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Senate

The Senate met at 9:30 a.m. and was called to order by the Honorable SAXBY CHAMBLISS, a Senator from Georgia.

PRAYER

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

Let us pray.

God of grace and glory, we owe You far more than we can ever repay. Thank You for Your gift of abundant life and freedom from the chains of evil. Thank You also for the love of family, for the joy of health, and for the challenges that make us stronger.

Lord, deliver us from pride and ingratitude. Inspire our leaders with Your presence. May each Senator enable You to lay the foundation for every decision he or she makes. Protect these leaders as they come and go.

Continue to keep each of us from falling. Empower us to be faithful to our high calling to be Your sons and daughters. Bless our military and all who risk their lives for freedom. We pray this in Your gracious Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable SAXBY CHAMBLISS 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. STEVENS).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, February 24, 2004.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable SAXBY CHAMBLISS, a Senator from the State of Georgia, to perform the duties of the Chair.

TED STEVENS,
President pro tempore.

Mr. CHAMBLISS thereupon assumed the Chair as Acting President pro tempore.

RESERVATION OF LEADER TIME

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

RECOGNITION OF THE ACTING MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The Senator from Nevada.

SCHEDULE

Mr. ENSIGN. Mr. President, today the Senate resumes consideration of the motion to proceed to S. 2061, the OB/GYN medical malpractice bill. Senators who wish to speak on the bill are encouraged to come to the floor during today's session. The Senate will recess from 12:30 until 2:15 for the weekly party lunches.

At 5 p.m. the Senate will vote on the motion to invoke cloture on the motion to proceed to the bill. As a reminder, last night the majority leader filed cloture on the motion to proceed to S. 1805, the gun liability bill. The cloture vote on the motion to proceed to the gun liability bill will occur on Wednesday.

I ask unanimous consent that the time until 12:30 p.m. be equally divided between the two managers or their designees; provided further that the time from 2:15 until 4:50 p.m. be equally divided in the same manner; with the final 10 minutes prior to the 5 p.m. cloture vote equally divided between the two leaders or their designees, with the majority leader in control of the final 5 minutes.

Mr. REID. Mr. President, this is an equitable distribution of time and will save a lot of confusion. We therefore agree.

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

HEALTHY MOTHERS AND HEALTHY BABIES ACCESS TO CARE ACT OF 2003—MOTION TO PROCEED

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of the motion to proceed to consideration of S. 2061.

Mr. ENSIGN. Mr. President, I wish to make a few opening comments on the medical liability bill. Last year we had a debate in the Senate on proceeding—not voting on but proceeding—to an overall medical liability reform bill. That vote was 49 to 48 in favor of going to the bill. Unfortunately, the rules of the Senate provide that one needs 60 votes. Otherwise, a filibuster, as it is commonly referred to, is continued. You cannot proceed to debating the legislation or to votes or amendments.

There are currently 19 States, according to the American Medical Association, that are in crisis. Nineteen States are experiencing some kind of crisis with their medical system because of problems with medical liability insurance. All but 5 States of the remaining are showing some problems, the type of problems that have led to those 19 States being in crisis.

We had the vote last year and couldn't get it done. Senator GREGG and I have introduced the bill before us today, the Healthy Mothers and Healthy Babies Access to Medical Care Act. This bill limits the scope of reform of the medical liability system to the practice of obstetrics and gynecology and the doctors involved in those practices.

Using my own State as an example, at the University of Nevada School of

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

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Medicine there has been a dramatic decrease in the number of medical students deciding to go into obstetrics. This is happening at a time when Nevada is the fastest growing State in the country. Southern Nevada—Las Vegas, in particular—is by far the fastest growing metropolitan area in the Nation. Not only are we not adding the OB/GYNs we need, we are actually losing them.

The other side will argue that the General Accounting Office did a study and determined that doctors are not giving up their licenses. They said that doctors are not leaving their States.

The problem with what the General Accounting Office did is, they went to the State boards and only did a survey of licenses. I was a practicing veterinarian and still have a license in veterinary medicine. Once you have a license, you never give it up because you never want to take the exam again. So when the General Accounting Office asked the State board of medical examiners how many doctors have given up their licenses, and they found out nobody had given up their licenses, that should not surprise anybody because they are not going to give them up. That does not mean these doctors are not quitting practice in Nevada and other States—Pennsylvania, West Virginia, Washington State, Mississippi, and many others around the country. It means they haven't given up their licenses because they don't want to take the exam again. But they are limiting their practices. And many of them are leaving those States that are affected.

Several years ago, California gave us a good model. California is right next to my State of Nevada. California passed what is known as MICRA. It is a medical liability reform bill. Luckily, they passed it back then because the trial lawyers have become so powerful across the United States that you could never get the same piece of legislation passed in California. That would be a shame because it has worked so well. It is the model around which we built the legislation on the Senate floor today.

In California—Los Angeles, for example—OB/GYN medical liability insurance is somewhere a little over $50,000 a year. In Las Vegas, where we don't have and haven't had this wonderful MICRA law on the books, premiums can run anywhere from $110,000 up to $200,000 a year. Not only that, they are telling the doctors in Las Vegas, you have to limit the number of deliveries you do, especially if you are practicing on high-risk deliveries.

If you are a woman who has a high-risk pregnancy, you want the best possible doctor you can get. Unfortunately, those doctors are having to limit their practice or retire or leave the State because they cannot afford medical liability coverage any longer.

This is a crisis—a crisis of access to health care for women who need the health care, women who are in search of gynecological services or women who are about to deliver babies. The stories—there are many of them—are tragic in many circumstances.

This is, by the way, only one area of our health care system that is in crisis. Trauma is another place, and we are going to address that later this year—emergency rooms. As a matter of fact, the level I trauma center in Las Vegas closed a couple of years ago because the doctors could not afford to practice there because of the liability. There were so many lawsuits—not lawsuits that actually had merit to them; some of them did but most of them did not. Because of the potential liability, the doctors said we cannot afford to work here. So the level I trauma center that serves a four-State region had to close. That is the same level I trauma center, for those who followed the national news this last year, where Roy Horn of Siegfried and Roy was treated after the tiger had attacked him. It is an excellent level I trauma center. It saves many lives.

We had a press conference last year where a woman whose father was in Las Vegas and had an accident while the level I trauma center was closed. He had to be transferred to another hospital, and because of the delay in treating him, we could definitely argue that this man would be alive today if the trauma center had not closed. That trauma center was only closed for 1 week, and it was closed for that reason. The State of Nevada stepped up; our Governor stepped up and said we will cover that trauma center under the laws of the State of Nevada.

What are the laws of the State of Nevada? It has a $50,000 cap of liability—total cap. Not $50,000 for pain and suffering but a total cap of $50,000. That is not even close to what this bill says. This bill has a $250,000 cap on noneconomic, nonmedical damages. You can still get all the economic damages you would have incurred; for instance, loss of income or other types of economic damages. You can get all of the medical coverage you would need. It is just that $250,000 cap on pain and suffering awards. Those are the awards we have seen that are getting outrageous all across America.

That level I trauma center, luckily for Roy Horn, was open. Without the type of intense care you can receive in a trauma center, Roy Horn, I think it could be argued, would not be with us today.

Mr. President, even though we have limited this bill to the practice of obstetrics and gynecology, we do have a much bigger problem in this country, a problem that must be addressed. We are in a political season today. We know that. It is an election year for the President, the Senate, and the House, and there is a lot of politics going on. Some people say: You guys are just doing this with OB/GYNs to make a political issue out of it.

If people want to stand up and say that they don't want to fix the problem happening with access to care for women and children, then I guess that is a political issue. I think it is a legitimate political issue. People need to know where Senators stand. They need to know where our Presidential candidates stand on issues of this importance. I believe that when they find out where candidates stand, whether they are incumbents or challengers, this issue will make a difference in their vote come November.

It is that important to our overall quality of life in America. I believe it is wrong that we have to have people moving, or not moving, from State to State because they cannot get access to quality care because the medical liability costs are too high—one reason versus another reason.

Some States have enacted good reform. Colorado and California are the best examples. My State enacted a bill, but, unfortunately, it will take several years before we know whether that bill will withstand challenge in the courts. Also, there were two huge loopholes in that bill that the trial lawyers were able to get in that you will be able to drive a truck through. That is why many in the medical community in Nevada are trying to close those loopholes.

We need enactment at the national level. Sixty percent of all medical bills are paid by the Federal Government between Medicare, Medicaid, and veterans. It is a national priority. We must get this medical liability crisis under control so that our trauma centers are not closing, so that women have access to their OBs, gynecologists, and nurse midwives, who are also covered under this bill. They sometimes get left out of the discussion, but they are a very important part of our health care delivery system in this country and delivering healthy babies.

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

Mr. DURBIN. Mr. President, I thank the Senator from Nevada. I know of his personal interest in this issue. He has offered legislation before. Today we are considering S. 2061, which has been offered initially by Senator GREGG of New Hampshire and Senator ENSIGN.

It is important to note that this bill, which was brought directly to the floor, has not been the subject of any committee hearings. In fact, there has been no effort, to my knowledge, to sit down and find a bipartisan compromise or sponsorship for this legislation. This bill was presented to the Senate a few days before we went into recess, and now it is being called this day.

What is interesting, as well, is that there are announcements from the Republican leadership that we will quickly move after the vote on this bill to other issues, and they have been enunciated.

The point I want to make is this: I don't believe this is a constructive effort that leads us to a solution to a national problem. This, instead, is a bill

being called for one reason only: To get a rollcall. It is a bill being called today to put Senators on the spot. Vote yes; vote no. Why? Because, frankly, there are some on one side of the issue who want to demonstrate that they are concerned. So they are bringing a bill to the floor. They want a rollcall so they can say to those who are looking for some change and for some legislative progress: See, we moved quickly on this. We brought a bill to the floor and, darn it, it didn't pass. We will try to get to it later in the session.

