOD VACCINES.

(a) SELECTION OF PERSONS INJURED BY VACCINES AS PUBLIC MEMBERS.—Section 2119(a)(1)(B) of the Public Health Service Act (42 U.S.C. 300aa–19(a)(1)(B)) is amended by striking ''of whom'' and all that follows and inserting the following: ''of whom 1 shall be the legal representative of a child who has suffered a vaccine-related injury or death, and at least 1 other shall be either the legal representative of a child who has suffered a vaccine-related injury or death or an individual who has personally suffered a vaccine-related injury.''.

(b) MANDATORY MEETING SCHEDULE ELIMINATED.—Section 2119(c) of the Public Health Service Act (42 U.S.C. 300aa–19(c)) is amended by striking ''not less often than four times per year and''.

SEC. ___34. CLARIFICATION OF STANDARDS OF RESPONSIBILITY.

(a) GENERAL RULE.—Section 2122(a) of the Public Health Service Act (42 U.S.C. 300aa–22(a)) is amended by striking ''and (e) State law shall apply to a civil action brought for damages'' and inserting ''(d), and (f) State law shall apply to a civil action brought for damages or equitable relief''; and

(b) UNAVOIDABLE ADVERSE SIDE EFFECTS.—Section 2122(b)(1) of the Public Health Service Act (42 U.S.C. 300aa–22(b)(1)) is amended by inserting ''or equitable relief'' after ''for damages''.

(c) DIRECT WARNINGS.—Section 2122(c) of the Public Health Service Act (42 U.S.C. 300aa–22(c)) is amended by inserting ''or equitable relief'' after ''for damages''.

(d) CONSTRUCTION.—Section 2122(d) of the Public Health Service Act (42 U.S.C. 300aa–22(d)) is amended—

(1) by inserting ''or equitable relief'' after ''for damages''; and

(2) by inserting ''or relief'' after ''which damages''.

(e) PAST OR PRESENT PHYSICAL INJURY.—Section 2122 of the Public Health Service Act (42 U.S.C. 300aa–22) is amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c) the following:

''(d) PAST OR PRESENT PHYSICAL INJURY.—No vaccine manufacturer or vaccine administrator shall be liable in a civil action brought after October 1, 1988, for equitable or monetary relief absent proof of past or present physical injury from the administration of a vaccine, nor shall any vaccine manufacturer or vaccine administrator be liable in any such civil action for claims of medical monitoring, or increased risk of harm.''.

SEC. ___35. CLARIFICATION OF DEFINITION OF MANUFACTURER.

Section 2133(3) of the Public Health Service Act (42 U.S.C. 300aa–33(3)) is amended—

(1) in the first sentence, by striking ''under its label any vaccine set forth in the Vaccine Injury Table'' and inserting ''any vaccine set forth in the Vaccine Injury table, including any component or ingredient of any such vaccine''; and

(2) in the second sentence, by inserting ''including any component or ingredient of any such vaccine'' before the period.

SEC. ___36. CLARIFICATION OF DEFINITION OF VACCINE-RELATED INJURY OR DEATH.

Section 2133(5) of the Public Health Service Act (42 U.S.C. 300aa–33(5)) is amended by adding at the end the following: ''For purposes of the preceding sentence, an adulterant or contaminant shall not include any component or ingredient listed in a vaccine's product license application or product label.''.

SEC. ___37. CLARIFICATION OF DEFINITION OF VACCINE.

Section 2133 of the Public Health Service Act (42 U.S.C. 300aa–33) is amended by adding at the end the following:

''(7) The term 'vaccine' means any preparation or suspension, including a preparation or suspension containing an attenuated or inactive microorganism or subunit thereof or toxin, developed or administered to produce or enhance the body's immune response to a disease or diseases and includes all components and ingredients listed in the vaccines's product license application and product label.''.

SEC. ___38. AMENDMENTS TO VACCINE INJURY COMPENSATION TRUST FUND.

(a) EXPANSION OF COMPENSATED LOSS.—Section 9510(c)(1)(A) of the Internal Revenue Code of 1986 is amended by inserting '', or related loss,'' after ''death''.

(b) INCREASE IN LIMIT ON ADMINISTRATIVE EXPENSES.—Subparagraph (B) of section 9510(c)(1) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''(but not in excess of the base amount of $9,500,000 for any fiscal year)''; and

(2) by striking the period and inserting '', provided that such administrative costs shall not exceed the greater of—

''(i) the base amount of $9,500,000,

''(ii) 125 percent of the base amount for any fiscal year in which the total number of claims pending under such subtitle exceeds 150 percent of the average number of claims pending in the preceding 5 years,

''(iii) 175 percent of the base amount for any fiscal year in which the total number of claims pending under such subtitle exceeds 200 percent of the average number of claims pending in the preceding 5 years,

''(iv) 225 percent of the base amount for any fiscal year in which the total number of claims pending under such subtitle exceeds 250 percent of the average number of claims pending in the preceding 5 years, or

''(v) 275 percent of the base amount for any fiscal year in which the total number of claims pending under such subtitle exceeds 300 percent of the average number of claims pending in the preceding 5 years.''.

(c) CONFORMING AMENDMENT.—Section 9510(c)(1)(A) of the Internal Revenue Code of 1986 is amended by striking ''October 18, 2000'' and inserting ''the date of enactment of the Improved Vaccine Affordability and Availability Act''.

SEC. ___39. ONGOING REVIEW OF CHILDHOOD VACCINE DATA.

Part C of title XXI of the Public Health Service Act (42 U.S.C. 300a–25 et seq.) is amended by adding at the end the following:

''SEC. 2129. ONGOING REVIEW OF CHILDHOOD VACCINE DATA.

''(a) IN GENERAL.—Not later than 6 months after the date of enactment of this section, the Secretary shall enter into a contract with the Institute of Medicine of the National Academy of Science under which the Institute shall conduct an ongoing, comprehensive review of new scientific data on childhood vaccines (according to priorities agreed upon from time to time by the Secretary and the Institute of Medicine).

''(b) REPORTS.—Not later than 3 years after the date on which the contract is entered into under subsection (a), the Institute of Medicine shall submit to the Secretary a report on the findings of studies conducted, including findings as to any adverse events associated with childhood vaccines, including conclusions concerning causation of adverse events by such vaccines, and other appropriate recommendations, based on such findings and conclusions.

''(c) FAILURE TO ENTER INTO CONTRACT.—If the Secretary and the Institute of Medicine are unable to enter into the contract described in subsection (a), the Secretary shall enter into a contract with another qualified nongovernmental scientific organization for the purposes described in subsections (a) and (b).

''(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2003, 2004, 2005 and 2006.''.

SEC. ___40. PENDING ACTIONS.

The amendments made by this title shall apply to all actions or proceedings pending on or after the date of enactment of this Act, unless a court of competent jurisdiction has entered judgment (regardless of whether the time for appeal has expired) in such action or proceeding disposing of the entire action or proceeding.

SEC. ___41. REPORT.

Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Advisory Commission on Childhood Vaccines shall report to the Secretary of Health and Human Services regarding the status of the Vaccine Injury Compensation Trust Fund, and shall make recommendations to the Secretary regarding the allocation of funds from the Vaccine Injury Compensation Trust Fund.

SA 4345. Mr. GRAHAM (for himself, Mr. SMITH of Oregon, Mr. MILLER, Mrs. LINCOLN, Mr. BINGAMAN, Mr. KENNEDY, and Ms. STABENOW) proposed an amendment to amendment SA 4299 proposed by Mr. REID (for Mr. DORGAN (for himself, Mr. WELLSTONE, Mr. JEFFORDS, Ms. STABENOW, Ms. COLLINS, Mr. LEVIN, Mr. JOHNSON, Mr. MILLER, Mr. DURBIN, Mr. FEINGOLD, and Mr. HARKIN)) to the bill (S. 812) to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; as follows:

At the end, add the following:

TITLE II—MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

SEC. 201. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the ''Medicare Prescription Drug Cost Protection Act of 2002''.

(b) TABLE OF CONTENTS.—The table of contents of this title is as follows:

SEC. 202. MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM.

(a) ESTABLISHMENT.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by redesignating part D as part E and by inserting after part C the following new part:

''PART D—OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

''DEFINITIONS

''SEC. 1860. In this part:

''(1) COVERED OUTPATIENT DRUG.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'covered outpatient drug' means any of the following products:

''(i) A drug which may be dispensed only upon prescription, and—

''(I) which is approved for safety and effectiveness as a prescription drug under section 505 of the Federal Food, Drug, and Cosmetic Act;

''(II)(aa) which was commercially used or sold in the United States before the date of enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (bb) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

''(III)(aa) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (bb) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling.

''(ii) A biological product which—

''(I) may only be dispensed upon prescription;

''(II) is licensed under section 351 of the Public Health Service Act; and

''(III) is produced at an establishment licensed under such section to produce such product.

''(iii) Insulin approved under appropriate Federal law, including needles and syringes for the administration of such insulin.

''(iv) A prescribed drug or biological product that would meet the requirements of clause (i) or (ii) except that it is available over-the-counter in addition to being available upon prescription.

''(B) EXCLUSION.—The term 'covered outpatient drug' does not include any product—

''(i) except as provided in subparagraph (A)(iv), which may be distributed to individuals without a prescription;

''(ii) for which payment is available under part A or B or would be available under part B but for the application of a deductible under such part (unless payment for such product is not available because benefits under part A or B have been exhausted), determined, except as provided in subparagraph (C), without regard to whether the beneficiary involved is entitled to benefits under part A or enrolled under part B; or

''(iii) except for agents used to promote smoking cessation and agents used for the treatment of obesity, for which coverage may be excluded or restricted under section 1927(d)(2).

''(C) CLARIFICATION REGARDING IMMUNOSUPPRESSIVE DRUGS.—In the case of a beneficiary who is not eligible for any coverage under part B of drugs described in section 1861(s)(2)(J) because of the requirements under such section (and would not be so eligible if the individual were enrolled under such part), the term 'covered outpatient drug' shall include such drugs if the drugs would otherwise be described in subparagraph (A).

''(2) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual that is entitled to benefits under part A or enrolled under part B.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any entity that the Secretary determines to be appropriate to provide eligible beneficiaries with covered outpatient drugs under a plan under this part, including—

''(A) a pharmacy benefit management company;

''(B) a retail pharmacy delivery system;

''(C) a health plan or insurer;

''(D) a State (through mechanisms established under a State plan under title XIX);

''(E) any other entity approved by the Secretary; or

''(F) any combination of the entities described in subparagraphs (A) through (E) if the Secretary determines that such combination—

''(i) increases the scope or efficiency of the provision of benefits under this part; and

''(ii) is not anticompetitive.

''(4) MEDICARE+CHOICE ORGANIZATION; MEDICARE+CHOICE PLAN.—The terms 'Medicare+Choice organization' and 'Medicare+Choice plan' have the meanings given such terms in subsections (a)(1) and (b)(1), respectively, of section 1859 (relating to definitions relating to Medicare+Choice organizations).

''(5) PRESCRIPTION DRUG ACCOUNT.—The term 'Prescription Drug Account' means the Prescription Drug Account (as established under section 1860K) in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''ESTABLISHMENT OF OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

''SEC. 1860A. (a) PROVISION OF BENEFIT.—

''(1) IN GENERAL.—Beginning in 2005, the Secretary shall provide for and administer an outpatient prescription drug benefit program under which each eligible beneficiary enrolled under this part shall be provided with coverage of covered outpatient drugs as follows:

''(A) MEDICARE+CHOICE PLAN.—If the eligible beneficiary is eligible to enroll in a Medicare+Choice plan, the beneficiary—

''(i) may enroll in such a plan; and

''(ii) if so enrolled, shall obtain coverage of covered outpatient drugs through such plan.

''(B) MEDICARE PRESCRIPTION DRUG PLAN.—If the eligible beneficiary is not enrolled in a Medicare+Choice plan, the beneficiary shall obtain coverage of covered outpatient drugs through enrollment in a plan offered by an eligible entity with a contract under this part.

''(2) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program established under this part.

''(3) SCOPE OF BENEFITS.—The program established under this part shall provide for coverage of all therapeutic categories and classes of covered outpatient drugs.

''(b) FINANCING.—The costs of providing benefits under this part shall be payable from the Prescription Drug Account.

''ENROLLMENT UNDER PROGRAM

''SEC. 1860B. (a) ESTABLISHMENT OF PROCESS.—

''(1) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election at any time to enroll under the program under this part.

''(2) ENROLLMENT AND REENROLLMENT AT ANY TIME.—Under the process established under paragraph (1), an eligible beneficiary, beginning January 1, 2005, may—

''(A) make an election to enroll under the program under this part at any time; and

''(B) terminate such election at any time and reenroll under such program at any time.

''(3) OPEN ENROLLMENT PERIOD PRIOR TO JANUARY 1, 2005, FOR INDIVIDUALS CURRENTLY ELIGIBLE.—The Secretary shall establish an open enrollment period of not less than 5 months to ensure that—

''(A) an individual who meets or will meet the definition of an eligible beneficiary under section 1860(2) as of January 1, 2005, is permitted to enroll under the program under this part prior to such date; and

''(B) coverage under this part for such an individual is effective as of such date.

''(4) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must be enrolled under this part in order to be eligible to receive coverage of covered outpatient drugs under this title.

''(5) LIMITATION.—Coverage under this part shall not begin prior to January 1, 2005.

''(b) TERMINATION.—

''(1) IN GENERAL.—The causes of termination specified in section 1838 shall apply to this part in a similar manner as such causes apply to part B.

''(2) COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B.—

''(A) IN GENERAL.—In addition to the causes of termination specified in paragraph (1), the Secretary shall terminate an individual's coverage under this part if the individual is no longer enrolled in either part A or B.

''(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of termination of coverage under part A or (if later) under part B.

''(3) PROCEDURES REGARDING TERMINATION OF A BENEFICIARY UNDER A PLAN.—The Secretary shall establish procedures for determining the status of an eligible beneficiary's enrollment under this part if the beneficiary's enrollment in a plan offered by an eligible entity under this part is terminated by the entity for cause (pursuant to procedures established by the Secretary under section 1860C(a)(1)).

''ENROLLMENT IN A PLAN

''SEC. 1860C. (a) PROCESS.—

''(1) ESTABLISHMENT.—

''(A) ELECTION.—

''(i) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part but not enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization—

''(I) shall make an annual election to enroll in any plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides; and

''(II) may make an annual election to change the election under this clause.

''(ii) DEFAULT ENROLLMENT.—Such process shall include for the default enrollment in such a plan in the case of an eligible beneficiary who is enrolled under this part but who has failed to make an election of such a plan.

''(B) RULES.—In establishing the process under subparagraph (A), the Secretary shall—

''(i) use rules similar to the rules for enrollment, disenrollment, and termination of enrollment with a Medicare+Choice plan under section 1851, including—

''(I) the establishment of special election periods under subsection (e)(4) of such section; and

''(II) the application of the guaranteed issue and renewal provisions of subsection (g) of such section (other than paragraph (3)(C)(i), relating to default enrollment); and

''(ii) coordinate enrollments, disenrollments, and terminations of enrollment under part C with enrollments,

disenrollments, and terminations of enrollment under this part.

''(2) FIRST ENROLLMENT PERIOD FOR PLAN ENROLLMENT FOR INDIVIDUALS CURRENTLY ELIGIBLE.—The process developed under paragraph (1) shall—

''(A) ensure—

''(i) that an individual who meets or will meet the definition of an eligible beneficiary under section 1860(2) as of January 1, 2005, is permitted to enroll with an eligible entity prior to January 1, 2005; and

''(ii) that coverage under this part for such an individual is effective as of such date; and

''(B) be coordinated with the open enrollment described in section 1860B(a)(3).

''(b) MEDICARE+CHOICE ENROLLEES.—

''(1) IN GENERAL.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization shall receive coverage of covered outpatient drugs under this part through such plan.

''(2) RULES.—Enrollment in a Medicare+Choice plan is subject to the rules for enrollment in such a plan under section 1851.

''PROVIDING INFORMATION TO BENEFICIARIES

''SEC. 1860D. (a) ACTIVITIES.—

''(1) IN GENERAL.—The Secretary shall conduct activities that are designed to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding the coverage provided under this part.

''(2) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in paragraph (1) shall ensure that individuals who meet or will meet the definition of an eligible beneficiary under section 1860(2) as of January 1, 2005, and other prospective eligible beneficiaries, are provided with such information at least 30 days prior to the open enrollment period described in section 1860B(a)(3).

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—The activities described in subsection (a) shall—

''(A) be similar to the activities performed by the Secretary under section 1851(d);

''(B) be coordinated with the activities performed by the Secretary under such section and under section 1804; and

''(C) provide for the dissemination of information comparing the plans offered by eligible entities under this part that are available to eligible beneficiaries residing in an area.

''(2) COMPARATIVE INFORMATION.—The comparative information described in paragraph (1)(C) shall include a comparison of the following:

''(A) BENEFITS.—The benefits provided under the plan, including the negotiated prices beneficiaries will be charged for covered outpatient drugs, any preferred pharmacy networks used by the eligible entity under the plan, and the formularies and appeals processes under the plan.

''(B) QUALITY AND PERFORMANCE.—To the extent available, the quality and performance of the eligible entity offering the plan.

''(C) BENEFICIARY COST-SHARING.—The cost-sharing required of eligible beneficiaries under the plan.

''(D) CONSUMER SATISFACTION SURVEYS.—To the extent available, the results of consumer satisfaction surveys regarding the plan and the eligible entity offering such plan.

''(E) ADDITIONAL INFORMATION.—Such additional information as the Secretary may prescribe.

''(3) INFORMATION STANDARDS.—The Secretary shall develop standards to ensure that the information provided to eligible beneficiaries under this part is complete, accurate, and uniform.

''(c) USE OF MEDICARE CONSUMER COALITIONS TO PROVIDE INFORMATION.—

''(1) IN GENERAL.—The Secretary may contract with Medicare Consumer Coalitions to conduct the informational activities under—

''(A) this section;

''(B) section 1851(d); and

''(C) section 1804.

''(2) SELECTION OF COALITIONS.—If the Secretary determines the use of Medicare Consumer Coalitions to be appropriate, the Secretary shall—

''(A) develop and disseminate, in such areas as the Secretary determines appropriate, a request for proposals for Medicare Consumer Coalitions to contract with the Secretary in order to conduct any of the informational activities described in paragraph (1); and

''(B) select a proposal of a Medicare Consumer Coalition to conduct the informational activities in each such area, with a preference for broad participation by organizations with experience in providing information to beneficiaries under this title.

''(3) PAYMENT TO MEDICARE CONSUMER COALITIONS.—The Secretary shall make payments to Medicare Consumer Coalitions contracting under this subsection in such amounts and in such manner as the Secretary determines appropriate.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, such sums as may be necessary to contract with Medicare Consumer Coalitions under this section.

''(5) MEDICARE CONSUMER COALITION DEFINED.—In this subsection, the term 'Medicare Consumer Coalition' means an entity that is a nonprofit organization operated under the direction of a board of directors that is primarily composed of beneficiaries under this title.

''NO PREMIUM FOR ENROLLMENT

''SEC. 1860E. (a) NO PREMIUM FOR ENROLLMENT.—An eligible beneficiary enrolled under the program under this part shall not be responsible for the payment of a premium for such enrollment.

''(b) ANNUAL ENROLLMENT FEE.—

''(1) IN GENERAL.—Subject to paragraph (2), enrollment under the program under this part is conditioned upon payment of an annual enrollment fee of $25.

''(2) INFLATION ADJUSTMENT.—

''(A) IN GENERAL.—For any year after 2005, the annual enrollment fee specified in paragraph (1) is equal to the annual enrollment fee determined under such paragraph (or this paragraph) for the previous year increased by the annual percentage increase described in subparagraph (B).

''(B) ANNUAL PERCENTAGE INCREASE SPECIFIED.—The annual percentage increase specified in this subparagraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year.

''(C) ROUNDING.—If any amount determined under subparagraph (A) is not a multiple of $1, such amount shall be rounded to the nearest multiple of $1.

''(3) COLLECTION.—

''(A) IN GENERAL.—Unless the eligible beneficiary makes an election under subparagraph (B), the annual enrollment fee described in paragraph (1) shall be collected and credited to the Prescription Drug Account in a similar manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

''(B) DIRECT PAYMENT.—An eligible beneficiary may elect to pay the annual enrollment fee directly to the Secretary or in any other manner approved by the Secretary. The Secretary shall establish procedures for making such an election.

''OUTPATIENT PRESCRIPTION DRUG BENEFITS

''SEC. 1860F. (a) REQUIREMENT.—A plan offered by an eligible entity under this part shall provide eligible beneficiaries enrolled in such plan with—

''(1) coverage of covered outpatient drugs—

''(A) without the application of any deductible; and

''(B) with the cost-sharing described in subsection (b); and

''(2) access to negotiated prices for such drugs under subsection (c).

''(b) COST-SHARING.—

''(1) COINSURANCE FOR FORMULARY DRUGS BEFORE CATASTROPHIC LIMIT REACHED.—Subject to paragraphs (2), (3), and (4), in the case of a covered outpatient drug that is included in the formulary established by the eligible entity (pursuant to section 1860H(c)) for the plan and that is dispensed to an eligible beneficiary, the beneficiary shall be responsible for coinsurance for the drug in an amount equal to the negotiated price for the drug (as reported to the Secretary pursuant to section 1860H(a)(6)(A)) minus 5 percent of such negotiated price.

''(2) BENEFICIARY RESPONSIBLE FOR NEGOTIATED PRICE FOR NONFORMULARY DRUGS BEFORE CATASTROPHIC LIMIT REACHED.—

''(A) IN GENERAL.—In the case of a covered outpatient drug that is not included in the formulary for the plan (and not treated as a brand name drug on the formulary under paragraph (B)) and that is dispensed to an eligible beneficiary in a year before the beneficiary has reached the catastrophic limit under paragraph (3) for the year, the beneficiary shall be responsible for the negotiated price for the drug (as reported to the Secretary pursuant to section 1860H(a)(6)(A)).

''(B) TREATMENT OF MEDICALLY NECESSARY NONFORMULARY DRUGS.—The eligible entity shall treat a drug not included in the formulary for the plan as a brand name drug on the formulary if such nonformulary drug is determined (pursuant to subparagraph (D) or (E) of section 1860H(a)(4)) to be medically necessary, and the beneficiary shall be responsible for the coinsurance described in paragraph (1).

''(3) COPAYMENT ONCE EXPENSES EQUAL ANNUAL CATASTROPHIC LIMIT.—

''(A) IN GENERAL.—Subject to paragraphs (4) and (5), in the case of a covered outpatient drug (regardless of whether it is included in the formulary or not so included) that is dispensed in a year to an eligible beneficiary after the beneficiary has incurred costs (as described in subparagraph (C)) for such drugs in a year equal to the annual catastrophic limit specified in subparagraph (B), the beneficiary shall be responsible for a copayment for the drug in an amount equal to $10 for each prescription (as defined in subparagraph (D)) of such drug.

''(B) ANNUAL CATASTROPHIC LIMIT.—Subject to paragraph (5), for purposes of this part, the 'annual catastrophic limit' specified in this subparagraph is equal to $3,300.

''(C) APPLICATION.—In applying subparagraph (A)—

''(i) incurred costs shall only include costs incurred for the cost-sharing described in this subsection (including the cost-sharing described in paragraph (2)(A)); but

''(ii) such costs shall be treated as incurred only if they are paid by the individual (or by another individual, such as a family member, on behalf of the individual), under title XIX, or by a State pharmacy assistance program,

and the individual (or other individual) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement for such costs.

''(D) PRESCRIPTION DEFINED.—

''(i) IN GENERAL.—Subject to clause (ii), for purposes of subparagraph (A), the term 'prescription' means—

''(I) a 30-day supply for a maintenance drug; and

''(II) a supply necessary for the length of the course that is typical of current practice for a nonmaintenance drug.

''(ii) SPECIAL RULE FOR MAIL ORDER DRUGS.—In the case of drugs obtained by mail order, the term 'prescription' may be for a supply that is longer than the period specified in subclause (I) or (II) of clause (i) (as the case may be) if the Secretary determines that the longer supply will not result in an increase in the expenditures made from the Prescription Drug Account.

''(E) COPAYMENT MAY NOT EXCEED NEGOTIATED PRICE.—If the amount of the copayment for a covered outpatient drug that would otherwise be required under this paragraph (but for this subparagraph) is greater than the negotiated price for the drug (as reported to the Secretary pursuant to section 1860H(a)(6)(A)), then the amount of such copayment shall be reduced to an amount equal to such negotiated price.

''(4) REDUCTION BY ELIGIBLE ENTITY.—An eligible entity offering a plan under this part may reduce the coinsurance amount that an eligible beneficiary enrolled in the plan is subject to under paragraph (1) or the copayment amount that such a beneficiary is subject to under paragraph (3) if the Secretary determines that such reduction—

''(A) is tied to the performance requirements described in section 1860I(b)(1)(C); and

''(B) will not result in an increase in the expenditures made from the Prescription Drug Account.

''(5) INFLATION ADJUSTMENT FOR COPAYMENT AND ANNUAL CATASTROPHIC LIMIT.—

''(A) IN GENERAL.—For any year after 2005—

''(i) the copayment amount described in paragraph (3)(A) is equal to the copayment amount determined under such paragraph (or this paragraph) for the previous year, increased by the annual percentage increase described in section 1860E(b)(2)(B); and

''(ii) the annual catastrophic limit specified in paragraph (3)(B) is equal to the annual catastrophic limit determined under such paragraph (or this paragraph) for the previous year increased by the annual percentage increase described in section 1860E(b)(2)(B).

''(B) ROUNDING.—If any amount determined under clause (i) or (ii) of subparagraph (A) is not a multiple of $1, such amount shall be rounded to the nearest multiple of $1.

''(c) ACCESS TO NEGOTIATED PRICES.—

''(1) ACCESS.—Under a plan offered by an eligible entity with a contract under this part, the eligible entity offering such plan shall provide eligible beneficiaries enrolled in such plan with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that only partial benefits or no benefits (because of the application of subsection (b)(2)(A)) may be payable under the coverage with respect to such drugs because of the application of the cost-sharing under subsection (b).

''(2) MEDICAID RELATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated under a plan under this part with respect to covered outpatient drugs, under a Medicare+Choice plan with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860J(e)(3)) with respect to such drugs, on behalf of eligible beneficiaries, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

''ENTITIES ELIGIBLE TO PROVIDE OUTPATIENT DRUG BENEFIT

''SEC. 1860G. (a) ESTABLISHMENT OF PANELS OF PLANS AVAILABLE IN AN AREA.—

''(1) IN GENERAL.—The Secretary shall establish procedures under which the Secretary—

''(A) accepts bids submitted by eligible entities for the plans which such entities intend to offer in an area established under subsection (b); and

''(B) awards contracts to such entities to provide such plans to eligible beneficiaries in the area.

''(2) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into contracts under this part.

''(b) AREA FOR CONTRACTS.—

''(1) REGIONAL BASIS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to paragraph (2), the contract entered into between the Secretary and an eligible entity with respect to a plan shall require the eligible entity to provide coverage of covered outpatient drugs under the plan in a region established by the Secretary under paragraph (2).

''(B) PARTIAL REGIONAL BASIS.—

''(i) IN GENERAL.—If determined appropriate by the Secretary, the Secretary may permit the coverage described in subparagraph (A) to be provided in a partial region determined appropriate by the Secretary.

''(ii) REQUIREMENTS.—If the Secretary permits coverage pursuant to clause (i), the Secretary shall ensure that the partial region in which coverage is provided is—

''(I) at least the size of the commercial service area of the eligible entity for that area; and

''(II) not smaller than a State.

''(2) ESTABLISHMENT OF REGIONS.—

''(A) IN GENERAL.—In establishing regions for contracts under this part, the Secretary shall—

''(i) take into account the number of eligible beneficiaries in an area in order to encourage participation by eligible entities;

''(ii) ensure that there are at least 10 different regions in the United States; and

''(iii) ensure that a region (or partial region under paragraph (1)(B)) would not discriminate based on the health or economic status of potential enrollees.