From my point of view, that is not the way to approach this. We should have dealt with this in good faith and constructive, bipartisan effort to try to find a solution to a serious national problem. But that is not the case. Instead, we are having a head-on collision between the trial lawyers on one side and the doctors on the other side.

I come to this debate as someone who had a little bit of experience in this issue a long time ago. Before I was elected to Congress 21 years ago, I was a practicing lawyer. I used to defend doctors who were sued for medical malpractice. I did that for 5 or 6 years. I came to understand the nature of these lawsuits and how complicated and painful many of them are. Then I was on the other side of the table, representing patients who went into a doctor's office or a hospital and were injured and they sought compensation because of these injuries. So I have seen both sides of the issue. I come to this debate with the belief that we need to bring all of the parties together to find a solution. What we have with this bill, I am afraid, does not come close to addressing a serious national issue.

Mr. President, I see that the Democratic leader, Senator DASCHLE, has taken to the Senate floor. I planned on giving a rather lengthy speech. At this point, I would like to yield the floor to the Senator from South Dakota and then I can resume after he is finished.

The ACTING PRESIDENT pro tempore. The minority leader is recognized.

Mr. DASCHLE. Mr. President, I thank the distinguished Senator from Illinois for his courtesy, and I appreciate very much the leadership he has provided. He has said on many occasions that it is imperative we address this issue in a meaningful, comprehensive way. Senators on both sides of the aisle recognize that this situation will not resolve itself; that it must be addressed. But like him, I share the concern that the bill before us just doesn't do that.

Last year, the Senate was asked to consider a bill that promised to reduce insurance premiums for doctors by restricting the legal rights of injured patients. That bill was rejected by a strong bipartisan margin in the Senate for one simple reason: It was a sham. It put the profits of insurers ahead of the rights of patients, while offering doctors no real relief whatsoever.

Today we are being asked to consider yet another bill that seeks to close the doors of the courthouse to victims of malpractice, this time under the guise of expanding health care access for women and infants.

Once again, the Senate should reject this bill for what it is: a maneuver designed to protect nothing but the profits of insurance companies, HMOs, pharmaceutical companies, and medical device manufacturers.

Democrats and Republicans agree that skyrocketing malpractice insurance premiums are a serious challenge. Too many doctors, especially obstetricians and gynecologists, are being forced to pay exorbitant premiums because of the arbitrary actuarial formulas of insurance companies. This is a national problem, and it demands our attention. But like last year, this bill actually does nothing to help doctors. Despite the claims of the insurance companies, every piece of available evidence shows that capping damages has absolutely no impact on the cost of malpractice insurance.

According to the Medical Liability Monitor in a sampling representative of all States with caps on damages, malpractice insurance premiums for OB/GYNs actually increased by as much as 54 percent in 2003. In States without caps on damages, OB/GYN premiums increased no more than 14 percent in 2003. Many States without caps saw no increases whatsoever.

We have a situation, again documented by the Medical Liability Monitor, that States with caps saw increases of as much as 54 percent last year. States with no caps saw increases of no more than 14 percent last year.

A recent study by the Weiss rating organization found that caps on noneconomic damages failed to result in lower premiums for doctors, despite the fact they did reduce the amount insurers had to pay out to victims. Insurers merely kept the savings for themselves and left doctors to fend for themselves.

In the months since we last discussed this issue, the GAO and the CBO both released reports demonstrating that the primary factor driving insurance premiums higher is not malpractice awards, but the insurance companies' desire to recover their investment losses. After trying to pass on the cost of their bad investments to doctors, they are now trying to do the same thing by limiting the rights of injured patients.

Even the insurance industry admits that caps will not protect doctors from higher insurance premiums. A press release published on March 13, 2002, by the American Insurance Association stated:

> Insurers never promised that tort reform would achieve specific premium savings. . . .

Just last year, Bob White, president of the largest medical malpractice insurer in Florida, stated:

> No responsible insurer can cut its rates after a [medical malpractice tort ''reform''] bill passes.

Take it from the insurers themselves, no doctor should expect lower insurance rates as a result of this bill, and no woman should expect greater access to health care for themselves or their babies.

What women should expect, on the other hand, is a two-tiered legal system that restricts their rights in the courthouse if they are hurt by the negligence of a doctor, HMO, drug company, or medical device manufacturer.

This bill is unjust. It restricts women's access to the legal system while preserving it actually for men.

Under this bill, if a man shows signs of lung cancer and his illness is misdiagnosed due to the negligence of his doctor, he can recover damages to compensate him fully for his injuries. But if a woman with cervical cancer suffers the same negligence, her damages will be arbitrarily capped. If a man is prescribed defective blood pressure medication by an internist, he can recover full damages. But if a woman is prescribed blood pressure medication during pregnancy that causes blood clots, her damages will be capped.

The real problem with this bill is not merely that it values the injuries of men and women differently, as troubling as that is, the real problem is that it presumes that politicians in Washington are better able to determine how to compensate injured patients.

Every year, tens of thousands of women and infants are injured at the hands of OB/GYNs.

Nine years ago, Colin Gourely of Nebraska suffered complications at birth due to his doctor's negligence. Today, he has cerebral palsy and is confined to a wheelchair. In his short life, he has needed five surgeries to correct bone problems and sleeps in a cast every night to prevent further orthopedic problems.

Shannon Hughes from South Carolina was in the middle of a difficult labor. Despite repeated calls, the doctor wouldn't come until her 35th hour of labor. It turned out that the umbilical cord was wrapped around her baby's neck cutting off oxygen. Today, Shannon's son, Tyler, is severely brain damaged and bedridden. He requires constant medical care and is fed through a tube.

When Alexandra Katada was born in McKinney, TX, the doctor stretched her spine, destroying her nerves, leaving her partially paralyzed. The baby's elbow was pulled from its socket and broken. She died 8 months later from her spinal injuries.

Let us be clear: No amount of money can compensate a parent for their child's pain, but malpractice awards are not simply about money. They are about offering victims a sense of justice, a way to hold accountable those responsible for their injuries or the death of their loved ones.

Some have said that without limits, the legal system looks more like a lottery. But no jury award could ever make the parents of Colin Gourely or Tyler Hughes or Alexandra Katada feel

that they were holding a winning ticket.

Malpractice awards are decided by juries and approved by judges. This is the same system on which we rely to decide life and death issues in capital cases. Why would we not trust our citizens to fairly evaluate how to deliver justice for the victims of medical malpractice?

Democrats are eager to work together with our colleagues to craft a real solution to the problem of rising malpractice premiums. But, once again, rather than working with us to craft a true compromise that would address the problems of increasing insurance premiums, the Republican leadership has decided to bring this bill to the floor with the same level of problems, the same concerns we had 7 months ago.

If our colleagues were serious about combating the rising cost of malpractice premiums, they would join us in supporting bipartisan legislation that includes both long-term and short-term solutions that directly address the rising premiums without harming injured Americans—solutions such as individual tax credits to offset costs when premiums rise sharply; reasonable limits to punitive damages; prohibitions against commercial insurers engaging in activities that violate Federal antitrust laws; sensible ways to reduce medical errors; and direct assistance to geographic areas that have a shortage of health care providers due to dramatic increases in malpractice premiums.

The Senate faced a similar situation discussing concerns about the rising terrorism insurance rates. Some thought then that the only solution was to undo the jury system. Instead, the Senate worked together and developed a bipartisan solution that fixed the problem and brought down insurance rates dramatically.

We should pursue the same model for addressing this problem as well.

There is no question that malpractice rates are a serious problem. Doctors and patients deserve a real answer. This bill is not it. I urge my colleagues to reject cloture.

I yield the floor.

The PRESIDING OFFICER (Mr. SANTORUM). The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank the Senator from South Dakota because I think he has raised an important issue of concern in this debate and that is one I have initiated in my opening remarks. We need to have a constructive bipartisan conversation about a serious national problem. Instead, this bill, S. 2061, was introduced just a few days ago without a committee hearing, reference to committee, without any attempt to find common ground and find a solution. In fact, it is being called today so there will be a vote on record and nothing else. It is anticipated the bill will not go forward.

I spoke to doctors in Illinois over the weekend, doctors who share my concern about the medical malpractice premium situation in our State. I have told them what we are doing today is frankly a political exercise. It is an exercise to come up with a roll call vote so those on one side of the issue can go to their supporters and say, we have worked hard. We brought this bill to the floor, we have been stopped, and we cannot get back to it because we are so busy. Frankly, that is no solution. In State after State, including my State, there are areas where there are serious medical malpractice premium problems. They arise for a variety of reasons. Memorial Hospital in Belleville, IL, has lost numerous obstetricians and gynecologists in the last year due to rising malpractice premiums. Community leaders in that town, which I am familiar with—it is an area I grew up in—have come to me and said, this is a real source of concern. We are losing doctors. They are doctors who are leaving the practice to retire early, and I met one doctor in that circumstance. There are some who are moving to rural counties where the malpractice premiums are lower and they are further away, of course, from the people they originally served. Some are moving across the river to Missouri where they are finding malpractice premiums are a fraction of what they are in Illinois.

There is no doubt in my mind there is a serious problem that needs to be addressed. It is not just in the obstetrical/gynecological area. The OB/GYN issue is an important one, but there are other areas of need relative to trauma care, neurosurgery, and orthopedic surgery. The list is long and we need to address it in a serious and responsible way.

This bill, however, is being brought to us on a moment's notice. This bill is being brought to us in an effort to really check off the box that says, yes, we considered medical malpractice and now we are going to move on. That is unfair and it is unfortunate, and we can do better.