''(B) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The establishment of regions and partial regions under this section shall not be subject to administrative or judicial review.

''(c) SUBMISSION OF BIDS.—

''(1) SUBMISSION.—

''(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity desiring to offer a plan under this part in an area shall submit a bid with respect to such plan to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

''(B) BID THAT COVERS MULTIPLE AREAS.—The Secretary shall permit an eligible entity to submit a single bid for multiple areas if the bid is applicable to all such areas.

''(2) REQUIRED INFORMATION.—The bid described in paragraph (1) shall include—

''(A) a proposal for the estimated negotiated prices of covered outpatient drugs and the projected annual increases in such prices, including differentials between formulary and nonformulary prices, if applicable;

''(B) a statement regarding the amount that the entity will charge the Secretary for managing, administering, and delivering the benefits under the contract;

''(C) a statement regarding whether the entity will reduce the applicable coinsurance or copayment amounts pursuant to section 1860F(b)(4)) and if so, the amount of such reduction and how such reduction is tied to the performance requirements described in section 1860I(b)(1)(C);

''(D) a detailed description of the performance requirements for which the payments to the entity will be subject to risk pursuant to section 1860I(b)(1)(C);

''(E) a detailed description of access to pharmacy services provided under the plan;

''(F) with respect to the formulary used by the entity, a detailed description of the procedures and standards the entity will use for—

''(i) adding new drugs to a therapeutic category or class within the formulary; and

''(ii) determining when and how often the formulary should be modified;

''(G) a detailed description of any ownership or shared financial interests with other entities involved in the delivery of the benefit as proposed under the plan;

''(H) a detailed description of the entity's estimated marketing and advertising expenditures related to enrolling eligible beneficiaries under the plan and retaining such enrollment; and

''(I) such other information that the Secretary determines is necessary in order to carry out this part, including information relating to the bidding process under this part.

''(d) ACCESS TO BENEFITS IN CERTAIN AREAS.—

''(1) AREAS NOT COVERED BY CONTRACTS.—The Secretary shall develop procedures for the provision of covered outpatient drugs under this part to each eligible beneficiary enrolled under this part that resides in an area that is not covered by any contract under this part.

''(2) BENEFICIARIES RESIDING IN DIFFERENT LOCATIONS.—The Secretary shall develop procedures to ensure that each eligible beneficiary enrolled under this part that resides in different areas in a year is provided the benefits under this part throughout the entire year.

''(e) AWARDING OF CONTRACTS.—

''(1) NUMBER OF CONTRACTS.—The Secretary shall, consistent with the requirements of this part and the goal of containing costs under this title, award in a competitive manner at least 2 contracts to offer a plan in an area, unless only 1 bidding entity (and the plan offered by the entity) meets the minimum standards specified under this part and by the Secretary.

''(2) DETERMINATION.—In determining which of the eligible entities that submitted bids that meet the minimum standards specified under this part and by the Secretary to award a contract, the Secretary shall consider the comparative merits of each bid, as determined on the basis of the past performance of the entity and other relevant factors, with respect to—

''(A) how well the entity (and the plan offered by the entity) meet such minimum standards;

''(B) the amount that the entity will charge the Secretary for managing, administering, and delivering the benefits under the contract;

''(C) the performance requirements for which the payments to the entity will be subject to risk pursuant to section 1860I(b)(1)(C);

''(D) the proposed negotiated prices of covered outpatient drugs and annual increases in such prices;

''(E) the factors described in section 1860D(b)(2);

''(F) prior experience of the entity in managing, administering, and delivering a prescription drug benefit program;

''(G) effectiveness of the entity and plan in containing costs through pricing incentives and utilization management; and

''(H) such other factors as the Secretary deems necessary to evaluate the merits of each bid.

''(3) EXCEPTION TO CONFLICT OF INTEREST RULES.—In awarding contracts under this part, the Secretary may waive conflict of interest laws generally applicable to Federal acquisitions (subject to such safeguards as the Secretary may find necessary to impose) in circumstances where the Secretary finds that such waiver—

''(A) is not inconsistent with the—

''(i) purposes of the programs under this title; or

''(ii) best interests of beneficiaries enrolled under this part; and

''(B) permits a sufficient level of competition for such contracts, promotes efficiency of benefits administration, or otherwise serves the objectives of the program under this part.

''(4) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of the Secretary to award or not award a contract to an eligible entity with respect to a plan under this part shall not be subject to administrative or judicial review.

''(f) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The provisions of section 1851(h) shall apply to marketing material and application forms under this part in the same manner as such provisions apply to marketing material and application forms under part C.

''(g) DURATION OF CONTRACTS.—Each contract awarded under this part shall be for a term of at least 2 years but not more than 5 years, as determined by the Secretary.

''(h) FINANCIAL INCENTIVES FOR PHARMACIES TO PARTICIPATE IN CERTAIN PROGRAMS AND SYSTEMS.—The Secretary may establish and provide for incentives for pharmacies to participate in the following:

''(1) COST AND DRUG UTILIZATION MANAGEMENT PROGRAMS.—Effective cost and drug utilization management programs, including such programs that promote appropriate use of generic drugs in order to maximize savings to the program under this part.

''(2) QUALITY ASSURANCE MEASURES AND SYSTEMS.—Quality assurance measures and systems to reduce medical errors.

''(3) PROGRAMS TO CONTROL FRAUD, ABUSE, AND WASTE.—Programs to control fraud, abuse, and waste.

''MINIMUM STANDARDS FOR ELIGIBLE ENTITIES

''SEC. 1860H. (a) IN GENERAL.—The Secretary shall not award a contract to an eligible entity under this part unless the Secretary finds that the eligible entity agrees to comply with such terms and conditions as the Secretary shall specify, including the following:

''(1) QUALITY AND FINANCIAL STANDARDS.—The eligible entity meets the quality and financial standards specified by the Secretary.

''(2) PROCEDURES TO ENSURE PROPER UTILIZATION, COMPLIANCE, AND AVOIDANCE OF ADVERSE DRUG REACTIONS.—

''(A) IN GENERAL.—The eligible entity has in place drug utilization review procedures to ensure—

''(i) the appropriate utilization by eligible beneficiaries enrolled in the plan covered by the contract of the benefits to be provided under the plan;

''(ii) the avoidance of adverse drug reactions among such beneficiaries, including problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse and misuse; and

''(iii) the reasonable application of peer-reviewed medical literature pertaining to improvements in pharmaceutical safety and appropriate use of drugs.

''(B) AUTHORITY TO USE CERTAIN COMPENDIA AND LITERATURE.—The eligible entity may use the compendia and literature referred to in clauses (i) and (ii), respectively, of section 1927(g)(1)(B) as a source for the utilization review under subparagraph (A).

''(3) ELECTRONIC PRESCRIPTION PROGRAM.—

''(A) IN GENERAL.—The eligible entity has in place, for years beginning with 2006, an electronic prescription drug program that includes at least the following components, consistent with national standards established under subparagraph (B):

''(i) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—Prescriptions are only received electronically, except in emergency cases and other exceptional circumstances recognized by the Secretary.

''(ii) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL.—The program provides, upon transmittal of a prescription by a prescribing health care professional, for transmittal by the pharmacist to the professional of information that includes—

''(I) information (to the extent available and feasible) on the drugs being prescribed for that patient and other information relating to the medical history or condition of the patient that may be relevant to the appropriate prescription for that patient;

''(II) cost-effective alternatives (if any) for the use of the drug prescribed; and

''(III) information on the drugs included in the applicable formulary.

To the extent feasible, such program shall permit the prescribing health care professional to provide (and be provided) related information on an interactive, real-time basis.

''(B) STANDARDS.—

''(i) DEVELOPMENT.—The Secretary shall provide for the development of national standards relating to the electronic prescription drug program described in subparagraph (A). Such standards shall be compatible with standards established under part C of title XI.

''(ii) ADVISORY TASK FORCE.—In developing such standards, the Secretary shall establish a task force that includes representatives of physicians, hospitals, pharmacists, and technology experts and representatives of the Departments of Veterans Affairs and Defense and other appropriate Federal agencies to provide recommendations to the Secretary on such standards, including recommendations relating to the following:

''(I) The range of available computerized prescribing software and hardware and their costs to develop and implement.

''(II) The extent to which such systems reduce medication errors and can be readily implemented by physicians and hospitals.

''(III) Efforts to develop a common software platform for computerized prescribing.

''(IV) The cost of implementing such systems in the range of hospital and physician office settings, including hardware, software, and training costs.

''(V) Implementation issues as they relate to part C of title XI, and current Federal and State prescribing laws and regulations and their impact on implementation of computerized prescribing.

''(iii) DEADLINES.—

''(I) The Secretary shall constitute the task force under clause (ii) by not later than April 1, 2003.

''(II) The task force shall submit recommendations to the Secretary by not later than January 1, 2004.

''(III) The Secretary shall develop and promulgate the national standards referred to in clause (ii) by not later than January 1, 2005.

''(C) WAIVER OF APPLICATION FOR CERTAIN RURAL PROVIDERS.—If the Secretary determines that it is unduly burdensome on providers in rural areas to comply with the requirements under this paragraph, the Secretary may waive such requirements for such providers.

''(4) PATIENT PROTECTIONS.—

''(A) ACCESS.—

''(i) IN GENERAL.—The eligible entity ensures that the covered outpatient drugs are accessible and convenient to eligible beneficiaries enrolled in the plan covered by the contract, including by offering the services 24 hours a day and 7 days a week for emergencies.

''(ii) NEGOTIATED PARTICIPATION AGREEMENTS WITH PHARMACIES.—The eligible entity shall negotiate and enter into a participation agreement with any pharmacy that meets the requirements of subsection (d) to dispense covered prescription drugs to eligible beneficiaries under this part. Such agreements shall include the payment of a reasonable dispensing fee for covered outpatient drugs dispensed to a beneficiary under the agreement.

''(iii) PREFERRED PHARMACY NETWORKS.—If the eligible entity utilizes a preferred pharmacy network, the network complies with the standards under subsection (e).

''(B) ENSURING THAT BENEFICIARIES ARE NOT OVERCHARGED.—The eligible entity has procedures in place to ensure that each pharmacy with a negotiated participation agreement under this part with the entity complies with the requirements under subsection (d)(1)(C) (relating to adherence to negotiated prices).

''(C) CONTINUITY OF CARE.—

''(i) IN GENERAL.—The eligible entity ensures that, in the case of an eligible beneficiary who loses coverage under this part with such entity under circumstances that would permit a special election period (as established by the Secretary under section 1860C(a)(1)), the entity will continue to provide coverage under this part to such beneficiary until the beneficiary enrolls and receives such coverage with another eligible entity under this part or, if eligible, with a Medicare+Choice organization.

''(ii) LIMITED PERIOD.—In no event shall an eligible entity be required to provide the extended coverage required under clause (i) beyond the date which is 30 days after the coverage with such entity would have terminated but for this subparagraph.

''(D) PROCEDURES REGARDING THE DETERMINATION OF DRUGS THAT ARE MEDICALLY NECESSARY.—

''(i) IN GENERAL.—The eligible entity has in place procedures on a case-by-case basis to treat a drug not included in the formulary for the plan as a brand name drug on the formulary under this part if the formulary drug for treatment of the same condition is determined—

''(I) to be not as effective for the enrollee as the nonformulary drug in preventing or slowing the deterioration of, or improving or maintaining, the health of the enrollee; or

''(II) to have a significant adverse effect on the enrollee.

''(ii) REQUIREMENT.—The procedures under clause (i) shall require that determinations under such clause are based on professional

medical judgment, the medical condition of the enrollee, and other medical evidence.

''(E) PROCEDURES REGARDING APPEAL RIGHTS WITH RESPECT TO DENIALS OF CARE.—The eligible entity has in place procedures to ensure—

''(i) a timely internal review for resolution of denials of coverage (in whole or in part and including those regarding the coverage of drugs not included on the formulary of the plan as brand name drugs on the formulary) in accordance with the medical exigencies of the case and a timely resolution of complaints, by enrollees in the plan, or by providers, pharmacists, and other individuals acting on behalf of each such enrollee (with the enrollee's consent) in accordance with requirements (as established by the Secretary) that are comparable to such requirements for Medicare+Choice organizations under part C (and are not less favorable to the enrollee than such requirements under such part as in effect on the date of enactment of the Medicare Prescription Drug Cost Protection Act of 2002);

''(ii) that the entity complies in a timely manner with requirements established by the Secretary that (I) provide for an external review by an independent entity selected by the Secretary of denials of coverage described in clause (i) not resolved in the favor of the beneficiary (or other complainant) under the process described in such clause, and (II) are comparable to the external review requirements established for Medicare+Choice organizations under part C (and are not less favorable to the enrollee than such requirements under such part as in effect on the date of enactment of the Medicare Prescription Drug Cost Protection Act of 2002); and

''(iii) that enrollees are provided with information regarding the appeals procedures under this part at the time of enrollment with the entity and upon request thereafter.

''(F) PROCEDURES REGARDING PATIENT CONFIDENTIALITY.—Insofar as an eligible entity maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in the plan that is covered by the contract, the entity has in place procedures to—

''(i) safeguard the privacy of any individually identifiable beneficiary information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033);

''(ii) maintain such records and information in a manner that is accurate and timely;

''(iii) ensure timely access by such beneficiaries to such records and information; and

''(iv) otherwise comply with applicable laws relating to patient confidentiality.

''(G) PROCEDURES REGARDING TRANSFER OF MEDICAL RECORDS.—

''(i) IN GENERAL.—The eligible entity has in place procedures for the timely transfer of records and information described in subparagraph (F) (with respect to a beneficiary who loses coverage under this part with the entity and enrolls with another entity (including a Medicare+Choice organization) under this part) to such other entity.

''(ii) PATIENT CONFIDENTIALITY.—The procedures described in clause (i) shall comply with the patient confidentiality procedures described in subparagraph (F).

''(H) PROCEDURES REGARDING MEDICAL ERRORS.—The eligible entity has in place procedures for—

''(i) working with the Secretary to deter medical errors related to the provision of covered outpatient drugs; and

''(ii) ensuring that pharmacies with a contract with the entity have in place procedures to deter medical errors related to the provision of covered outpatient drugs.