I will tell my colleagues a story about some of the situations I know of in my State. Eduardo Barriuso, who is a physician in the Humboldt Park area of Chicago, pays $104,000 a year for malpractice insurance. He earns about $175,000 because the patients he sees are poor patients, Medicaid and Medicare patients. Doctors who depend on Medicaid and Medicare are not wealthy individuals, but they perform a valuable function because if they are not there to serve the poorest of the poor, then who will?

This doctor says that faced with $104,000 in annual premiums and a $175,000 annual income, he cannot continue his practice, and he certainly cannot pass on the higher costs of medical malpractice insurance to his patients who are poor people.

Another Chicago area OB/GYN has announced he is going to study to obtain his pharmacist license. Right now he is paying $115,000 a year for liability insurance.

Let's go to the root cause of the issue. Why are we even debating this issue of medical malpractice? There are several reasons. First, the men and women who are engaged in the medical profession are some of the most important people in our lives, some of the most important people in America. These are men and women who at great personal sacrifice go to medical school so that they are trained and skilled to be there when we need them, when our families need them. Time and again, my family and most who are following this debate have turned to a doctor in the hopes that he or she can cure an illness, provide some hope, give people some reason to believe they can overcome a disease, disability, or an injury.

Doctors are so critically important to all of us and yet when one takes a look at a doctor's practice, at a doctor's skills, there is a human side to the equation. They are human beings. They do make mistakes. Some are simple negligence. Some are far worse. When these mistakes occur, when a patient is in a hospital or a doctor's office and the wrong thing is done and that patient is injured, what should happen? In most walks of life in America, we are held accountable for our actions.

If I decide this evening to take my car and go out speeding on a highway, strike another car and injure someone, I will be held accountable. I was negligent. I did not reach the standard of safety that is expected of me as a driver and I must pay the price. That is true for businesspeople, for individuals, for virtually everyone in America. It is certainly true for medical professionals. When they make a mistake by negligence or intentional misconduct, they can and should be held accountable. I think that is part of our system of justice. Very few, if any, people argue that is not a reasonable thing to do.

How serious then are the number of medical errors and medical malpractice cases that occur across the United States? Well, the most far-reaching study of the extended cost of medical errors in hospitals and doctors' offices was published by the Journal of the American Medical Association last October. This is a dispassionate, objective analysis of the likelihood of medical errors and medical negligence in America. The authors of the study analyzed 7.4 million patient records from 994 hospitals in 28 States, representing some 20 percent of all the hospitals in America. This was an exhaustive study.

They concluded medical injuries in hospitals ''pose a significant threat to patients and incur substantial costs to society,'' and ''are a serious epidemic confronting our health care system.''

A study in the Journal of the American Medical Association has told us as we go into this debate the first thing we can acknowledge is we have an epidemic of medical negligence in America. Now this was not the Journal of

the American Trial Lawyers. This was the Journal of the American Medical Association. They published a study that told us and warned us we have a serious problem in America.

The study found injuries in U.S. hospitals in the year 2000, for just one year, led to approximately 32,600 deaths, at least 2.4 million extra days of patient hospitalization, and additional costs of up to $9.3 billion. These injuries did not include adverse drug reactions or malfunctioning medical devices.

Dr. Carolyn Clancy, Director of the Agency for Health Care Research and Quality, called medical errors ''a national problem of epidemic proportions.''

This was at a hearing before the Government Affairs Committee last June. She said Congress and the Bush administration need to make sure health care professionals work in systems that are designed to prevent mistakes and catch problems before patients are injured.

According to the Institute of Medicine, the medical errors epidemic has caused more American deaths per year than breast cancer, AIDS, and automobile accidents combined. It is the equivalent to a jumbo jetliner crashing every 24 hours for an entire year.

More than 70 studies of the past decade have documented serious quality problems in medical treatment, yet this bill before us today, S. 2061, does absolutely nothing to address this underlying problem of patient safety. How can we in good conscience talk about a medical malpractice problem and conclude the only place we need look is to the courtroom, to the patient once injured who goes to the courthouse seeking some compensation, some accountability for an injury that was absolutely no fault of their own? Yet the bill before us is absolutely silent when it comes to making doctors' offices, hospitals, and patient treatment safer.

This last Sunday in the New York Times, an interesting article on patient safety was published. I ask unanimous consent that the article be printed in the CONGRESSIONAL RECORD.

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

[From the New York Times, Feb. 22, 2004]

RUNNING A HOSPITAL LIKE A FACTORY, IN A GOOD WAY

(By Andrea Gabor)

On the face of it, SSM St. Joseph Health Center, a small hospital in suburban St. Louis, does not seem very revolutionary in business terms. The hospital is a nonprofit institution run by the Franciscan Sisters of Mary. The chief executive, Alan Kevin Kast, is a former seminarian who begins his meetings with prayer and refers to his hospital as a ministry. A crucifix hangs in every room.

Yet St. Joseph is also guided by worldly objectives. The 364-bed hospital, part of SSM Health Care, which has 20 hospitals in four states and is led by Sister Mary Jean Ryan, is in the vanguard of health care change. By using the quality and productivity techniques that helped strengthen American industry in the 1980's, the hospital has improved patient care and reduced medication errors, waiting time in the emergency room and infection rates. It has even sharply reduced nursing turnover, which prevents many hospitals from delivering consistent care.

Other hospitals are also starting to use some of the techniques that have made industry more efficient in its quest to improve quality and save money. Every year, preventable medical errors cost $9 billion, and tens of thousands of lives, according to a recent study by the Agency for Healthcare Research and Quality, part of the Department of Health and Human Services, and Johns Hopkins University.

Whether in industry or in health care, a quality strategy ''gives a unified vocabulary for thinking about production as a system with a focus on customers,'' said Donald Berwick, founder of the Institute for Healthcare Improvement, an advocacy organization based in Boston.

Many hospitals are using a road map provided by General Electric, which has been selling its productivity-enhancing, cost-cutting elixir known as Six Sigma, along with medical imaging equipment, to hospitals around the country. Six Sigma is a statistical measure that can be applied to any industry and refers to a goal of reducing errors to 3.5 parts per million. Two years ago, for example, the North Shore-Long Island Jewish Health System contracted with GE Medical Systems and the Harvard School of Public Health to help start a leadership training center. Similarly, after close to a decade of cost-cutting, the Yale New Haven Hospital also recently signed up with GE.

New devotees of quality are beginning to measure and analyze everything from waste and waiting time to infection rates and the narrow avoidances of mistakes in treatment, as well as organizational barriers to improvement.

In a culture ruled by a fear of malpractice, the focus on quality involves a shift from secrecy to transparency—including reporting and dissecting mistakes.

That shift may be helped by a provision of the Medicare legislation passed in December that withholds a small part of Medicare payments if a hospital refuses to disclose quality data. ''It's not a lot of money, but it's incredibly historic,'' said Robert Galvin, director for global health care of G.E. and a founder of the Leapfrog Group, an industry consortium aimed at improving health care.

A few hospitals, including Dartmouth Hitchcock Medical Center in New Hampshire and the nine hospitals that form the Wisconsin Collaborative for Healthcare Quality, have begun to publish comparative quality data on their Web sites, including statistics like mortality rates.

At St. Joseph, where a quality strategy was first embraced in the late 1980's, measurement, standardization and analysis are obsessions.

''When I came here, everything was done differently,'' said Filippo Ferrigni, who has led the hospital's intensive care unit since 1987. ''We didn't even measure blood pressure the same way in everyone. We decided we needed to have internal standards for measurement of at least blood pressure, pulmonary artery pressure, temperature, the fundamental building blocks of medicine.''

The quality push at St. Joseph and the other hospitals in the group has led to systemwide benefits. In 1999, the company was in the red, but in 2002 it had net income of $17 million, on revenue of $1.8 billion. Amid nationwide nursing shortages, it lowered annual turnover to about 10 percent in 2002 from 15 percent in 2000. The national average turnover rate is more than 20 percent.

At St. Joseph, the zeal for quality improvement is helping the sickest patients. When Dr. Ferrigni read an article in a recent issue of The New England Journal of Medicine linking high glucose levels to an increased chance of infections, he knew that he had found his next big opportunity for improving patient care. Infections acquired in hospitals and intensive care units are common, according to a report released in December by the government's Agency for Healthcare Research and Quality; about two million patients are infected each year at a cost of more than $4.5 billion.

The stress of illness results in higher gluclose levels for most patients—not just those with diabetes. Dr. Ferrigni decided to see if lowering glucose levels in the intensive care unit by giving patients intravenous insulin would lower infection levels. Initially, the project ran into ''tremendous resistance,'' he said. Doctors were concerned that giving patients insulin might result in brain injury and seizures. Dr. Ferrigni, however, persuaded his colleagues to allow him to gradually reduce blood sugars of patients in the intensive care unit. As blood sugars declined among the patients, overall mortality in the unit declined by 40 percent.

The results were so astonishing that the hospital decided to make the reduction of glucose levels for all patients, not just those in intensive care, a quality goal. Today, all patients are given glucose tests and, if necessary, get insulin. Hospitalwide, that change is credited with reducing deaths over all, not just from infections, by 28 percent from the average recorded from 1998 to 2001.

Because each serious infection costs about $35,000, the savings are also huge. ''This is the single most important leverage point for reducing mortality that's available to hospitals,'' Dr. Ferrigni said. ''This is incredibly powerful stuff.''

The effort, however, also demonstrated a major organizational challenge. ''Doctors write the orders, but nurses have to make it work,'' Dr. Ferrigni said, explaining that the glucose initiative significantly increased nurses' workloads.

Blood sugar, once measured four times a day, now must be measured 12 times a day in intensive care. Once nurses saw the impact of the glucose testing, however, ''they got all over it,'' Dr. Ferrigni said.

Some of the greatest quality challenges involve persuading employees in various departments to cooperate. Consider the effort, known as 30/30, to cut waiting time in emergency rooms. The goal is to evaluate patients with life-threatening illnesses or injuries in just 30 seconds and to reduce the time needed to admit patients to a hospital bed from the emergency room to 30 minutes.