''(5) PROCEDURES TO CONTROL FRAUD, ABUSE, AND WASTE.—

''(A) IN GENERAL.—The eligible entity has in place procedures to control fraud, abuse, and waste.

''(B) APPLICABILITY OF FRAUD AND ABUSE PROVISIONS.—The provisions of section 1128 through 1128C (relating to fraud and abuse) apply to eligible entities with contracts under this part.

''(6) REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—The eligible entity provides the Secretary with reports containing information regarding the following:

''(i) The negotiated prices that the eligible entity is paying for covered outpatient drugs.

''(ii) The negotiated prices that eligible beneficiaries enrolled in the plan that is covered by the contract will be charged for covered outpatient drugs.

''(iii) The management costs of providing such benefits.

''(iv) Utilization of such benefits.

''(v) Marketing and advertising expenditures related to enrolling and retaining eligible beneficiaries.

''(B) TIMEFRAME FOR SUBMITTING REPORTS.—

''(i) IN GENERAL.—The eligible entity shall submit a report described in subparagraph (A) to the Secretary within 3 months after the end of each 12-month period in which the eligible entity has a contract under this part. Such report shall contain information concerning the benefits provided during such 12-month period.

''(ii) LAST YEAR OF CONTRACT.—In the case of the last year of a contract under this part, the Secretary may require that a report described in subparagraph (A) be submitted 3 months prior to the end of the contract. Such report shall contain information concerning the benefits provided between the period covered by the most recent report under this subparagraph and the date that a report is submitted under this clause.

''(C) CONFIDENTIALITY OF INFORMATION.—

''(i) IN GENERAL.—Notwithstanding any other provision of law and subject to clause (ii), information disclosed by an eligible entity pursuant to subparagraph (A) (except for information described in clause (ii) of such subparagraph) is confidential and shall only be used by the Secretary for the purposes of, and to the extent necessary, to carry out this part.

''(ii) UTILIZATION DATA.—Subject to patient confidentiality laws, the Secretary shall make information disclosed by an eligible entity pursuant to subparagraph (A)(iv) (regarding utilization data) available for research purposes. The Secretary may charge a reasonable fee for making such information available.

''(7) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The eligible entity complies with the requirements described in section 1860G(f).

''(8) RECORDS AND AUDITS.—The eligible entity maintains adequate records related to the management, administration, and delivery of the benefits under this part and affords the Secretary access to such records for auditing purposes.

''(b) SPECIAL RULES REGARDING COST-EFFECTIVE PROVISION OF BENEFITS.—

''(1) IN GENERAL.—In providing the benefits under a contract under this part, an eligible entity shall—

''(A) employ mechanisms to provide the benefits economically, such as through the use of—

''(i) alternative methods of distribution;

''(ii) preferred pharmacy networks (pursuant to subsection (e)); and

''(iii) generic drug substitution;

''(B) use mechanisms to encourage eligible beneficiaries to select cost-effective drugs or less costly means of receiving drugs, such as through the use of—

''(i) pharmacy incentive programs;

''(ii) therapeutic interchange programs; and

''(iii) disease management programs;

''(C) encourage pharmacists to—

''(i) inform beneficiaries of the differentials in price between generic and brand name drug equivalents; and

''(ii) provide medication therapy management programs in order to enhance beneficiaries' understanding of the appropriate use of medications and to reduce the risk of potential adverse events associated with medications; and

''(D) develop and implement a formulary in accordance with subsection (c).

''(2) RESTRICTION.—If an eligible entity uses alternative methods of distribution pursuant to paragraph (1)(A)(i), the entity may not require that a beneficiary use such methods in order to obtain covered outpatient drugs.

''(c) REQUIREMENTS FOR FORMULARIES.—

''(1) STANDARDS.—

''(A) IN GENERAL.—The formulary developed and implemented by the eligible entity shall comply with standards established by the Secretary in consultation with the Medicare Prescription Drug Advisory Committee established under section 1860L.

''(B) NO NATIONAL FORMULARY OR REQUIREMENT TO EXCLUDE SPECIFIC DRUGS.—

''(i) SECRETARY MAY NOT ESTABLISH A NATIONAL FORMULARY.—The Secretary may not establish a national formulary.

''(ii) NO REQUIREMENT TO EXCLUDE SPECIFIC DRUGS.—The standards established by the Secretary pursuant to subparagraph (A) may not require that an eligible entity exclude a specific covered outpatient drug from the formulary developed and implemented by the entity.

''(2) REQUIREMENTS FOR STANDARDS.—The standards established under paragraph (1)(A) shall require that the eligible entity—

''(A) use a pharmacy and therapeutic committee (that meets the standards for a pharmacy and therapeutic committee established by the Secretary in consultation with such Medicare Prescription Drug Advisory Committee) to develop and implement the formulary;

''(B) include in the formulary—

''(i) all generic covered outpatient drugs; and

''(ii) covered outpatient drugs within each therapeutic category and class (as defined by the Secretary in consultation with such Medicare Prescription Drug Advisory Committee) of such drugs, although not necessarily for all drugs within such categories and classes;

''(C) develop procedures for the modification of the formulary, including for the addition of new drugs to an existing therapeutic category or class;

''(D) pursuant to section 1860F(b)(2)(B), provide for the treatment of drugs not included in the formulary for the plan as brand name drugs on the formulary when determined under subparagraph (D) or (E) of subsection (a)(4) to be medically necessary;

''(E) disclose to current and prospective beneficiaries and to providers in the service area the nature of the formulary restrictions, including information regarding the drugs included in the formulary and any difference in the cost-sharing for drugs—

''(i) included in the formulary; and

''(ii) not included in the formulary; and

''(F) provide a reasonable amount of notice to beneficiaries enrolled in the plan that is covered by the contract under this part of any change in the formulary.

''(3) CONSTRUCTION.—Nothing in this part shall be construed as precluding an eligible entity from—

''(A) educating prescribing providers, pharmacists, and beneficiaries about the medical and cost benefits of drugs included in the formulary for the plan (including generic drugs); or

''(B) requesting prescribing providers to consider a drug included in the formulary for the plan prior to dispensing of a drug not so included, as long as such a request does not unduly delay the provision of the drug.

''(d) TERMS OF NEGOTIATED PARTICIPATION AGREEMENT WITH PHARMACIES.—

''(1) IN GENERAL.—A negotiated participation agreement between an eligible entity and a pharmacy under this part (pursuant to subsection (a)(4)(A)(ii)) shall include the following terms and conditions:

''(A) APPLICABLE REQUIREMENTS.—The pharmacy shall meet (and throughout the contract period continue to meet) all applicable Federal requirements and State and local licensing requirements.

''(B) ACCESS AND QUALITY STANDARDS.—The pharmacy shall comply with such standards as the Secretary (and the eligible entity) shall establish concerning the quality of, and enrolled beneficiaries' access to, pharmacy services under this part. Such standards shall require the pharmacy—

''(i) not to refuse to dispense covered outpatient drugs to any eligible beneficiary enrolled under this part;

''(ii) to keep patient records (including records on expenses) for all covered outpatient drugs dispensed to such enrolled beneficiaries;

''(iii) to submit information (in a manner specified by the Secretary to be necessary to administer this part) on all purchases of such drugs dispensed to such enrolled beneficiaries; and

''(iv) to comply with periodic audits to assure compliance with the requirements of this part and the accuracy of information submitted.

''(C) ENSURING THAT BENEFICIARIES ARE NOT OVERCHARGED.—

''(i) ADHERENCE TO NEGOTIATED PRICES.—The total charge for each covered outpatient drug dispensed by the pharmacy to a beneficiary enrolled in the plan, without regard to whether the individual is financially responsible for any or all of such charge, shall not exceed the negotiated price for the drug (as reported to the Secretary pursuant to subsection (a)(6)(A)).

''(ii) ADHERENCE TO BENEFICIARY OBLIGATION.—The pharmacy may not charge (or collect from) such beneficiary an amount that exceeds the cost-sharing that the beneficiary is responsible for under this part (as determined under section 1860F(b) using the negotiated price of the drug).

''(D) ADDITIONAL REQUIREMENTS.—The pharmacy shall meet such additional contract requirements as the eligible entity specifies under this section.

''(2) APPLICABILITY OF FRAUD AND ABUSE PROVISIONS.—The provisions of section 1128 through 1128C (relating to fraud and abuse) apply to pharmacies participating in the program under this part.

''(e) PREFERRED PHARMACY NETWORKS.—

''(1) IN GENERAL.—If an eligible entity uses a preferred pharmacy network to deliver benefits under this part, such network shall meet minimum access standards established by the Secretary.

''(2) STANDARDS.—In establishing standards under paragraph (1), the Secretary shall take into account reasonable distances to pharmacy services in both urban and rural areas.

''PAYMENTS

''SEC. 1860I. (a) PROCEDURES FOR PAYMENTS TO ELIGIBLE ENTITIES.—The Secretary shall establish procedures for making payments to each eligible entity with a contract to offer a plan under this part for the management, administration, and delivery of the benefits under the plan.

''(b) REQUIREMENTS FOR PROCEDURES.—

''(1) IN GENERAL.—The procedures established under subsection (a) shall provide for the following:

''(A) MANAGEMENT PAYMENT.—Payment for the management, administration, and delivery of the benefits under the plan.

''(B) REIMBURSEMENT FOR NEGOTIATED COSTS OF DRUGS PROVIDED.—Payments for the negotiated costs of covered outpatient drugs provided to eligible beneficiaries enrolled under this part and in the plan, reduced by any applicable cost-sharing under section 1860F(b).

''(C) RISK REQUIREMENT TO ENSURE PURSUIT OF PERFORMANCE REQUIREMENTS.—An adjustment of a percentage (as determined under paragraph (3)) of the payments made to an entity under subparagraph (A) to ensure that the entity, in managing, administering, and delivering the benefits under the plan, pursues performance requirements established by the Secretary, including the following:

''(i) CONTROL OF MEDICARE AND BENEFICIARY COSTS.—The entity contains costs to the Prescription Drug Account and to eligible beneficiaries enrolled under this part and in the plan, as measured by generic substitution rates, price discounts, and other factors determined appropriate by the Secretary that do not reduce the access of such beneficiaries to medically necessary covered outpatient drugs.

''(ii) QUALITY CLINICAL CARE.—The entity provides such beneficiaries with quality clinical care, as measured by such factors as—

''(I) the level of adverse drug reactions and medical errors among such beneficiaries; and

''(II) providing specific clinical suggestions to improve health and patient and prescriber education as appropriate.

''(iii) QUALITY SERVICE.—The entity provides such beneficiaries with quality services, as measured by such factors as sustained pharmacy network access, timeliness and accuracy of service delivery in claims processing and card production, pharmacy and member service support access, response time in mail delivery service, and timely action with regard to appeals and current beneficiary service surveys.

''(2) SECRETARY TO CONSIDER RISK PROFILE OF ENROLLEES.—The Secretary shall take into account the risk profile of beneficiaries enrolled under this part and in the plan in assessing the degree to which the entity is meeting the performance requirements under paragraph (1)(C).

''(3) PERCENTAGE OF PAYMENT TIED TO RISK.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall determine the percentage (which may be up to 100 percent) of the payments made to an entity under paragraph (1)(A) that will be tied to the performance requirements described in paragraph (1)(C).

''(B) LIMITATION ON RISK TO ENSURE PROGRAM STABILITY.—In order to provide for program stability, the Secretary may not establish a percentage to be adjusted under this subsection at a level that jeopardizes the ability of an eligible entity to administer and deliver the benefits under this part or administer and deliver such benefits in a quality manner.

''(4) PASS-THROUGH OF REBATES, DISCOUNTS, AND PRICE CONCESSIONS OBTAINED BY THE ELIGIBLE ENTITY.—The Secretary shall establish procedures for reducing the amount of payments to an eligible entity under paragraph (1) to take into account any rebates, discounts, or price concessions obtained by the entity from manufacturers of covered outpatient drugs, unless the Secretary determines that such procedures are not in the best interests of the medicare program or eligible beneficiaries.

''(c) PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS.—For provisions related to payments to Medicare+Choice organizations for the management, administration, and delivery of benefits under this part to eligible beneficiaries enrolled in a Medicare+Choice plan offered by the organization, see section 1853(c)(8).

''(d) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

''EMPLOYER INCENTIVE PROGRAM FOR EMPLOYMENT-BASED RETIREE DRUG COVERAGE

''SEC. 1860J. (a) PROGRAM AUTHORITY.—The Secretary is authorized to develop and implement a program under this section to be known as the 'Employer Incentive Program' that encourages employers and other sponsors of employment-based health care coverage to provide adequate prescription drug benefits to retired individuals by subsidizing, in part, the sponsor's cost of providing coverage under qualifying plans.

''(b) SPONSOR REQUIREMENTS.—In order to be eligible to receive an incentive payment under this section with respect to coverage of an individual under a qualified retiree prescription drug plan (as defined in subsection (e)(3)), a sponsor shall meet the following requirements:

''(1) ASSURANCES.—The sponsor shall—

''(A) annually attest, and provide such assurances as the Secretary may require, that the coverage offered by the sponsor is a qualified retiree prescription drug plan, and will remain such a plan for the duration of the sponsor's participation in the program under this section; and

''(B) guarantee that it will give notice to the Secretary and covered retirees—

''(i) at least 120 days before terminating its plan; and

''(ii) immediately upon determining that the actuarial value of the prescription drug benefit under the plan falls below the actuarial value of the outpatient prescription drug benefit under this part.

''(2) BENEFICIARY INFORMATION.—The sponsor shall report to the Secretary, for each calendar quarter for which it seeks an incentive payment under this section, the names and social security numbers of all retirees (and their spouses and dependents) covered under such plan during such quarter and the dates (if less than the full quarter) during which each such individual was covered.

''(3) AUDITS.—The sponsor and the employment-based retiree health coverage plan seeking incentive payments under this section shall agree to maintain, and to afford the Secretary access to, such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, the accuracy of incentive payments made, and such other matters as may be appropriate.

''(4) OTHER REQUIREMENTS.—The sponsor shall provide such other information, and comply with such other requirements, as the Secretary may find necessary to administer the program under this section.

''(c) INCENTIVE PAYMENTS.—

''(1) IN GENERAL.—A sponsor that meets the requirements of subsection (b) with respect to a quarter in a calendar year shall be entitled to have payment made by the Secretary

on a quarterly basis (to the sponsor or, at the sponsor's direction, to the appropriate employment-based health plan) of an incentive payment, in the amount determined in paragraph (2), for each retired individual (or spouse or dependent) who—

''(A) was covered under the sponsor's qualified retiree prescription drug plan during such quarter; and

''(B) was eligible for, but was not enrolled in, the outpatient prescription drug benefit program under this part.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—The amount of the payment for a quarter shall be, for each individual described in paragraph (1), ¾ of the sum of the monthly Government contribution amounts (computed under subparagraph (B)) for each of the 3 months in the quarter.

''(B) COMPUTATION OF MONTHLY GOVERNMENT CONTRIBUTION AMOUNT.—For purposes of subparagraph (A), the monthly Government contribution amount for a month in a year is equal to the amount by which—

''(i) 1/12 of the amount estimated under subparagraph (C) for the year involved; exceeds

''(ii) 1/12 of the annual enrollment fee for the year under section 1860E(b).

''(C) ESTIMATE OF AVERAGE ANNUAL PER CAPITA AGGREGATE EXPENDITURES.—

''(i) IN GENERAL.—The Secretary shall for each year after 2004 estimate for that year an amount equal to average annual per capita aggregate expenditures payable from the Prescription Drug Account for that year.

''(ii) TIMEFRAME FOR ESTIMATION.—The Secretary shall make the estimate described in clause (i) for a year before the beginning of that year.

''(3) PAYMENT DATE.—The payment under this section with respect to a calendar quarter shall be payable as of the end of the next succeeding calendar quarter.

''(d) CIVIL MONEY PENALTIES.—A sponsor, health plan, or other entity that the Secretary determines has, directly or through its agent, provided information in connection with a request for an incentive payment under this section that the entity knew or should have known to be false shall be subject to a civil monetary penalty in an amount up to 3 times the total incentive amounts under subsection (c) that were paid (or would have been payable) on the basis of such information.

''(e) DEFINITIONS.—In this section:

''(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage, whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation, of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

''(2) EMPLOYER.—The term 'employer' has the meaning given the term in section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of 2 or more employees).

''(3) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' means health insurance coverage included in employment-based retiree health coverage that—

''(A) provides coverage of the cost of prescription drugs with an actuarial value (as defined by the Secretary) to each retired beneficiary that equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription drug benefit program under this part; and

''(B) does not deny, limit, or condition the coverage or provision of prescription drug benefits for retired individuals based on age or any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(4) SPONSOR.—The term 'sponsor' has the meaning given the term 'plan sponsor' in section 3(16)(B) of the Employer Retirement Income Security Act of 1974.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, such sums as may be necessary to carry out the program under this section.

''PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

''SEC. 1860K. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Account' (in this section referred to as the 'Account').

''(2) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, the account as provided in this part.

''(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

''(b) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including payments to eligible entities under section 1860I, payments to Medicare+Choice organizations under section 1853(c)(8), and payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

''(c) APPROPRIATIONS TO COVER BENEFITS AND ADMINISTRATIVE COSTS.—There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part in the year exceed the annual enrollment fees collected under section 1860E(b) for the year.

''MEDICARE PRESCRIPTION DRUG ADVISORY COMMITTEE

''SEC. 1860L. (a) ESTABLISHMENT OF COMMITTEE.—There is established a Medicare Prescription Drug Advisory Committee (in this section referred to as the 'Committee').

''(b) FUNCTIONS OF COMMITTEE.—On and after January 1, 2004, the Committee shall advise the Secretary on policies related to—

''(1) the development of guidelines for the implementation and administration of the outpatient prescription drug benefit program under this part; and

''(2) the development of—

''(A) standards for a pharmacy and therapeutics committee required of eligible entities under section 1860H(c)(2)(A);

''(B) standards required under subparagraphs (D) and (E) of section 1860H(a)(4) for determining if a drug is medically necessary;

''(C) standards for—

''(i) establishing therapeutic categories and classes of covered outpatient drugs;

''(ii) adding new therapeutic categories and classes of covered outpatient drugs to a formulary; and

''(iii) defining maintenance and nonmaintenance drugs and determining the length of the course that is typical of current practice for nonmaintenance drugs for purposes of applying section 1860F(b)(3);

''(D) procedures to evaluate the bids submitted by eligible entities under this part; and

''(E) procedures to ensure that eligible entities with a contract under this part are in compliance with the requirements under this part.

''(c) STRUCTURE AND MEMBERSHIP OF THE COMMITTEE.—

''(1) STRUCTURE.—The Committee shall be composed of 19 members who shall be appointed by the Secretary.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—The members of the Committee shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, attainments, and understanding of pharmaceutical cost control and quality enhancement, exceptionally qualified to perform the duties of members of the Committee.

''(B) SPECIFIC MEMBERS.—Of the members appointed under paragraph (1)—

''(i) five shall be chosen to represent physicians, 2 of whom shall be geriatricians;

''(ii) two shall be chosen to represent nurse practitioners;

''(iii) four shall be chosen to represent pharmacists;

''(iv) one shall be chosen to represent the Centers for Medicare & Medicaid Services;

''(v) four shall be chosen to represent actuaries, pharmacoeconomists, researchers, and other appropriate experts;

''(vi) one shall be chosen to represent emerging drug technologies;

''(vii) one shall be chosen to represent the Food and Drug Administration; and

''(viii) one shall be chosen to represent individuals enrolled under this part.

''(d) TERMS OF APPOINTMENT.—Each member of the Committee shall serve for a term determined appropriate by the Secretary. The terms of service of the members initially appointed shall begin on March 1, 2003.

''(e) CHAIRPERSON.—The Secretary shall designate a member of the Committee as Chairperson. The term as Chairperson shall be for a 1-year period.

''(f) COMMITTEE PERSONNEL MATTERS.—

''(1) MEMBERS.—

''(A) COMPENSATION.—Each member of the Committee who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Committee. All members of the Committee who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

''(B) TRAVEL EXPENSES.—The members of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Committee.

''(2) STAFF.—The Committee may appoint such personnel as the Committee considers appropriate.

''(g) OPERATION OF THE COMMITTEE.—

''(1) MEETINGS.—The Committee shall meet at the call of the Chairperson (after consultation with the other members of the

Committee) not less often than quarterly to consider a specific agenda of issues, as determined by the Chairperson after such consultation.

''(2) QUORUM.—Ten members of the Committee shall constitute a quorum for purposes of conducting business.

''(h) FEDERAL ADVISORY COMMITTEE ACT.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee.

''(i) TRANSFER OF PERSONNEL, RESOURCES, AND ASSETS.—For purposes of carrying out its duties, the Secretary and the Committee may provide for the transfer to the Committee of such civil service personnel in the employ of the Department of Health and Human Services (including the Centers for Medicare & Medicaid Services), and such resources and assets of the Department used in carrying out this title, as the Committee requires.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.''.

(b) EXCLUSIONS FROM COVERAGE.—

(1) APPLICATION TO PART D.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking ''part A or part B'' and inserting ''part A, B, or D''.

(2) PRESCRIPTION DRUGS NOT EXCLUDED FROM COVERAGE IF REASONABLE AND NECESSARY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(A) in subparagraph (H), by striking ''and'' at the end;

(B) in subparagraph (I), by striking the semicolon at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(J) in the case of prescription drugs covered under part D, which are not reasonable and necessary to prevent or slow the deterioration of, or improve or maintain, the health of eligible beneficiaries;''.

(c) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended—

(1) in the last sentence of subsection (a)—

(A) by striking ''and'' before ''such amounts''; and

(B) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Prescription Drug Account established by section 1860K'';

(2) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),'';

(3) in subsection (h), by inserting after ''1840(d)'' the following: ''and section 1860E(b)(3) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund)''; and

(4) in subsection (i), by inserting after ''section 1840(b)(1)'' the following: '', section 1860E(b)(3) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),''.

(d) CONFORMING REFERENCES TO PREVIOUS PART D.—

(1) IN GENERAL.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this title.

SEC. 203. PART D BENEFITS UNDER MEDICARE+CHOICE PLANS.

(a) ELIGIBILITY, ELECTION, AND ENROLLMENT.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended—

(1) in subsection (a)(1)(A), by striking ''parts A and B'' and inserting ''parts A, B, and D''; and

(2) in subsection (i)(1), by striking ''parts A and B'' and inserting ''parts A, B, and D''.

(b) VOLUNTARY BENEFICIARY ENROLLMENT FOR DRUG COVERAGE.—Section 1852(a)(1)(A) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting ''(and under part D to individuals also enrolled under that part)'' after ''parts A and B''.

(c) ACCESS TO SERVICES.—Section 1852(d)(1) of the Social Security Act (42 U.S.C. 1395w–22(d)(1)) is amended—

(1) in subparagraph (D), by striking ''and'' at the end;

(2) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(F) in the case of covered outpatient drugs (as defined in section 1860(1)) provided to individuals enrolled under part D, the organization complies with the access requirements applicable under part D.''.

(d) PAYMENTS TO ORGANIZATIONS FOR PART D BENEFITS.—

(1) IN GENERAL.—Section 1853(a)(1)(A) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(A)) is amended—

(A) by inserting ''determined separately for the benefits under parts A and B and under part D (for individuals enrolled under that part)'' after ''as calculated under subsection (c)'';

(B) by striking ''that area, adjusted for such risk factors'' and inserting ''that area. In the case of payment for the benefits under parts A and B, such payment shall be adjusted for such risk factors as''; and

(C) by inserting before the last sentence the following: ''In the case of the payments under subsection (c)(8) for the provision of coverage of covered outpatient drugs to individuals enrolled under part D, such payment shall be adjusted for the risk factors of each enrollee as the Secretary determines to be feasible and appropriate to ensure actuarial equivalence.''.

(2) AMOUNT.—Section 1853(c) of the Social Security Act (42 U.S.C. 1395w–23(c)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''for benefits under parts A and B'' after ''capitation rate''; and

(B) by adding at the end the following new paragraph:

''(8) CAPITATION RATE FOR PART D BENEFITS.—

''(A) IN GENERAL.—In the case of a Medicare+Choice plan that provides coverage of covered outpatient drugs to an individual enrolled under part D, the capitation rate for such coverage shall be the amount described in subparagraph (B). Such payments shall be made in the same manner and at the same time as the payments to the Medicare+Choice organization offering the plan for benefits under parts A and B are otherwise made, but such payments shall be payable from the Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(B) AMOUNT.—The amount described in this paragraph is an amount equal to 1/12 of the average annual per capita aggregate expenditures payable from the Prescription Drug Account for the year (as estimated under section 1860J(c)(2)(C)).''.

(e) LIMITATION ON ENROLLEE LIABILITY.—Section 1854(e) of the Social Security Act (42 U.S.C. 1395w–24(e)) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR PART D BENEFITS.—With respect to outpatient prescription drug benefits under part D, a Medicare+Choice organization may not require that an enrollee pay any deductible or pay a cost-sharing amount that exceeds the amount of cost-sharing applicable for such benefits for an eligible beneficiary under part D.''.

(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—Section 1854(f)(1) of the Social Security Act (42 U.S.C. 1395w–24(f)(1)) is amended by adding at the end the following new sentence: ''Such determination shall be made separately for the benefits under parts A and B and for prescription drug benefits under part D.''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services provided under a Medicare+Choice plan on or after January 1, 2005.

SEC. 204. ADDITIONAL ASSISTANCE FOR LOW-INCOME BENEFICIARIES.

(a) INCLUSION IN MEDICARE COST-SHARING.—

(1) IN GENERAL.—Section 1905(p)(3) of the Social Security Act (42 U.S.C. 1396d(p)(3)) is amended—

(A) in subparagraph (B), by inserting ''and, subject to paragraph (7), cost-sharing described in section 1860F(b), subject to payment by the individual of a cost-sharing charge for the dispensing of a covered outpatient drug (as defined in section 1860(1)) that is equal to $2 for a prescription (as defined in section 1860F(b)(3)(D)) of a generic drug and $5 for a prescription (as so defined) of a brand name drug'' after ''section 1813''; and

(B) by inserting after subparagraph (D) the following new subparagraph:

''(E) The annual enrollment fee under section 1860E(b).''.

(2) INDEXING.—Section 1905(p) of the Social Security Act (42 U.S.C. 1396d(p)) is amended—

(A) by redesignating paragraph (6) as paragraph (8); and

(B) by inserting after paragraph (5) the following new paragraph:

''(6)(A) For any year after 2005, the cost-sharing amounts specified in paragraph (3)(B) for covered outpatient drugs (as defined in section 1860(1)) are equal to the cost-sharing amounts for such drugs determined under such paragraph (or this paragraph) for the previous year increased by the annual percentage increase described in section 1860E(b)(2)(B).

''(B) If any amount determined under subparagraph (A) is not a multiple of $1, such amount shall be rounded to the nearest multiple of $1.''.

(b) EXPANSION OF MEDICAL ASSISTANCE.—Section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) is amended—

(1) in clause (iii)—

(A) by inserting after ''section 1905(p)(3)(A)(ii)'' the following: '', for medicare cost-sharing described in section 1905(p)(3)(B) (but only insofar as it relates to benefits provided under part D of title XVIII), and for medicare cost-sharing described in section 1905(p)(3)(E),''; and

(B) by striking ''and'' at the end;

(2) by redesignating clause (iv) as clause (v); and

(3) by inserting after clause (iii) the following new clause:

''(iv) for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(B) (but only insofar as it relates to benefits provided under part D of title XVIII) and for medicare cost-sharing described in section 1905(p)(3)(E) for—

''(I) individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds 120 percent but does not exceed 150 percent of the official poverty line (referred to in section 1905(p)(2)) for a family of the size involved; and

''(II) individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds 150 percent but does not exceed 200 percent of the official poverty line (referred to in section 1905(p)(2)) for a family of the size involved; and''.