Improvements in the emergency room involved a number of departments. When X-rays were needed, it often took an hour for an X-ray technician to get to the emergency room. To solve the problem, one X-ray technician was permanently transferred there. Or, in admitting psychiatric patients, the hospital had to wait for an evaluation by an outside psychological social worker before moving patients out of the emergency room, a process that averaged 90 minutes. To reduce the wait, the hospital hired a psychological social worker.

Within two years, SSM St. Joseph has met its objectives in the emergency room 94 percent of the time, up from about 65 percent when the project began. To help keep the organization from becoming complacent, patients receive a coupon for $10 of groceries when SSM misses its 30/30 target. The hospital spent $14,450 in 2003 on coupons.

The hospital now spends about $200,000 more each year on increased emergency-room staffing. But a jump in admissions has

more than made up for that cost. In 2002, St. Joseph garnered about 68 percent of all new emergency room admissions in St. Charles County. After years without growth, the hospital also had a 7 percent increase in patient admissions in general in 2001, and the same increase in 2002.

Some major health care institutions, like Johns Hopkins and the Mayo Clinic, have been pursuing quality initiatives for years, but generally the mantra has been slower to penetrate big institutions.

Large teaching hospitals, which juggle teaching, research and patient care, have special challenges. Because of their residency programs, many of their doctors are temporary. At Yale-New Haven, one big question is whether a hospitalwide quality effort can succeed when only 10 percent of the hospital's 2,600 physicians are full-time. The rest are community physicians or professors at the School of Medicine.

The hospital began its Six Sigma effort in the intensive care unit, which had its own staff of nurses. The project involved reducing a relatively high rate of blood-stream infections that occur in patients who have catheters.

When management broached the subject with Heidi Frankel, director of surgical critical care at the hospital and a doctor at the Yale School of Medicine, she was skeptical. ''This isn't an assembly line; it's an I.C.U.,'' Dr. Frankel recalled saying. ''But it turned out to be a brilliant and inspired thing to use rigid corporate improvement techniques in a patient model because there are many things we do that are repetitive, and that we could standardize.''

After winning over fellow doctors and residents, Dr. Frankel standardized the catheterization procedure and created a training video for the regular influx of new residents. During the last year, the surgical intensive care unit cut its catheter-related infection rates by about 75 percent. A rigorous quality strategy appeals to many hospitals not only because it controls costs, but also because it can improve care. But the process can take years to master. That is why, at St. Joseph, the true believers would also recommend a little prayer.

Mr. DURBIN. Let me just note a few things about it. It is entitled ''Running a Hospital Like a Factory, in a Good Way.''

The article tells a story of a hospital in suburban St. Louis, the SSM St. Joseph Health Center. It is a very complimentary article. The hospital is a nonprofit institution run by the Franciscan Sisters of Mary and the chief executive, a former seminarian, has really decided to make St. Joseph's Hospital different. They have decided they are going to go after quality control and the reduction of patient injuries and accidents at their hospital. They are using techniques that are used by private industry. I will quote from the article:

Other hospitals are also starting to use some of the techniques that have made the hospital industry more efficient in its quest to improve quality and save money. Every year, preventable medical errors cost $9 billion, and tens of thousands of lives, according to a recent study by the Agency for Healthcare Research and Quality, . . .

So this hospital, St. Joseph's, in suburban St. Louis, decided to consult with General Electric, a major corporation, to find a way to make the services they offer to their patients better. They are using a process called Six Sigma. It is a statistical measure and refers to the goal of reducing errors to 3.5 parts per million. What they found is this:

New devotees of quality are beginning to measure and analyze everything from waste and waiting time to infection rates and the narrow avoidances of mistakes in treatment, as well as organizational barriers to improvement.

The article says:

In a culture ruled by a fear of malpractice, the focus on quality involves a shift from secrecy to transparency—including reporting and dissecting mistakes.

Let me go on in the article. They noted here one specific example. The New England Journal of Medicine had linked high glucose levels to an increased chance of infection, so this hospital decided, particularly in the emergency room and for critical patients, to continue to monitor their glucose levels to avoid the incidence of infection. The blood sugars declined among patients when they started monitoring them and administering insulin to keep blood sugars down. Simply by using this quality approach to reduce the likelihood of infection, this hospital reduced the overall mortality in the intensive care unit by 40 percent. The results were so astonishing that the hospital—and I quote again:

. . . decided to make the reduction of glucose levels of all patients, not just those in intensive care, a quality goal. Today, all patients are given glucose tests and, if necessary, get insulin. Hospitalwide, that change is credited with reducing deaths overall, not just from infection, by 28 percent from the average recorded from 1998 to 2001.

Blood sugar in this hospital, once measured four times a day, now is measured 12 times a day.

Those who follow this debate and will read this article in the CONGRESSIONAL RECORD I think will understand the point I am trying to make. If we are going to reduce the likelihood of doctors being sued for malpractice, the first stop in that conversation should be the reduction of medical errors. If we do that, we are serving two goals: reducing doctors' exposure to malpractice and we are making certain that patients will go through their medical experience with a much better outcome.

You would think that would be the first title in this bill, ''Reducing Medical Accidents, Reducing Medical Errors.'' This bill does not even address that. This bill says that after you are injured, after you have gone to court, after you have successfully been given a verdict, this bill is going to restrict and reduce the amount of money you can recover.

From an insurance company's point of view and the view of some doctors, that is good enough. But from the viewpoint of making American hospitals and medical practice safer, that is hardly the place to start. Frankly, this bill does not address the core issue.

Mr. CORNYN. Will the Senator yield for a question?

Mr. DURBIN. I am happy to yield for a question.

Mr. CORNYN. In my own State of Texas, that passed a constitutional amendment along with implementing legislation to reduce the cost of medical liability insurance, we have seen reductions offered by medical liability carriers of 12 percent in one case and projected to be as much as a 19 percent reduction in medical liability insurance costs.

While I certainly would agree with the Senator from Illinois that reduction of errors is an important goal, would he not find a reduction of medical liability insurance rates of 12 to 19 percent one way to reduce the cost of health insurance and health care generally, in a way that would benefit the public generally?

Mr. DURBIN. I thank the Senator from Texas. I am aware of his State's experience. I am not an expert on it, but I read a little bit about it.

I will say to him I will be citing some statistics in the course of my remarks that will show that the caps on recovery for victims of medical negligence have reduced premiums in some States but not in others. It is an unpredictable outcome, when you reduce the exposure of a doctor for his malpractice, as to whether or not the cost of medical malpractice premiums goes down.

I would further say to the Senator from Texas, if our goal is simply to reduce medical malpractice premiums, frankly, we could stop people from suing in court. We could basically say you can't go to a courthouse if you are a victim. Malpractice insurance would cease to exist in that case.

What we are trying to do here is find a balance, a balance that is just and fair and says if you are an innocent victim of medical negligence, you are entitled to a day in court and a reasonable recovery. That doesn't mean you can come in and expect punitive damages in every instance, or some enormous verdict in every instance, but we should be able to say that if you are a victim, you will be able to recover a reasonable amount for your injuries.

I say to the Senator from Texas, in this bill, this jury of the Senate has decided that we know the maximum amount any woman or baby should be entitled to recover in a medical malpractice action for noneconomic losses. We are saying here that, regardless of the facts, regardless of the culpability of the doctor, regardless of the circumstances, regardless of how serious the injury is, the maximum amount which the jury of the Senate will render in verdict for the victim is $250,000 for pain, suffering, and disfigurement.

I say to my friend from Texas, there are some who say that is just the price you have to pay; if you want to keep malpractice premiums down, you are going to have to say in some circumstances there is going to be an outcome that makes us feel a little uncomfortable. I am going to give examples of specific cases where $250,000 in

pain and suffering is not even close to compensating the family and the child who are the victims of malpractice in these OB/GYN circumstances.

Mr. CORNYN. Will the Senator yield for a further question?

Mr. DURBIN. I am happy to yield without yielding the floor.

Mr. CORNYN. The Senator from Illinois makes an important point, and that is there will invariably be one or two, perhaps, cases, or a handful of cases, or an example you can point to where a $250,000 limit on noneconomic damages might seem to be too low. But would the Senator agree that what we are trying to do is use a rather indirect means to try to accomplish a greater good for the patients who are denied access to health care?

For example, in 154 of the 254 counties in my State, a woman cannot find a baby doctor to deliver her baby because of the cost of malpractice insurance. Many obstetricians simply decide to give up and retire or to move someplace else where malpractice liability rates are lower.

While the Senator no doubt can find an example where the amount is lower than a jury perhaps might award, why shouldn't we take a step in the direction of bringing some predictability and thus bringing some reasonableness in reducing the rates for liability insurance so people can have access to doctors where they live?

Mr. DURBIN. The Senator from Texas makes an excellent point. I think that is the reason, I would say to my colleague, why once this bill is defeated—and I hope it is defeated—once it is defeated, we really have a responsibility here.

We come from different sides of the political spectrum. We are about as far apart as they come in this Chamber in terms of our political philosophy, but I think we both can see there has a been problem. The medical malpractice premiums in parts of your State and parts of my State have reached record high levels. These premiums are forcing my good doctors in Illinois to retire, move away to another State or to an area that is friendlier when it comes to the cost of the premiums. There is a denial of coverage. There is a denial of services to a lot of poor people in Texas, Illinois, and a lot of other States.

Shouldn't we come together instead of a take it or leave it bill that has never been referred to the Senate Judiciary Committee, never been the subject of a hearing, does not address issues of medical safety and other issues we can agree should be part of this conversation? Shouldn't we at the end of this debate on this bill sit down and honestly try, on a bipartisan basis, to find common ground and compromise that would serve the goal the Senator is suggesting, the greater good, to make sure these good doctors across America will be there when we need them?