(c) NONDISCRIMINATION.—Section 1905(p) of the Social Security Act (42 U.S.C. 1396d(p)), as amended by subsection (a)(2), is amended by inserting after paragraph (6) the following new paragraph:

''(7) With respect to determining the eligibility of individuals described in clause (i), (iii), or (iv) of section 1902(a)(10)(E) for medicare cost-sharing described in paragraph (3)(B) (but only insofar as it relates to benefits provided under part D of title XVIII) and for medicare cost-sharing described in paragraph (3)(E), the State shall—

''(A) use the same methodology in determining income eligibility for all such individuals;

''(B) use the same simplified eligibility form (including, if applicable, permitting application other than in person) for all such individuals;

''(C) provide for initial eligibility determinations and redeterminations and renewals of eligibility using the same verification policies, forms, and frequency for all such individuals; and

''(D) use the same face-to-face interview policy (including, if applicable, not requiring such an interview) for purposes of initial eligibility determinations and redeterminations, and renewals for all such individuals.''.

(d) NONAPPLICABILITY OF RESOURCE REQUIREMENTS TO MEDICARE PART D COST-SHARING.—Section 1905(p)(1) of the Social Security Act (42 U.S.C. 1396d(p)(1)) is amended by adding at the end the following flush sentence:

''In determining if an individual is a qualified medicare beneficiary under this paragraph, subparagraph (C) shall not be applied for purposes of providing the individual with medicare cost-sharing described in section 1905(p)(3)(B) (but only insofar as it relates to benefits provided under part D of title XVIII) or with medicare cost-sharing described in section 1905(p)(3)(E).''.

(e) NONAPPLICABILITY OF PAYMENT DIFFERENTIAL REQUIREMENTS TO MEDICARE PART D COST-SHARING.—Section 1902(n)(2) of the Social Security Act (42 U.S.C. 1396a(n)(2)) is amended by adding at the end the following new sentence: ''The preceding sentence shall not apply to the cost-sharing described in section 1860F(b).''.

(f) INCREASED FEDERAL MATCHING ASSISTANCE PERCENTAGE FOR CERTAIN INDIVIDUALS.—

(1) USE OF ENHANCED FMAP FOR INDIVIDUALS WITH INCOMES THAT EXCEED 120 PERCENT, BUT DO NOT EXCEED 150 PERCENT, OF THE POVERTY LINE.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)(4)) is amended—

(A) in paragraph (4), by inserting ''(A)'' after ''2105(b)''; and

(B) by inserting before the period at the end the following: '', and (B) with respect to medicare cost-sharing described in subparagraph (B) of section 1905(p)(3) (but only insofar as it relates to benefits provided under part D of title XVIII) and medicare cost-sharing described in subparagraph (E) of that section, but only in the case of individuals who are eligible for such assistance on the basis of clause (iv)(I) of section 1902(a)(10)(E)''.

(2) 100 PERCENT FEDERAL MATCHING ASSISTANCE PERCENTAGE FOR INDIVIDUALS WITH INCOMES THAT EXCEED 150 PERCENT, BUT DO NOT EXCEED 200 PERCENT, OF THE POVERTY LINE.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)(4)), as amended by paragraph (1), is amended—

(A) by striking ''and'' before ''(4)''; and

(B) by inserting before the period at the end the following: '', and (5) the Federal medical assistance percentage shall be 100 percent with respect to medicare cost-sharing described in subparagraph (B) of section 1905(p)(3) (but only insofar as it relates to benefits provided under part D of title XVIII) and medicare cost-sharing described in subparagraph (E) of that section, but only in the case of individuals who are eligible for such assistance on the basis of clause (iv)(II) of section 1902(a)(10)(E)''.

(g) TREATMENT OF TERRITORIES.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended by adding at the end the following new paragraph:

''(3) Notwithstanding the preceding provisions of this subsection, with respect to fiscal year 2005 and any fiscal year thereafter, the amount otherwise determined under this subsection (and subsection (f)) for the fiscal year for a Commonwealth or territory shall be increased by the ratio (as estimated by the Secretary) of—

''(A) the aggregate amount of payments made to the 50 States and the District of Columbia for the fiscal year under title XIX that are attributable to making medical assistance available for individuals described in clauses (i), (iii), and (iv) of section 1902(a)(10)(E) for payment of medicare cost-sharing described in section 1905(p)(3)(B) (but only insofar as it relates to benefits provided under part D of title XVIII) and medicare cost-sharing described in section 1905(p)(3)(E); to

''(B) the aggregate amount of total payments made to such States and District for the fiscal year under such title XIX.''.

(h) AMENDMENT TO BEST PRICE.—Section 1927(c)(1)(C)(i) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

(1) by striking ''and'' at the end of subclause (III);

(2) by striking the period at the end of subclause (IV) and inserting ''; and''; and

(3) by adding at the end the following new subclause:

''(V) any prices charged which are negotiated under a plan under part D of title XVIII with respect to covered outpatient drugs, under a Medicare+Choice plan under part C of such title with respect to such drugs, or by a qualified retiree prescription drug plan (as defined in section 1860J(e)(3)) with respect to such drugs, on behalf of eligible beneficiaries (as defined in section 1860(2)).''.

(i) CONFORMING AMENDMENTS.—Section 1933 of the Social Security Act (42 U.S.C. 1396u–3) is amended—

(1) in subsection (a), by striking ''section 1902(a)(10)(E)(iv)'' and inserting ''section 1902(a)(10)(E)(v)'';

(2) in subsection (c)(2)(A)—

(A) in clause (i), by striking ''section 1902(a)(10)(E)(iv)(I)'' and inserting ''section 1902(a)(10)(E)(v)(I)''; and

(B) in clause (ii), by striking ''section 1902(a)(10)(E)(iv)(II)'' and inserting ''section 1902(a)(10)(E)(v)(II)'';

(3) in subsection (d), by striking ''section 1902(a)(10)(E)(iv)'' and inserting ''section 1902(a)(10)(E)(v)''; and

(4) in subsection (e), by striking ''section 1902(a)(10)(E)(iv)'' and inserting ''section 1902(a)(10)(E)(v)''.

(j) EFFECTIVE DATE.—The amendments made by this section shall apply to medical assistance provided under section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) on and after January 1, 2005.

(k) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as precluding a State from using State funds to provide coverage of outpatient prescription drugs that is in addition to the coverage of such drugs required under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by this section.

(l) SENSE OF THE SENATE.—It is the sense of the Senate that during consideration of any conference report for this legislation, conferees should explore ways to provide incentives to States (and in particular to those States that, as of the date of enactment of this Act, offer some form of prescription drug assistance to the elderly and the disabled) to maintain existing State commitments to provide prescription drug assistance to the elderly and disabled or to supplement the drug benefit established by the conference report.

SEC. 205. MEDIGAP REVISIONS.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) MODERNIZED BENEFIT PACKAGES FOR MEDICARE SUPPLEMENTAL POLICIES.—

''(1) REVISION OF BENEFIT PACKAGES.—

''(A) IN GENERAL.—Notwithstanding subsection (p), the benefit packages classified as 'H', 'I', and 'J' under the standards established by subsection (p)(2) (including the benefit package classified as 'J' with a high deductible feature, as described in subsection (p)(11)) shall be revised so that—

''(i) the coverage of outpatient prescription drugs available under such benefit packages is replaced with coverage of outpatient prescription drugs that complements but does not duplicate the coverage of outpatient prescription drugs that is otherwise available under this title;

''(ii) the revised benefit packages provide a range of coverage options for outpatient prescription drugs for beneficiaries, but do not provide coverage for more than 90 percent of the cost-sharing amount applicable to an individual under section 1860F(b);

''(iii) uniform language and definitions are used with respect to such revised benefits;

''(iv) uniform format is used in the policy with respect to such revised benefits;

''(v) such revised standards meet any additional requirements imposed by the amendments made by the Medicare Outpatient Prescription Drug Act of 2002; and

''(vi) except as revised under the preceding clauses or as provided under subsection (p)(1)(E), the benefit packages are identical to the benefit packages that were available on the date of enactment of the Medicare Outpatient Prescription Drug Act of 2002.

''(B) MANNER OF REVISION.—The benefit packages revised under this section shall be revised in the manner described in subparagraph (E) of subsection (p)(1), except that for purposes of subparagraph (C) of such subsection, the standards established under this subsection shall take effect not later than January 1, 2005.

''(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as 'A' through 'G' under the standards established by subsection (p)(2) (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)) shall be construed as providing coverage for benefits for which payment may be made under part D.

''(3) GUARANTEED ISSUANCE AND RENEWAL OF REVISED POLICIES.—The provisions of subsections (q) and (s), including provisions of subsection (s)(3) (relating to special enrollment periods in cases of termination or disenrollment), shall apply to medicare supplemental policies revised under this subsection in the same manner as such provisions apply to medicare supplemental policies issued under the standards established under subsection (p).

''(4) OPPORTUNITY OF CURRENT POLICYHOLDERS TO PURCHASE REVISED POLICIES.—

''(A) IN GENERAL.—No medicare supplemental policy of an issuer with a benefit package that is revised under paragraph (1) shall be deemed to meet the standards in subsection (c) unless the issuer—

''(i) provides written notice during the 60-day period immediately preceding the open enrollment period established under section 1860B(a)(3), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer (at the most recent available address of that individual) of the offer described in clause (ii) and of the fact that such individual will no longer be covered under such policy as of January 1, 2005; and

''(ii) offers the policyholder or certificate holder under the terms described in subparagraph (B), during at least the period established under section 1860B(a)(3), a medicare supplemental policy with the benefit package that the Secretary determines is most comparable to the policy in which the individual is enrolled with coverage effective as of the date on which the individual is first entitled to benefits under part D.

''(B) TERMS OF OFFER DESCRIBED.—The terms described in this subparagraph are terms which do not—

''(i) deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (A)(ii) that is offered and is available for issuance to new enrollees by such issuer;

''(ii) discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition; or

''(iii) impose an exclusion of benefits based on a preexisting condition under such policy.

''(5) ELIMINATION OF OBSOLETE POLICIES WITH NO GRANDFATHERING.—No person may sell, issue, or renew a medicare supplemental policy with a benefit package that is classified as 'H', 'I', or 'J' (or with a benefit package classified as 'J' with a high deductible feature) that has not been revised under this subsection on or after January 1, 2005.

''(6) PENALTIES.—Each penalty under this section shall apply with respect to policies revised under this subsection as if such policies were issued under the standards established under subsection (p), including the penalties under subsections (a), (d), (p)(8), (p)(9), (q)(5), (r)(6)(A), (s)(4), and (t)(2)(D).''.

SEC. 206. COMPREHENSIVE IMMUNOSUPPRESSIVE DRUG COVERAGE FOR TRANSPLANT PATIENTS UNDER PART B.

(a) IN GENERAL.—Section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)), as amended by section 113(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–473), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by striking '', to an individual who receives'' and all that follows before the semicolon at the end and inserting ''to an individual who has received an organ transplant''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to drugs furnished on or after the date of enactment of this Act.

SEC. 207. HHS STUDY AND REPORT ON UNIFORM PHARMACY BENEFIT CARDS.

(a) STUDIES.—The Secretary of Health and Human Services shall conduct a study to determine the feasibility and advisability of establishing a uniform format for pharmacy benefit cards provided to beneficiaries by eligible entities under the outpatient prescription drug benefit program under part D of title XVIII of the Social Security Act (as added by section 202).

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the results of the study conducted under subsection (a) together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.

SEC. 208. GAO STUDY AND BIENNIAL REPORTS ON COMPETITION AND SAVINGS.

(a) ONGOING STUDY.—The Comptroller General of the United States shall conduct an ongoing study and analysis of the outpatient prescription drug benefit program under part D of title XVIII of the Social Security Act (as added by section 202), including an analysis of—

(1) the extent to which the competitive bidding process under such program fosters maximum competition and efficiency; and

(2) the savings to the medicare program resulting from such outpatient prescription drug benefit program, including the reduction in the number or length of hospital visits.

(b) INITIAL REPORT ON COMPETITIVE BIDDING PROCESS.—Not later than 9 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the results of the portion of the study conducted pursuant to subsection (a)(1).

(c) BIENNIAL REPORTS.—Not later than January 1, 2006, and biennially thereafter, the Comptroller General of the United States shall submit to Congress a report on the results of the study conducted under subsection (a) together with such recommendations for legislation and administrative action as the Comptroller General determines appropriate.

SEC. 209. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXPANSION OF MEMBERSHIP.—

(1) IN GENERAL.—Section 1805(c) of the Social Security Act (42 U.S.C. 1395b–6(c)) is amended—

(A) in paragraph (1), by striking ''17'' and inserting ''19''; and

(B) in paragraph (2)(B), by inserting ''experts in the area of pharmacology and prescription drug benefit programs,'' after ''other health professionals,''.

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b–6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under paragraph (1)(A) are as follows:

(i) One member shall be appointed for 1 year.

(ii) One member shall be appointed for 2 years.

(B) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2004.

(b) EXPANSION OF DUTIES.—Section 1805(b)(2) of the Social Security Act (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

''(D) PRESCRIPTION MEDICINE BENEFIT PROGRAM.—Specifically, the Commission shall review, with respect to the outpatient prescription drug benefit program under part D, the impact of such program on—

''(i) the pharmaceutical market, including costs and pricing of pharmaceuticals, beneficiary access to such pharmaceuticals, and trends in research and development;

''(ii) franchise, independent, and rural pharmacies; and

''(iii) beneficiary access to outpatient prescription drugs, including an assessment of out-of-pocket spending, generic and brand name drug utilization, and pharmacists' services.''.

SA 4346. Ms. LANDRIEU submitted an amendment intended to be proposed by her to the bill H.R. 5010, making appropriations for the Department of Defense for the fiscal year ending September 30, 2003, and for other purposes; which was ordered to lie on the table; as follows:

On page 223, between lines 20 and 21, insert the following:

SEC. 8124. Of the amount appropriated by title II under the heading ''OPERATION AND MAINTENANCE, NAVY'', up to $4,000,000 may be available for Configuration Management Information Systems.

SA 4347. Ms. LANDRIEU submitted an amendment intended to be proposed by her to the bill H.R. 5010, making appropriations for the Department of Defense for the fiscal year ending September 30, 2003, and for other purposes; which was ordered to lie on the table; as follows:

On page 223, between lines 20 and 21, insert the following:

SEC. 8124. Of the amount appropriated by title II under the heading ''OPERATION AND MAINTENANCE, ARMY'', up to $5,000,000 may be available for the Field Pack-up Containerized Storage Unit.

SA 4348. Ms. LANDRIEU submitted an amendment intended to be proposed by her to the bill H.R. 5010, making appropriations for the Department of Defense for the fiscal year ending September 30, 2003, and for other purposes; which was ordered to lie on the table; as follows:

On page 223, between lines 20 and 21, insert the following:

SEC. 8124. The Secretary of Defense may, using amounts appropriated or otherwise made available by this Act, make a grant to the National D–Day Museum in the amount of $5,000,000.

SA 4349. Mr. HUTCHINSON submitted an amendment intended to be proposed to amendment SA 4345 proposed by Mr. GRAHAM (for himself, Mr. SMITH of Oregon, Mr. MILLER, Mrs. LINCOLN, Mr. BINGAMAN, Mr. KENNEDY, and Ms. STABENOW) to the amendment SA 4299 proposed by Mr. REID (for Mr. DORGAN (for himself, Mr. WELLSTONE, Mr. JEFFORDS, Ms. STABENOW, Ms. COLLINS, Mr. LEVIN, Mr. JOHNSON, Mr. MILLER, Mr. DURBIN, Mr. FEINGOLD, and Mr. HARKIN) to the bill (S. 812) to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

On Page 21, strike lines 6 through 20.
On Page 24, strike lines 14 through 22.
On Page 26, strike lines 18 through 25.

On Page 27, strike lines 1 through 3.
On Page 57, strike lines 1 through 25.
On Page 58, strike lines 1 through 22.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on Tuesday, July 30, 2002, at 2 p.m. to conduct a hearing on the nominations of Mr. Ben S. Bernanke, of New Jersey, to be a member of the Board of Governors of the Federal Reserve System; and Mr. Donald L. Kohn, of Virginia, to be a member of the Board of Governors of the Federal Reserve System.

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

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on Tuesday, July 30, 2002, at 9:30 a.m. on the Financial Turmoil in the Telecommunications Marketplace; Maintaining the Operations of Essential Communications Facilities.

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

COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Environment and Public Works be authorized to meet on Tuesday, July 30, 2002, at 9:30 a.m. to conduct a hearing to examine the effectiveness of the current Congestion Mitigation and Air Quality, CMAQ, program, conformity, and the role of new technologies.

The hearing will be held in SD–406.

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

COMMITTEE ON FINANCE

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session of the Senate on Tuesday, July 30, 2002, at 10 a.m. to hear testimony on the Role of the Extraterritorial Income Exclusion Act in the International Competitiveness of U.S. Companies.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Tuesday, July 30, 2002, at 9 a.m. to hold a business meeting.

Agenda

The Committee will consider and vote on the following agenda items:

Treaties

1. Treaty Doc. 96–53; Convention on the Elimination of All Forms of Discrimination Against Women, adopted by the U.N. General Assembly on December 18, 1979, and signed on behalf of the United States of America on July 17, 1980.

2. Treaty Doc. 103–5; Protocol Concerning Specially Protected Areas and Wildlife to the Convention for the Protection and Development of the Marine Environment of the Wider Caribbean Region, done at Kingston on January 18, 1990.

2. Treaty Doc. 107–2; Protocol to Amend the 1949 Convention on the Establishment of an Inter-American Tropical Tuna Commission, done at Guayaquil, June 11, 1999, and signed by the United States, subject to ratification, in Guayaquil, Ecuador, on the same date.

Legislation

1. S. 1777, A bill to authorize assistance for individuals with disabilities in foreign countries, including victims of landmines and other victims of civil strife and warfare, and for other purposes, with amendments.

Nominations

1. Mr. John Blaney, of Virginia, to be Ambassador to the Republic of Liberia.

2. Ms. Aurelia Brazeal, of Georgia, to be Ambassador to the Federal Democratic Republic of Ethiopia.

3. Mr. Martin Brennan, of California, to be Ambassador to the Republic of Zambia.

4. Mr. J. Anthony Holmes, of California, to be Ambassador to Burkina Faso.

5. Ms. Vicki Huddleston, of Arizona, to be Ambassador to the Republic of Mali.

6. Mr. Donald Johnson, of Texas, to be Ambassador to the Republic of Cape Verde.

7. Ms. Kristie A. Kenney, of Maryland, to be Ambassador to the Republic of Ecuador.

8. Mr. Jimmy Kolker, of Missouri, to be Ambassador to the Republic of Uganda.

9. Ms. Gail Mathieu, of New Jersey, to be Ambassador to the Republic of Niger.

10. Mrs. Barbara C. Moore, of Maryland, to be Ambassador to the Republic of Nicaragua.

11. Mr. Larry L. Palmer, of Georgia, to be Ambassador to the Republic of Honduras.

12. Mr. James Yellin, of Pennsylvania, to be Ambassador to the Republic of Burundi.

Additional items may be announced.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Tuesday, July 30, 2002, at 11 a.m. to hold a nomination hearing.

Agenda

Nominees

Ms. Nancy J. Powell, of Iowa, to be Ambassador to the Islamic Republic of Pakistan.

Mr. Richard L. Baltimore, III, of New York, to be Ambassador to the Sultanate of Oman.

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

COMMITTEE ON INDIAN AFFAIRS

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet on Tuesday, July 30, 2002, at 10:00 a.m. in Room 106 of the Dirksen Senate Office Building to conduct a hearing on a Legislative Proposal of the Department of Interior/Tribal Trust Fund Reform Task Force; to be followed immediately by a second hearing on S. 2212, a bill to establish a direct line of authority for the Office of Trust Reform Implementations and Oversight to oversee the management and reform of Indian trust funds and assets under the jurisdiction of the Department of the Interior, and to advance tribal management of such funds and assets, pursuant to the Indian Self-Determinations Act and for other purposes.

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

SUBCOMMITTEE ON CONSUMER AFFAIRS

Mr. REID. Mr. President, I ask unanimous consent that the subcommittee on Consumer Affairs of the Committee on Commerce, Science, and Transportation be authorized to meet on Tuesday, July 30, 2002, at 2:30 pm on improving consumer choice in auto repair shops.

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

SUBCOMMITTEE ON EMERGING THREATS AND CAPABILITIES

Mr. REID. Mr. President, I ask unanimous consent that the Subcommittee on Emerging Threats and Capabilities of the Committee on Armed Services be authorized to meet during the session of the Senate on Tuesday, July 30, 2002, at 2:30 p.m., in open session to receive testimony on the report of the General Accounting Office on Nuclear Nonproliferation and efforts to help other countries combat nuclear smuggling.

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

SUBCOMMITTEE ON PUBLIC LANDS AND FORESTS

Mr. REID. Mr. President, I ask unanimous consent that the Subcommittee on Public Lands and Forests of the Committee on Energy and Natural Resources be authorized to hold a Hearing during the session of the Senate on Tuesday, July 30, 2002, at 2:30 p.m. in SD–366. The purpose of this hearing is to receive testimony on the following bills:

S. 2016, to authorize an exchange of lands between an Alaska Native Village Corporation and the Department of the Interior, and for other purposes;

S. 2565, to enhance ecosystem protection and the range of outdoor opportunities protected by statute in the

Skykomish River Valley of the State of Washington by designating certain lower-elevation Federal lands as wilderness, and for other purposes;

S. 2587, to establish the Joint Federal and State Navigable Waters Commission for Alaska;

S. 2612, to establish wilderness areas, promote conservation, improve public land, and provide for high quality development in Clark County, Nevada, and for other purposes;

S. 2652, to authorize the Secretary of Agriculture to sell or exchange certain land in the State of Florida, and for other purposes; and

S. Con. Res. 107, expressing the sense of Congress that Federal land management agencies should fully support the Western Governors Association ''Collaborative 10-year Strategy for Reducing Wildland Fire Risks to Communities and the Environment'', as signed August 2001, to reduce the overabundance of forest fuels that place national resources at high risk of catastrophic wildfire, and prepare a National Prescribed Fire Strategy that minimizes risks of escape.

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

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Mr. REID. Mr. President, I ask unanimous consent that the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs be authorized to meet on Tuesday, July 30, 2002, at 9:30 a.m., for a hearing entitled ''The Role of the Financial Institutions In Enron's Collapse.''

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

PRIVILEGES OF THE FLOOR

Mrs. LINCOLN. Mr. President, I ask unanimous consent that privilege of the floor be granted to Michael Anzick and Elizabeth Pika, two fellows in my office, during debate on this legislation.

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

Mr. GRAHAM. Mr. President, I ask unanimous consent to grant floor privileges to Dr. Louis Kazal, a health fellow from the office of Senator KENT CONRAD, for the duration of debate on S. 812 and related amendments.

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

Mr. HATCH. Madam President, I ask unanimous consent that my aides, Christopher Rogers and Matt Hargraves, be granted the privilege of the floor for the duration of the debate on Judge D. Brooks Smith.

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

ORDER OF PROCEDURE

Mr. REID. Mr. President, I have a few things to do here to close, a very few. Then the Senator from Utah wants to speak for 5 minutes, and the Senator from Florida will speak for 10.

APPOINTMENTS

The PRESIDING OFFICER. The Chair announces, on behalf of the two Leaders, pursuant to provisions of S. Res. 98, agreed to July 25, 1997, the appointment of the Senator from Nevada [Mr. REID] to the Global Climate Change Observer Group, vice the Senator from Nebraska [Mr. Kerrey], retired.

The Chair, on behalf of the President pro tempore, pursuant to P.L. 103–227, reappoints Barbara Kairson, of New York, Representative of Labor, to the National Skill Standards Board, effective August 13, 2002.

ORDERS FOR WEDNESDAY, JULY 31, 2002

Mr. REID. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand adjourned until 9:30 a.m. Wednesday, July 31; that on Wednesday, following the prayer and the pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, and the time for the two leaders be reserved for their use later in the day; that the Senate then resume consideration of Calendar No. 491, S. 812, as provided for under the previous order; provided further that after the first vote on the motion to waive the Budget Act with respect to the Graham amendment, there be 2 minutes of debate before each succeeding vote, equally divided and controlled in the usual form; and each succeeding vote following the first in the sequence be 10 minutes in duration; that the mandatory quorum required under rule XXII be waived with respect to the cloture motion and the conference report accompanying H.R. 3009.

I have a parliamentary inquiry, Mr. President. Under this unanimous consent agreement, would the debate time prior to the vote on judicial nomination of Brooks Smith be 2 minutes equally divided?

The PRESIDING OFFICER. Yes. The Senator is correct in assuming that.

Mr. REID. I ask unanimous consent that be modified to give Senator LEAHY 2½ minutes and Senator HATCH 2½ minutes.

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

ORDER FOR ADJOURNMENT

Mr. REID. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent we stand in adjournment under the previous order, following the remarks of the Senator from Utah, for 6 minutes, and the Senator from Florida, for 12 minutes.

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

The Senator from Utah is recognized.

JUDICIAL NOMINATIONS

Mr. HATCH. Mr. President, I do have to make a few remarks since my colleague from New York made some very cogent, very important remarks this evening.

I happen to have a lot of respect for my colleague from New York, and he has the guts to really stand up and say that one of the reasons he is voting against some of these judges is the question of ideology. I think he is dead wrong on that, but the fact is, I respect him for at least being upfront and stating what he believes.

He has also said we need to have balance on the courts. I am not so sure that is a bad concept, but I believe whoever is President, we have to have that President's choice of judges. That is one thing we do when we elect a President. Unless you can find some really valid reason for voting against these judges, that I think has to be more than ideology—at least that is my view—then you should vote for those judges, which is a practice I have followed throughout the Clinton administration and throughout the Carter administration, as a matter of fact. I think it is the correct practice.

I still respect my colleague for his beliefs, for his forthright statements.

I want to correct the record on a few things. No. 1, with regard to balance, there is a lack of balance in many circuit courts of appeals today one way or the other. In the Ninth Circuit Court of Appeals, 17 of the 23 judges are Democrats; 14 were appointed by none other than President William Jefferson Clinton.

In the Second Circuit Court of Appeals, the majority of them are Democrats.

These are two very important circuit courts. In the Circuit Court of Appeals for the District of Columbia, it could very easily have been that way.

It comes down to whoever is President. That is one of the things we do when we choose a President: We choose the person who is going to pick the judges for the next 4 years. And I believe, unless you have a legitimate reason—and it has to be a very legitimate reason for opposing those judges—you need to vote for them.

I heard the distinguished Senator from Vermont tonight say Judge Smith rules too much for corporations. Give me a break. He has been on the bench 14 years. He has ruled for everybody during those 14 years. And, by the way, occasionally corporations are right. And if they are right, as judges in this country they ought to rule in their favor if it is a nonjury trial. They ought to be fair in their instructions if it is a jury trial and in the conduct of the trial if it is a jury trial. Brooks Smith has had that type of reputation.

With regard to another comment of my friend from New York, he continues to repeat a myth that arose out of the Clarence Thomas proceedings. I happened to be there during those Clarence Thomas proceedings, and that myth is that he said he never discussed Roe v. Wade. That is not what he said. He was

asked directly, and he said: I never debated it with my philosophy classmates. That is a considerably different answer.

And from that, they extrapolated he never discussed it, and he wasn't asked any further questions about it by the same person who asked that question.

The fact of the matter is, some ideologically disagree with Justice Thomas. Many on our side disagree with Justice Thurgood Marshall. I happened to have respected him greatly. I didn't agree with a lot of the things he wrote, but I also respected him.

Clarence Thomas is writing some of the most literate, intelligent decisions on the Supreme Court right now.

Let me say the danger of the position of my friend from New York, in saying ideology counts, is: Whose ideology? Because I have seen some very conservative judges get on the bench and become very liberal judges almost overnight. I have seen some very liberal judges get on the bench and become very conservative judges—maybe not overnight but certainly in time.

I have to ask you, if you start talking ideology, whose ideology? There are differences on the Democratic side on ideology. There are differences on the Republican side on ideology. Are we going to have a single litmus test to bar somebody from serving just because they may be against Roe v. Wade or may be pro-life? Are we going to have a litmus test against somebody serving because they once participated as a corporate lawyer? A terrible thing to do, I guess.