I thank the Senator from Texas.

Mr. CORNYN. If the Senator will yield for a final question.

Mr. DURBIN. I am happy to yield.

Mr. CORNYN. I appreciate the spirit in which the comments are offered by the Senator from Illinois, because this is a subject where we do need to have a rational debate. Unfortunately, because we cannot get 60 votes to allow the floor debate and actually vote, we are engaging in a hypothetical exercise.

Wouldn't the Senator from Illinois deem it important for this body to have a realistic, rational debate and ultimately vote to see what the will of this body and the people we represent is when it comes to trying to get some handle on reducing the costs of liability insurance so more mothers can have access to obstetricians and more people can have access to health insurance by reducing health insurance costs?

Mr. DURBIN. I agree with the Senator from Texas. I thank him for his comments which I believe are good-faith comments.

In my rank on this side, I do not set the calendar of how bills are determined; your leader, Senator FRIST, does that. I suggest the best place to start is not on the floor of the Senate but for a group, on a bipartisan basis, to try to come up with an honest answer to this issue and bring it to the floor and stand together to try to pass this bill in a responsible way. Simply bringing a bill, take it or leave it, a few days, no committee hearings, does not serve the needs we are addressing.

I see a few other colleagues on the floor so I will go through a few points quickly and return to the Senate later in the day if there is an opportunity.

This particular bill does not address the problems of malpractice premiums in an honest fashion. The problem with malpractice premiums is a cyclical insurance problem. We have had crises before with high premiums in the 1970s and 1980s. Many States passed changes in the law to address this, some in tort reform and some in insurance reform.

This bill does not even look at the insurance companies that are offering medical malpractice insurance. What it is basically saying is that we are not even going to ask the question as to whether these companies are overcharging doctors and hospitals. Instead, we are going to say that the only culprits, the only people who are at fault in this conversation, are the victims of medical malpractice. They are the ones who have to tighten their belt, take fewer dollars. We will not even consider in 2061 asking that the insurance companies be held accountable for their own conduct and ask whether they are gouging us when it comes to prices.

How can we have an honest discussion of the medical malpractice issue without addressing medical safety, without asking these important questions of the insurance company?

This bill does not address frivolous lawsuits. The proponents of tort reform claim frivolous lawsuits are at the root of the problem. This bill does not do anything to cut down on the number of such suits but only punishes those who make it to court.

Keep this in mind: If a lawsuit is worth $250,000 in noneconomic losses, which is the maximum under this bill, this is a lawsuit where the plaintiff clearly has a cause of action which a jury or judge has decided is a worthy cause of action worth compensation. These are not frivolous lawsuits that would have $250,000 in noneconomic losses. Something happened. A patient went to a hospital or to a doctor and was injured wrongly.

This bill is saying we are not going to address frivolous lawsuits. We will basically say those who are entitled to recover are limited in the amount they can recovery.

One of the worst parts of this bill, we will hear arguments in the Senate that we need OB/GYNs across America and without these doctors to deliver babies we will be at a disadvantage. Frankly, no one can argue with that. But when we read the bill, it is about more than doctors. This bill, like the last one we considered last year, has been expanded to provide protection against lawsuits filed against pharmaceutical companies and medical device companies.

We are finding, time and again in the Senate, whatever the issue, the Republican side of the aisle insists there be at least one provision in every bill that is going to benefit the drug companies of America. In this situation they are saying these drug companies should not be held accountable for the damages and injuries caused by their products involved in OB/GYN practice.

Why would we do this? Why would we decide we are going to exempt them from exposure, liability, and accountability for some of the drugs and devices that are being used across America that cause injury to innocent people? That is exactly what they do.

Let me give some examples of the types of litigation that would have been eliminated by this bill, had it been in law. The Dalkon Shield was an IUD on the market in the early 1970s and caused thousands of women to suffer miscarriages, loss of their female organs, and infertility. It took eight punitive damage awards to force the manager of the Dalkon Shield to finally recall the product. It was not a law passed by Congress. It was a lawsuit filed against the company because of their dangerous product; 400,000 claims were eventually filed against A.H. Robins, the manufacturer of Dalkon Shields. Evidence established that Robins, the device company, knew that its IUD was associated with high rates of pelvic disease and septic abortion and that this company had misled doctors about the device's safety and had dropped or concealed studies on the device.

Why in the world we would protect this brand of reckless, irresponsible corporate behavior with this bill? The honest answer is because politically

the pharmaceutical companies and the medical device companies have a death grip on this Congress. They get what they want. We saw that when we considered the prescription drug bill for seniors and we are seeing it again. There is not a bill that comes through here, not one that passes through the traffic in the Senate, where somebody is not looking for a way to increase the profits and reduce the liability of pharmaceutical companies. This is a further illustration of it.

There are other things I could point out, drugs or devices that have been used. Let me give one from the State of Georgia. A&A Medical, a Georgia-based manufacturer of OB/GYN devices such as forceps, failed to sterilize tens of thousands of devices from 1999 to 2002, posing life-threatening injuries to women. Former staff of this company told FDA investigators that sterile and nonsterile devices were routinely shipped in the same batches. A month after urging the company to voluntarily recall its products, the FDA seized and destroyed the company's inventory. The owners of A&A Medical left the country after the seizure.

These are the kinds of companies we are trying to protect with this bill? This is not a question about whether a doctor could deliver a baby in Texas, Connecticut, Ohio, or Alabama. It is a question about whether or not these companies will be held accountable for their wrongdoing.

There is an approach that can be used and should be used that can bring a positive outcome. Senator LINDSEY GRAHAM from the State of South Carolina and I have introduced bipartisan legislation. We have worked to try to include in this legislation the key elements that we think are necessary for medical malpractice reform. Let me tell you what they include.

First, dealing with medical safety, establish a voluntary system to share medical error information among providers and patient safety organizations. The information shared will be immune from legal discovery so there is some transparency in what occurs but no liability, so a greater likelihood they would exchange information.

Also, consistent with the Institute of Medicine, the bill creates a new center for quality improvement. We provide immediate relief for doctors and hospitals.

If there is one point I make, it is this: If Senators are hearing back home that medical malpractice premiums are too high and that you should vote for this bill, keep in mind what Senator ENSIGN of Nevada said in the debate we had a few months ago on a similar bill. Capping noneconomic losses will not reduce medical malpractice premiums for doctors for 4 to 6 to 8 years. Why? Because there is a long tail of liability. Doctors' acts today that constitute negligence can result in court suits tomorrow, next year, and for years to come when those injuries are finally discovered. If we cap noneconomic losses today, there will not be a relief for doctors in their medical malpractice premiums for years to come.

Senator GRAHAM and I considered that and said we have to deal with this directly. And dealing with it directly means offering a tax credit, particularly to those doctors in specialties where the premiums have gone too high. Doctors today deduct the cost of medical malpractice premiums from their business expenses.

We would go further and offer to doctors and hospitals a tax credit when their premiums skyrocket. That is the only reasonable way to provide immediate relief. We have given tax breaks to a lot of wealthy people across America under this Bush administration. Why can't we, when it comes to the medical professionals, say they should have a tax credit so that skyrocketing premiums do not force them out of business into retirement or to move their practice?

In our legislation, we reduce frivolous lawsuits. We put in the Durbin-Graham bill penalties for attorneys who file frivolous lawsuits: The first time, damages; the second time, even more expense; and the third time we would subject them to losing their license to practice law for a frivolous lawsuit. There is no reason any doctor or any person, for that matter, should be subjected to a lawsuit which ties them up at great expense, costs their insurance company money, and raises their premiums when, in fact, that lawsuit is frivolous. There are few of these, but there should be none. We think there should be a penalty for those who take advantage.

We also stop any competitive activities by insurers under the McCarran-Ferguson Act, and we provide resources to help hard-hit areas of doctor shortages, particularly rural and inner-city areas, through the Department of Health and Human Services.

We also address the issue of reinsurance. This is a topic we never talk about. Most medical malpractice premiums are charged against the initial liability which is usually in the range of $1 million, and then the umbrella policy which covers all the damages which might exceed $1 million. Then companies are brought in, reinsurance companies, that sell the original insurance policy. These are the areas where we believe there is a need for reform.

Reinsurance costs are about 28 percent of medical malpractice premiums. Their prices swing widely. They are mainly international corporations subjected to little regulation. Frankly, since September 11, reinsurance costs have gone up dramatically across America.

As this chart illustrates, this is Hurricane Andrew; reinsurance costs spiked in America. Then they went back down again. This is 9/11. After 9/11, reinsurance costs have gone up. So why are these medical malpractice insurance companies charging higher premiums? Part of it is the cost of reinsurance. Senator GRAHAM and I address this and believe that we should create a Federal fund which deals with reinsurance, where there would be contributions from doctors, hospitals, and health care professionals, and we can see some stability in the amount that is charged.

This situation we have before us is clear. Caps don't work. This chart shows the percentage increase in median premiums for medical malpractice from 1991 to 2002, the States without caps, no limitations on recoveries in verdicts, and the States with caps are shown in red. You can see that Arizona, New York, Georgia, and Washington, with no caps, had very modest increases in malpractice premiums.

Take a look at California, which has a $250,000 cap, Kansas, Utah, and Louisiana. In this period of time, malpractice premiums went up dramatically in the States with the caps. There is little or no correlation between the caps and the fact that malpractice premiums are going up.

Look at these OB/GYN insurance premiums in damage cap States versus noncap States in 2003: In California, a State with caps, there was a 54-percent increase in OB/GYN premiums with caps in place at the State level; in Oregon, zero percent increase; against the State of Washington, California, 15 percent, State of Washington, zero percent; Colorado, 29 percent with caps, Georgia, only 10 percent without caps; New Mexico, 52 percent increase in OB/GYN medical malpractice premiums with caps, and in the State of Arizona, 14 percent. It is an illustration that you just can't rely on these caps to bring down malpractice premiums for many years, if at all, and in many cases not at all.