No, we should not do that. If we took that attitude, that Roe v. Wade is paramount and preeminent in all judicial considerations, there would have been very few Clinton judges. As I say, he came very close, virtually was the same as the all-time confirmation champion, Ronald Reagan.

So that is the danger, in my belief and in my philosophy, of the position of the distinguished Senator from New York. I respect the position. I respect his openness. I respect his forthrightness. I respect him personally. He is very intelligent, a good lawyer—some would say a great lawyer. I would say that. I enjoy being with him on the Judiciary Committee. But his doctrine is a dangerous doctrine because—whose ideology?

People have tried to stereotype me the whole time I have been in the Senate. I just got finished writing a book that will be published this fall. It is going to be called ''The Square Peg.'' Guess who the square peg is. The fact is, that book is going to show I don't particularly fit in any category. Neither does the Senator from New York. In some respects, he is a very conservative Senator. In other respects, he is very liberal. I have had the same thing said about me. Does that mean neither of us could serve on any court because we might be conservative on some issues, we might be liberal on other issues, that offend some in this body? No, it should not mean that.

Look, if a person is out of the mainstream, that is another matter. But I have seen the argument come up time after time the judges are outside of the judicial mainstream. That is pure bunk, to be honest with you. They do not get through this process where they are nominated by any President of the United States by being outside of the mainstream. They just do not. Some are conservative and some are liberal. This President has nominated some very liberal judges. He has nominated some very good conservative judges. He has nominated people in between. He has nominated Democrats. He has nominated Republicans.

But it is dangerous to say that anybody's personal ideology ought to determine whether a person serves on the bench if that person is otherwise qualified.

I hope my colleague who is forced to sit there and listen to me at this time as the Presiding Officer will reconsider at least some aspects of his position because he may be chairman of the Judiciary Committee someday. When he is, he is going to find that in the interest of fairness, you have to presume and give the benefit of the doubt to the President's nominee, especially unless you can show that they are outside of the mainstream of American jurisprudence.

I have to tell you that I haven't seen many—in my whole time in 26 years in the Senate and confirming almost every judge that currently sits on the Federal bench—that I would consider coming close to being outside of the mainstream of American jurisprudence. By the time they get through the vetting process at the White House, the vetting process of the FBI, the vetting process of the American Bar Association, and when they wind up with a well-qualified rating from the American Bar Association, you can't say they are outside of the mainstream of American jurisprudence, nor can you say that because they differ with you ideologically you have to vote against them.

I happen to love my colleague. I just hope he will reconsider because I don't want him leading those who are less mentally equipped down the primrose path of partisan politics.

I yield the floor to my dear colleague and friend from Florida, who has really fought that good battle on S. 812, which is something I very much respect.

The PRESIDING OFFICER. The Senator from Florida is recognized after the eloquent and kind remarks of the Senator from Utah.

Mr. GRAHAM. Mr. President, I also appreciate the kind remarks of the Senator from Utah and hope that he will open his CONGRESSIONAL RECORD tomorrow and will read the remarks that I am going to be delivering shortly, as we both share a very strong interest in the same destination, which is to assure that the 40 million Americans who are currently benefitting by Medicare will see in this year a fulfillment of a long held aspiration, which is to expand Medicare benefits to include prescription drugs.

GREATER ACCESS TO AFFORDABLE PHARMACEUTICALS

Mr. GRAHAM. Mr. President, along with my colleague, Senator GORDON SMITH of Oregon, and a number of other Members of the Senate, earlier today I introduced an amendment which will be debated beginning at 9:30 tomorrow, and voted on at 11 o'clock.

I would like to use this opportunity to briefly summarize some of the elements of that amendment, and then use that as the basis to respond to some comments which have been made questioning the desirability and appropriateness of passage of this amendment.

Our amendment has a simple objective. It is to bring Medicare into the 21st century by providing for it what virtually every private health insurance plan has—coverage of prescription drugs.

When Medicare was established in 1965, prescription drugs were a relatively minor part of a comprehensive health care program. In fact, it is surprising to know that in 1965 the average senior American spent $65 a year on prescription drugs. That number has increased 35 times to over $2,100 as the average amount that senior Americans are spending this year on prescription drugs.

Our objective is to provide a modern Medicare Program by providing a critical missing element from the current program.

In our debate a week ago, there was a great deal of concern about the cost of the plan. I introduced a plan which would have met fully the standards of universal coverage, comprehensive in terms of drugs covered, and affordable to the beneficiary. That plan received 52 votes, which obviously is a majority of the Senate. Unfortunately, we weren't debating under the rules of majority rule. We were debating under the rules that said you had to have 60 votes in order to overcome procedural hurdles. We fell short of those 60 votes.

One of the reasons given for not voting for our plan was that it was just too expensive; it had to be reined in.

So we spent the last week reviewing our proposal to see what we could do in order to make it more acceptable to our brethren so that we can get the 60 votes.

I want to again recognize and thank my colleague, Senator GORDON SMITH, for the great contribution he has made in accomplishing this task.

But one of the things we did was to say we are going to develop a plan which would cost no more than $400 billion over the next 10 years. We received today from the Congressional Budget Office their scoring of our plan where they found the plan actually had a cost of $389 billion over the next 10 years. We thought that would be a goal—holding the cost to under $400 billion that

would result in the support of people who had not voted for our bill last year, saying: This is a proposition for which I can vote. Unfortunately, we didn't get that reaction. But we got the reaction that challenged the Congressional Budget Office, and whether it had accurately scored our bill.

That is a little bit like challenging the umpire in a baseball game you think is not calling the ball in the strike zone. We decided, just like the American and National leagues decided, that we were going to have an umpire for our deliberations, including an umpire for our deliberations over a whole variety of spending, tax, health care, and other proposals that are going to cost the Federal Treasury. The Congressional Budget Office is that umpire. They have looked at our plan. They have given it a score of $389 billion.

It is interesting that the same persons who were challenging us and who offered a competing plan have not received a Congressional Budget Office estimate of their cost. We don't know what their plan is going to cost when the common standards of evaluation are applied. The one that will be before us tomorrow has a Congressional Budget Office estimate of $389 billion.

The second thing we did was we looked at the architecture of the bill. We said we would like to have universal coverage, but we don't have enough resources to provide meaningful universal coverage.

So we have two basic choices: One, you can put water in the soup, make it thinner, and spread it out over more people or you can say, no, we are going to identify those Americans who are most adversely affected by the Medicare benefit for prescription drugs. We identify those people as being in two groups. One is those older Americans who have unlikely high prescription drug bills.

I mentioned earlier the average senior American is a little more than $2,100. We set the standard of $3,300 for catastrophic. That is when the cost of prescription drugs becomes beyond what you can expect many senior Americans can pay. Remember, the average income for senior Americans this year is about $14,000 to $15,000.

Second, we said the next group we would like to help is the neediest, those who have the lowest income; and, therefore, the cost of prescription drugs takes a disproportionate amount of their meager income.

We also said, however, there should be some benefits that all of America's seniors can secure. For that group of Americans, we are going to provide the opportunity for a modest $25 a year enrollment fee to get a card, which will entitle them to get the benefits of pharmacy benefit managers, who will negotiate with the pharmaceutical companies to get discounted prices, which will then be made available to the Medicare beneficiaries.

In order to assure that those PBMs will be part of this and that all the seniors will get even beyond what can be negotiated, we are going to provide a 5-percent supplemental reduction of the cost.

For example, if a senior had the standard cost of $100 for a particular prescription, PBMs are estimated to be able to negotiate between a 15 and a 25-percent discount, so assume they can get 20 percent; that would reduce the cost of the drugs to 80 percent. Then the Federal Government would pick up 5 percent of that cost, or $4, so that the senior, instead of paying $100, would be paying $76. That is not an insignificant benefit.

That same senior would also have an insurance policy against catastrophic losses at $3,300. The peace of mind, the reduction of the fear of what the consequences would be if a healthy senior has a heart attack or develops some other serious chronic disease, where suddenly their prescription drug costs are escalating, this will give them that peace of mind.

There was another objection raised to that format that I just outlined, and that is, for the first time in the history of Medicare, we are going to be making a differential; we are going to be recognizing these Americans who have the lowest income among the 40 million seniors and give them some special benefits to help them, because they are the neediest of our seniors, to be able to meet the cost of their prescription drugs. I plead guilty. We are doing that.

We are saying that the poorest of America's seniors, which we define as those who are at or below 200 percent of poverty, will get prescription drugs from the time they enroll in this program, with only a modest copayment of $2 for generic drugs and $5 for brand name drugs.

It is said this is the first time we have ever split the Medicare population and provided such special treatment for a class; in this case, a class defined because of the level of their need. That is not true. In fact, we have a number of examples in Medicare today where we are providing different benefits based on income. Just to mention two of those, we have a program called SLiMBies and QMBies.

SLiMBies are for those Americans who have an income between 100 percent and 120 percent of poverty. For those, there is a payment of the Part B premiums, which today are running approximately $50 a month. The Federal Government picks up the cost of those payments for Americans between 100 and 120 percent of poverty. For those who are at or below 100 percent of poverty, we not only pay for their premiums, we also pay for their deductibles and their coinsurance.

So America, a compassionate society, has had a history of recognizing the special circumstances of the neediest of our elderly. We will extend that policy by the amendment which we will vote on tomorrow.

We will have, as the delivery system for this drug benefit, Medicare as we have known it, Medicare as it has served the interests of senior Americans for 37 years.

There are some who say that is an out-of-date system; it is an antiquated process, that we need to get private insurance to deliver prescription drug benefits.

That was an intriguing idea, so I began to ask: What is our experience with private insurance delivering a prescription drug benefit? In fact, I had the conversation with a number of pharmaceutical company executives who have been a primary advocate of this plan, private insurance delivering prescription drug benefits. I asked: How do you, and how do your employees, get their prescription drugs? They said: Well, we have a contract with an insurance company that provides for the health care coverage of our employees, including myself and they, in turn, contract with a pharmacy benefit manager to administer the drug component of our health care program.

I said: No. Do you have, for the drug component of health care for your employees, a separate program with a separate private insurance policy?

They said: No, we don't have such a program. In fact, I don't think one exists.

Do know what. They are right. One does not exist. Nobody is offering a prescription drug-only private insurance policy, which is what some would say should be the method by which we deliver prescription drugs to 40 million older Americans.

I would analogize it to putting those 40 million older Americans on the Wright brothers first flight at Kitty Hawk. Do you want to really experiment with such a significant part of the health care of older Americans when nobody in any other sector, public or private, is using such a plan? I don't think that is a very prudent or conservative idea.

Why are there no insurance companies that are providing a drug-only prescription benefit? The answer is: Because they say it is not an insurable risk. It would be the same answer that you would get if you were to ask: I own a house, and I want to buy fire insurance, but I only want to buy the fire insurance to cover the kitchen, or I have a rear bedroom which is next to an old and creeky tree that might fall over and crush the roof in a wind storm, so I only want to cover that back room.

The insurance company would turn you down. They would say: We are not going to insure a specific room within your house; we will insure your whole house and take the total risk, but we won't let you parcel it out piece by piece.

That is the same answer as to why no private insurance company today is providing a prescription drug-only benefit. They will insure your whole body. They will insure all of the health care that you might require. But they will

not break it down into individual fragmented pieces, such as a prescription drug-only insurance policy.

There are some other concerns, such as if you were to go to a private insurance policy, you would run very strong possibilities that there would be big sections of the country that would not be covered because they have populations that are peculiarly expensive. One of those which we are already seeing in the whole body of insurance called Medicare+Choice—an HMO that insures not just prescription drugs but all of your health care needs—is almost nonexistent in rural America.

Why are they not in rural America? It is not because there are not doctors and hospitals and other facilities that can treat people in rural America. It is because the population of seniors in rural America is actuarially expensive and, therefore, an unattractive population to insure and treat.

According to a 1998 report by the Kaiser Family Foundation, rural beneficiaries are 20 percent more likely to be in fair or poor health than their urban cousins. Rural seniors are 20 percent more likely to be under 150 percent of the Federal poverty level than their urban cousins.

A study that was done in June of this year by the National Economic Council said that rural beneficiaries are 50 percent less likely to have drug coverage compared to their urban counterparts, which probably means they are less healthy because they have not had equal access to drugs. They use 10 percent more prescriptions than urban seniors, and nearly 60 percent of rural beneficiaries reported not being able to purchase drugs because of their cost.

We know from our experience with Medicare+Choice that HMOs will not accept the risk of covering this urban population. What leads us to believe they are not similarly going to be left behind with this effort to have prescription drug only insurance policies? I think the answer is, unfortunately, they will be left behind.

This last issue is not really a debate about drug coverage. It is a debate, rather, about Medicare itself. Shall Medicare continue to be a universal program that is administered through the Federal Government or shall it be a program whose administration will be privatized? That is the debate.

We know there are people in this Chamber and particularly the predecessors who were here in the 1960s who thought that Medicare would fail, that it was not a sustainable system. I say quite to the contrary, Medicare has delivered on its promise of substantially increasing the health and welfare of older Americans.

That brings me to my concluding observation which is that today is a fortuitous day to be having this debate because it happens to be the anniversary of Medicare. On July 30, 1965, then-President Lyndon Johnson went to Independence, MO, the home of President Harry Truman, a man who had spent much of his political career advocating for the needs of senior Americans and particularly access to affordable health care. So it was fitting and proper that President Johnson signed the bill at their home and then gave the first two Medicare cards to President Harry Truman and his wife Bess. That is the tradition we have had, a great tradition of service, respectful and compassionate, to America's seniors.

We would honor that tradition if tomorrow we adopt the amendment which will for the first time in its history expand a prescription drug benefit for the beneficiaries of Medicare. It is a step which will not only honor those who 37 years ago championed this program, but it will also honor those who are served by it today, our grandparents, our parents, our family, and friends who look to Medicare as the means of securing their health care. Those are the people for whom we will be voting tomorrow.

I hope my colleagues will grasp this opportunity to see that we bring Medicare into the 21st century.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9:30 a.m., Wednesday, July 31, 2002.

Thereupon, the Senate, at 9:03 p.m., adjourned until Wednesday, July 31, 2002, at 9:30 a.m.