Look at the percentage increase in median premiums: States with caps, 48 percent between 1991 and 2002; States without caps, 36 percent.

This is an important issue that needs to be addressed. I see my colleagues waiting. I will yield the floor but return later in the debate.

I hope my colleagues will understand that we have a serious national problem that needs to be addressed, but we should not address it in a way that is partial, that does not do justice to the serious challenges we face. We need to reduce medical errors. We need to hold insurance companies accountable. We need to bring about tort reform which stops frivolous lawsuits. We need to move into the area of tax credits for doctors now—not 4, 6, and 8 years from now—so they can pay their malpractice premiums and do it in a fashion that is fair—fair to the people who have been injured and fair to the medical professionals who are so important to all of our communities.

I yield the floor.

The PRESIDING OFFICER (Mr. BROWNBACK). The Senator from Alabama.

Mr. SESSIONS. Mr. President, we are, indeed, losing physicians in the

practice of medicine throughout America. Senator DURBIN expressed concern in the conversations he has been having with doctors in his State, even though he opposes this bill. I traveled to Alabama this past week and visited five or six hospitals. I was at Fayette and Wedowee and Gadsden and Alexander City. As I traveled the State talking to doctors, to hospitals about their insurance premiums, it is a very real problem.

This is not a new issue. We have been talking about it for a number of years. The reform of litigation of malpractice cases in California is the model for this legislation. It has worked very well in California.

The people who are paying the premiums, people who are subjected to lawsuits, people who care about this every day, people who are giving up their practice every day as a result of abusive lawsuits, they support this legislation. Do they not know what this is all about? Do they not know what they are asking for? These are matters that are quite serious.

I believe capping noneconomic damages has a good effect. When you look at a doctor who delivers a baby, is that doctor a guarantor of a healthy baby? They can't do that. They cannot be the guarantor that every birth they preside over will result in a healthy baby. They are responsible if they are negligent and that negligence causes damage to a child. There is no doubt about that. So that is what we need to focus on.

The limit on damages does not limit damages for injuries in care for a child who lives many years with a great disability. They can recover unlimited amounts for that.

Under California law, these are some of the verdicts that have been rendered to compensate families for children who were born with serious disabilities: In December, an $84 million verdict was rendered because of a 5-year-old with cerebral palsy after a mishandled birth; $25 million in San Diego County because a boy had severe brain damage; $27 million in San Bernardino for a woman who was a quadriplegic because of failure to diagnose a spinal injury; $21 million in Los Angeles for a newborn girl with cerebral palsy and mental retardation as a result of a birth-related injury. They go on.

These are real recoveries to compensate people for economic losses they will have in the future and to allow them every possibility to see that the child or the person who is injured can be taken care of with the best conditions we can make. We are concerned about the explosion of punitive damages. Some people say the person who did wrong ought to be punished.

As a matter that we need to think about, the system is out of whack. The person who commits malpractice is not the one who is punished. The person who commits malpractice—for the most part, hopefully, certainly, all of them doctors—has insurance. They don't pay the verdict. The insurance company pays the verdict. How do they get the $21 million or whatever they have to pay out in the verdict? How do they get that money to compensate the victims? They raise the rates on everybody; the innocent and those who commit errors. It is driving up the cost to practice.

I have a wonderful friend, an OB/GYN, in my hometown of Mobile. We go to church together. He was telling me about a doctor that just gave up his practice. He handled 60 or 80 births a year. His insurance was $60,000 a year. That is almost $1,000 per birth. This week, I was in a hospital in Alabama. They told me 3 years ago they gave up deliveries—there were 200 deliveries a year in this small town, and the hospital had less than 50 beds—because they could not afford the insurance. The hospital quit doing it. The physician in the community also quit delivering. This is a fact, a reality, and it is driving good physicians out of health care.

No group of doctors in America has the hammer falling harder on them than the doctors who deliver our babies. They are getting hit with extraordinary increases. They are getting sued to an extraordinary degree. We need to do something about it. We have bills here, and whatever the bill is, they say ''we need to do something, but this isn't the way to do it; but we want to do something.'' They say ''there are problems, I will admit, Senator, but this isn't the right bill.'' They say ''you have not done this or that,'' and on and on. The result of that is we never pass anything. I believe it is time to do something about this issue. We can do something about this.

When you look at the cost of delivering babies in America today, the liability cost is a very significant portion of it. Not only that, doctors—particularly those who have been practicing for a number of years—do not like the agony of going through a lawsuit. There is the combination of premiums and the threat of being dragged through court for long periods of time, and that is not good. That is why they are quitting.

I was at one of the hospitals in Gadsden this week. One of the nurse supervisors came up to me after I had been asked in the meeting whether we were going to do anything about the liability problem. She said she and the hospital had been in litigation. She had been away from the hospital for 10 days during the trial of this case. They were not negligent and they won the lawsuit, but millions of dollars were spent on that litigation. This is happening all over America. Most of the cases are defendants' verdicts, but many cases are coming in with extraordinarily high verdicts. The BMW case out of Alabama, decided by the Supreme Court, raised real questions about how do you decide what punitive damages ought to be. Does the jury just feel bad this day or look at the victim and feel sympathetic, or are they more sympathetic to one person than another? They come up with $50 million for one person, and maybe in a similar situation they would come up with $500,000. These are aberrational verdicts in the country.

We are saying that there should be a limit for compensating noneconomic damages. It is modeled on a successful program in California. I believe we are facing a national crisis in health care. It is a crisis that ought to be confronted. It is not going to go away. A big part of it is litigation. If you don't believe it, ask any doctor or hospital you know. They sue everybody, including the nurses, doctors, the aides, the hospital, the manufacturer of the hospital bed, or whatever, that might be possibly construed as being connected. All of that adds up to a tremendous burden, a tremendous cost on our health care system.

The truth is health care costs are continuing to go up. One of the factors is litigation costs, which are going up even faster than other costs. We need to contain that and bring some rationality into it. I am willing to listen to other ideas. I am not sure California is perfect, but I will say it is working there. I believe it will work for our country. I thank our majority leader, Dr. BILL FRIST, for bringing this up. It is time to debate this. We need to pass something soon to protect the availability of health care. We need to make sure hospitals and doctors are not quitting delivering babies. That hurts us in America and hurts health care in America.

I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, I have been listening to the arguments posed by our colleague from Illinois, Senator DURBIN, and our colleague from Alabama, Senator SESSIONS. I find myself sort of agreeing with both of these individuals. Clearly, this is an area that cries out for some solution. We have been back at this issue over and over again. Like my colleague from Alabama, and I suspect my colleague from Illinois as well, I was home in Connecticut over the past week and I have received letters from radiologists, and I have talked to OB/GYNs and others. My State ranks third in the country in the rate of premiums for OB/GYNs, which I will address in a minute. This is an area that clearly needs to be addressed. So I appreciate the comments of my colleague from Alabama, that is, to see if we cannot find solutions to this.

As the Senator may recall, I have not been shy when it comes to tort reform issues, having authored the securities litigation reform bill, uniform standards legislation; and I have dealt with the issue of terrorism insurance, and Y2K legislation with BOB BENNETT. I am someone who wishes we were debating class action reform now. There, we

have an agreement. It is not going to satisfy everybody, but I have agreed with BILL FRIST and others. Senators SCHUMER and LANDRIEU and I have worked across party lines to come up with a compromise solution on class action reform. That is a bill I believe we could actually adopt.

Here we are going to spend 2 days debating a cloture motion we both recognize is probably going to fail this evening. But we have a class action reform bill we can get done. I regret I am not arguing on behalf of that proposal, rather than standing here and reluctantly disagreeing with this particular bill; although I am agreeing with my colleague from Alabama that we cannot allow year after year to go by without addressing this issue. I regret we didn't make the effort here we did on class action. On class action, once the cloture motion was defeated on the motion to proceed, people reached out and said let's see where we can find common ground on this. I think we have done that. Only time will tell if the compromise will work. That is how you have to function in this body, when you have 100 Members representing different constituencies and ideas and proposals, where there is a commonality and purpose to try to arrive at an answer to a staggering problem. One of the problems—not all, but one of the problems—is associated with health care. I will go into that in a minute. It seems to me we should pause and reach out and see if we cannot find that common answer. It may not satisfy everybody, but certainly it will come up with some intelligent responses to this problem.

So I say to my constituency in Connecticut, and elsewhere, I am listening to you and I hear you. I know we have to answer this. The question is, is this particular proposal the answer to the problem we face, with the rising increase in malpractice premiums. What actually could be done that may address the issue?

As my colleagues know, this legislation is similar to the one the Senate rejected last year. It would place, as we all know, a $250,000 cap on noneconomic damages that can be awarded to a plaintiff in a medical malpractice case. The bill we are considering today has been narrowed, but in narrowing it, its defects have not been remedied. Like S. 11, the previous bill, this bill would apply to claims brought by health care professionals, health care organizations, such as HMOs, insurance companies, as well as product liability claims brought against medical device and drug manufacturers, by and on behalf of pregnant women and children. However, it would only apply to claims relating to obstetrics and gynecological services. We are dealing with a reduced universe of people in this area, much narrower from the proposal of last year.

Once again, this legislation would cap noneconomic damages at $250,000. It would put the same cap on punitive damages while imposing a stiffer evidentiary standard. It would also reduce economic damages a victim could collect by subtracting benefits paid by health insurance, life insurance, disability insurance, and Social Security benefits. In short, it would make it much harder for the victims of medical malpractice in this narrow area to receive fair and just compensation, in my view.

This legislation would not affect all victims of malpractice. We pointed out the bill we are dealing with seeks to limit the legal rights of a specific segment of our society, women and newborns.

It is important to remember that this bill is going to affect those who have actually been injured by malpractice. We are not debating whether there has been a judgment. There has been a decision that malpractice has occurred. A jury has already, in these cases, decided the victims are eligible to collect noneconomic damages. Furthermore, it will hurt the most seriously injured, those who might receive a noneconomic damage award of more than $250,000 were it not for the arbitrary cap.

We are essentially telling women and infants that the injuries and suffering they experience are not worth as much as injuries and suffering of others.

The assumption is if we just do this in this one area, we are then going to be able to bring down the costs of these premiums. In fact, I suggest that if the empirical evidence made that case, I would be very tempted to support this bill. I say that to my colleagues who are the authors of this legislation. But, in fact, the data and information, unfortunately, does not substantiate the claim that by establishing a cap, you will achieve the desired results of lesser premiums on malpractice insurance.

The argument used by supporters of this bill is OB/GYNs are particularly hit by rising medical premiums. I want to make it clear that I am not insensitive to that claim. As I said earlier, I have heard from many in my own State. In Connecticut, we face the third highest premiums in the country for OB/GYNs. My doctors pay an average of $102,000 every year in medical liability premiums. I have heard from them on numerous occasions about the difficulties they face in the current environment. The vast majority are good doctors who are working to provide the best possible care they can for their patients. They are doctors on whom families in Connecticut and newborns can rely. It is the same across the country. I know, having had a newborn in my own household, a child born to my wife Jackie and me a little over 2 years ago, the tremendous care and attention we received from our OB/GYN in Virginia, where Grace was born.

The question is not whether these people are paying higher premiums. The question is, Is the solution being proposed by this legislation actually going to address this problem? Again, if I thought it would do that, I would be very tempted to support this legislation, as someone who has offered legislation dealing with frivolous lawsuits and other claims. I am not adverse to tort reform. In fact, I am disappointed. We are discussing tort reform in this instance, and we are also going to be talking about the tort liability of gun manufacturers. It is going to be interesting to hear people on that issue.

We had language included in the Energy bill to deal with MTBE. Senator SCHUMER of New York eloquently made the case, asking why we should be eliminating the liability of a product that was causing such damage. I am frustrated to know that we are protecting people from liability because of the political pressures that occur.

I am prepared to support intelligent tort reform, but this problem, as serious as it is, is not addressed by this solution. Will this legislation do anything to reduce premiums? Let me tell you why I don't think it does.

If we are limiting the ability of women and young children to hold accountable doctors, nurses, insurance companies, and others for harm resulting from a mistake, we certainly must make sure we are doing so for a very good reason.

The answer to the question posed above is a resounding no, in my view. The suggestive link between jury awards and rising premiums has not been established at all. In fact, to the contrary. Nor is there a link between insurance premiums and access to health care. In fact, the evidence suggests quite the opposite.

The two pillars upon which this bill is based are deeply flawed, in my view. First, some would suggest jury awards have exploded in both numbers and dollar amounts. That is something we will hear over and over, that victims are winning more and more so-called jackpot malpractice cases. But the facts are quite different.

The amount defendants and insurers are paying for medical malpractice claims, including jury awards and settlements, has increased in a manner that is consistent with and even lags behind medical inflation. Over the 10-year period from 1992 to 2001, the mean payout in medical malpractice cases rose by 6.2 percent per year, while medical inflation was rising at 6.7 percent annually over the same period of time. In other words, malpractice awards are rising exactly in the manner we would expect. They are tracking health care costs.

Of course, a rise in premiums might also be explained by an increase in the number of malpractice claims. That is also an argument we are hearing. Again, this is not the case. Between 1995 and 2000, the number of claims filed actually decreased by 4 percent, and the number of medical malpractice payouts decreased by 8.2 percent between 2001 and 2002. So we are not seeing these numbers go up financially, nor are the actual numbers of malpractice cases increasing. Both are the

two pillars upon which this bill is based. It is the reason people are saying we need to have the cap on these noneconomic awards.

The case made by supporters of this legislation is further damaged, in my view, when we compare States that currently have caps on noneconomic damages with States that have no such caps. As I mentioned previously, my home State of Connecticut has the third highest average premium for OB/GYNs. Connecticut has no cap. However, seven of the 10 States with the highest premiums do have caps. Last year, premiums actually increased by 17.1 percent for OB/GYNs in States with caps compared to a 16.6 percent increase in States without caps.

In the year 2003, the average premium for an OB/GYN in States with caps was $63,000. The average premium in States without caps was $59,000. So if anything, the evidence suggests caps on patient damages actually correspond to higher insurance premiums for doctors.

I said that rather quickly. Let me run by it again and make the case. The argument, again, is if you don't have caps, then these premiums go up. But if you look at places that have caps, seven of the 10 States with the highest premiums for OB/GYNs do have caps—seven of the 10. Last year, premiums actually increased by 17.1 percent in States with caps—an increase of 17.1 percent—compared to 16.6 percent in States without caps.

Again, if anything, the evidence suggests caps on patient damages actually correspond to higher insurance premiums for doctors.

The ineffectiveness of caps is illustrated by the experience in the State of California. Ironically, supporters of caps point to California as the model for limiting noneconomic damages. The State does, in fact, have a $250,000 cap and premiums have remained stable relative to the rest of the country. However, California adopted the cap in 1975, and over the next 13 years in California, with a cap of $250,000, premiums increased by 450 percent. This is comparable to a nationwide trend during that same period.

Then in 1988, California did something else. It passed comprehensive insurance reform. Only at that point did insurance premiums stabilize, decreasing 2 percent between 1988 and 2001. So for 13 years, when they had caps on the awards, they actually had premiums go up 450 percent, tracking the national average. In 1988, they put a cap on insurance premiums. Then they began to see the decline.

California is very worthwhile to look at, but we have to look at it in its totality. Don't disregard what happened in 1988. If we only look at 1975 to 1988, for that 13 years, there is nothing to brag about at all. The numbers went up as much as they did all across the country. It is only from 1988 up to now that we begin to see the real changes as a result of the insurance reforms in that State.

So California is a good example, but look to all of California. I could continue to quote numbers to underscore my point, but I do not want to bore my colleagues with recitations of data. I think it is important because without knowing what the facts are and understanding the argument, we cannot understand how best to deal with a very legitimate problem of trying to get these premium costs down. Does this solution meet that problem? One has to look at the data and the facts, and the facts are not holding this point up very well, in my view.

The point is very simple: The number of medical malpractice claims is not rising. The amount awarded to victims is consistent with inflation. The story in States with caps is similar to that without caps. Based on this evidence, we are being asked to limit the rights of pregnant mothers and infants. I do not think we ought to do that. The facts fail utterly to dictate such a conclusion.

If neither the number nor the amount of malpractice awards can explain rising premiums, then what is the explanation? Something is going on that is causing these premiums to continue to skyrocket as they are in my State and others across the country. According to several analyses that have been done, the increase in premiums does in fact correlate with the stock market and interest rates.

One recent study showed that premiums very closely tracked the insurers' economic cycle. During good economic times, insurers slash premiums in order to attract as much business as possible. Insurance companies receive their money from two sources. They get it from premium payments as well as investments. So when there is a good, healthy market going on, then they will reduce premiums because the cycles in the market are allowing them to sustain their economic growth. When there is a downturn in the economy and the stock market is not doing as well, the insurance industry is faced with only one other solution and that is to raise the premiums in order to keep the cashflow coming in.

So it is not complicated. As someone who comes from a State with a lot of insurance companies, I know that is how this is done. There is not some great magical secret out there. This is exactly how it occurs. So, obviously, during good economic times, insurers will cut the premiums in order to attract as much business as possible, which makes sense. This is because every new policy brings in additional float, money to invest in a booming market so they bring in the dollars. However, when the market turns and investment returns are weak, as has happened in the last few years, insurers raise their rates or, in some cases, leave the market altogether. When this happens, the result is often a crisis in the availability and affordability of insurance, and that is exactly what we are seeing today.

I will take a moment to address one other claim made by the supporters of this bill, and that is that rising premiums have reduced access to care for women and infants. Again, this is a very significant claim and needs to be addressed. Once again, I do not think the facts support that argument.

Between 1999 and the year 2002, the number of OB/GYNs across the country actually increased by 1,700 people. Only 6 States out of 50 saw a decrease in the number of OB/GYNs. That is not good news for those six States, but the argument that across the country this is occurring is not borne out by the facts. Actually, there were 1,700 new OB/GYNs in 44 States, so the number is stable or increasing, and in 6 States the number is going down. We ought to be conscious of that because that could be a trend that needs to be addressed.

Again, I underscore what I said at the outset. This is a serious problem but a serious problem demands a serious solution. Unfortunately, this bill is not that answer.

As an interesting note, by the way, where we are losing OB/GYNs, half of those six States have caps on the amount that can be collected in noneconomic terms. So we are talking about a bill that places caps on noneconomic awards, and in six States the number of OB/GYNs is declining, and yet three out of the six States have actual caps. One has to ask oneself: If this is failing in half of the States in terms of attracting or keeping OB/GYNs, is this bill or this idea the right solution to this problem? I think the conclusion is no, it is not, unfortunately, if those are the facts.

A GAO report from August of last year identified access to care as a problem—and I am quoting—''in scattered, often rural areas where providers identified other long-standing factors that also affect the availability of services.''

The question was asked: Why is this happening? The General Accounting Office comes back and said there are a lot of other factors that are causing a decline in the number of OB/GYNs. In addition, the GAO found—and I am quoting them again—''that many of the reported provider actions were not substantiated or did not affect access to health care on a widespread basis.''

Unfortunately, this bill is a misguided attempt to solve a health care problem with a tort reform solution. I am disappointed that we are not using this time today to discuss the real issues. One issue I wish we were discussing is class action reform because I think we have come up with an answer that a majority of us could support. Regrettably, we are not spending two days debating that issue. We are debating a bill that is not going to go anywhere because the solution that is being called for does not do the job.

So instead of taking the few valuable days we have in this Chamber to deal with some issues before we adjourn for elections and conventions, we are not debating class action reform, we are

debating a bill that is going nowhere. That does not make any sense to me at all in terms of this agenda. So this is a waste of our time.

Let me get into other areas of health care because there are health care problems that need addressing. I am disappointed, though, that we are not going to debate class action reform but instead these tort reform issues. We do have problems with access to care in our country. We do have a patient safety problem in our country. We do have a health care quality issue in this Nation of ours. We do have a problem with rising health care costs in the Nation. This bill does not answer any of those problems.

Why are we not discussing real solutions to the issue of access to health care, to patient safety, to health care quality in this country, and to the problem of rising health care costs? The American people have a right to expect from this body better answers than the ones we are giving them on this bill dealing with the issue of rising premium costs.

Supporters of this bill are right about one thing: Far too many in this country have little or no access to health care. The latest Census Bureau figures released in September are alarming, to say the least. Forty-four million of our fellow countrymen, more than one out of every seven people in our great Nation, were without health care in the year 2002. This figure represents a 10 percent increase in the number of uninsured since the year 2000.

Numerous studies have shown that being uninsured has a drastic impact on the amount and quality of care individuals receive. Put very simply, the uninsured receive less care, lower quality care, and are at a greater risk of dying. The Institute of Medicine has estimated that every year 18,000 of our fellow citizens die prematurely in this country as a result of the effects of being uninsured.

Our country has a growing health care underclass. The Bush administration's response to this crisis has been woefully inadequate. Tax credits and health savings accounts will do little or nothing to help the vast majority of the 44 million people who are uninsured, such as low-income working families. By the way, the majority of the uninsured work every day on one, two, three, and four jobs. These are not people sitting around doing nothing. They are working. And we have nothing to say to them.

We are debating an issue of tort reform when we ought to be dealing with how to provide some health care coverage for these people and explain why 18,000 lives a year are being lost prematurely because of the lack of health insurance. We should be talking about creative ideas to offer meaningful assistance to the uninsured. There are a variety of ideas out there that are worth discussing.

We also have a health care quality and patient safety problem in the country. Again, according to the Institute of Medicine, as many as 98,000 Americans are killed every year as a result of medical errors. A study conducted by the Rand Corporation and published in the New England Journal of Medicine last year came to a similar conclusion. Individuals received the recommended treatment for their condition in only 55 percent of the cases, according to that study. In other words, nearly half the time patients did not receive the appropriate care. Why are we not debating that and discussing that issue today?

There are a variety of proposals to address this real threat to the American public. I am currently working with our colleagues on both sides of the aisle on issues that would have some real impact on the quality of care in our country. One meaningful step we can take almost immediately is to encourage the use of information technology in the health care setting.

The Senator from New York, Mrs. CLINTON, is deeply interested in this subject matter, as are several other colleagues. Improving quality is the best tool we have to address rising health care costs. Supporters of this legislation we are debating today would have you believe medical liability costs are the main driver of rising health care costs. But that is simply not the case. The Congressional Budget Office has estimated that malpractice costs represent, at most, only 2 percent of the overall health care costs in our country.

We ought to address this issue, but let's talk about it in the context in which it is really a problem. Furthermore, while health care costs more than doubled between the years 1987 and 2001, the total amount spent on medical liability premiums rose by only 52 percent over that same period. The real drivers of health care costs are prescription drugs and hospital spending. We should be using the time to pursue proposals to address these issues, including expanding the use of inexpensive generic prescription drugs, better chronic disease management and preventive medicine, and improving health care quality and efficiency.

Let me finish by saying, as ranking member of the Subcommittee on Children and Families, improving the health of women and children has been a priority of mine and many others who serve on that committee, including the Presiding Officer. If my colleagues are genuinely interested in healthier mothers and healthier babies, I can suggest any number of pieces of legislation that are pending here that would represent real steps towards achieving that goal. I am the coauthor of two bills, the Newborn Screening Save Lives Act and the Prematurity Research Expansion and Education for Mothers who Deliver Infants Early Act, the PREEMIE legislation, that I believe would go a long way towards improving the health and well-being of newborns. During the 107th Congress, Senator HARKIN introduced the Safe Motherhood Act a comprehensive bill to ensure safe pregnancy for all women. Senator BINGAMAN introduced legislation to expand health care coverage for pregnant women under Medicaid and the State Children's Health Insurance Program.

There are a variety of such bills out there, offered on a bipartisan basis. The Senator from Ohio, Mr. DEWINE, and I have worked very hard on a number of these bills. I am not going to suggest they solve all the problems, but they are designed to deal with some of the very issues pregnant women and infants face every day. The idea that you are going to put a cap on noneconomic recoveries here and that is somehow going to address these other issues is ludicrous on its face. We ought to be spending the valuable time of this institution in debating and discussing and getting some of this legislation passed that could make a difference to these people.

I am not shy when it comes to tort reform. I have spent a good deal of time in my Senate career authoring bills dealing with tort reform. This is not one of them. This is not tort reform. This is not addressing the issue that people face every day and doctors face with rising premiums. There is a way of addressing that problem. When we get around to doing it and working on it, then we can take some pride in passing something that does something meaningful in this area. This bill doesn't do it.

I hope cloture will be denied. I yield the floor.

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

Mr. VOINOVICH. Mr. President, I rise today in strong support of S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act, and I strongly encourage my colleagues to vote for cloture on the motion to proceed on this very important legislation.

I would like to point out in the beginning of my remarks, in response to some of the statements that have been made on the floor this morning, that there has to be a reason the American College for Obstetrics and Gynecology, the American Medical Association, and just about every medical group in the United States of America is supportive of this legislation. We would not be talking about it unless they really believed the passage of this legislation would have a dramatic impact on the liability costs that OB/GYNs are experiencing, causing so many of them to leave their practices.

This is a personal issue for me. Last summer when my daughter-in-law was expecting her fourth child, she learned that after the delivery, her doctor would no longer deliver babies. At the time, her doctor was in a four-physician group, all of them obstetricians. They never had any lawsuits against them. Yet their insurance premiums had skyrocketed from $81,000 to over $381,000 in just 3 years. That is $75,000

per person over a period of 3 years. How could physicians be expected to afford rate hikes such as these?

We need to be doing something about it. This legislation is going to help. This legislation is so important because the effects of the medical liability crisis can be felt acutely by the obstetrics/gynecology community. Data from the American Medical Association indicates that 19 States currently face a medical liability crisis and 25 States show problem signs. Women of childbearing age have been impacted the most because 1 out of 11 obstetricians nationwide has stopped delivering babies and, instead, has scaled back their practice to gynecology only or just gotten out of the practice. In addition, one in six has begun to refuse high-risk cases.

How does this affect a patient's access to care? As premiums increase, women's access to general health care, including regular screenings for reproductive cancers, high blood pressure, cholesterol, diabetes, and other serious health risks, will decrease. It leads to more uninsured women because of health care costs that have gone up as a result of the fact that malpractice costs have gone up so astronomically in the last couple of years.

In 2002, 11.7 million women of childbearing age were uninsured. Without medical liability reform, a greater number of women ages 19 to 44 will move into the ranks of the uninsured. With fewer health care providers offering full services, the workload has increased significantly for those who still do. Wait times increase, putting women at risk. A physician facing higher premiums is likely to practice defensively, ordering more tests than medically necessary, seeking more opinions, and giving more referrals.

Women receive less prenatal care in our current environment. Improved access to prenatal care has resulted in record low infant mortality rates, an advance now threatened as OB/GYNs drop obstetrics. As some of you may have read, for the first time since 1958, the U.S. infant mortality rate is up. According to preliminary data released this month by statisticians from the CDC, the Nation's infant mortality rate in 2002 was 7 per 1,000 births. That is up from 6.8 in 2001. Some experts are attributing this to poor access to prenatal care, that that is the cause of this problem. Women have less preventive care. Women's general health care is routinely provided by community clinics and OB/GYNs. Women receive fewer screenings for reproductive cancers, high blood pressure and cholesterol, diabetes, and other serious health risks as OB/GYNs and community clinics reduce care.

The ramifications of this medical liability crisis on women's health care are shocking, and we feel this crisis very strongly in Ohio. The Medical Liability Monitor ranked Ohio among the top five States for premium increases in 2002. The OHIC Insurance Company, among the largest medical liability insurers in the State, has reported that average premiums for Ohio doctors have doubled over the last 3 years.

I would like to point out that the argument that the insurance industry is ripping off doctors and raising rates to make up for investment losses, as some contended here on the floor of the Senate this morning, is preposterous.

I invite those Members who believe this to read an article from Brown Brothers Harriman Insurance Asset Management Group.

I ask unanimous consent that the article be printed in the RECORD.

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

[From BBH & Co. Insurance Asset Management, Jan. 21, 2003]

DID INVESTMENTS AFFECT MEDICAL MALPRACTICE PREMIUMS?

(By Raghu Ramachandran)

It's deja vu all over again in the medical malpractice arena.

Last July, the only trauma center in Las Vegas was forced to close. At the beginning of this year, doctors in Pennsylvania threatened to go on strike but relented when the incoming governor promised to support legislative reforms to limit jury awards in malpractice suits. Also in January, doctors in Weirton, West Virginia went on strike, forcing patients to travel up to 40 miles to find medical care. Doctors in neighboring areas of West Virginia considered joining the strike, threatening a near complete shutdown of the medical delivery system in the region. Doctors and hospitals around the country are suspending their practices and closing their doors because they can no longer afford the huge and increasing cost of medical malpractice insurance. The situation is increasingly reminiscent of the malpractice crisis of the 1970's. What is causing this controversy and what can be done about it?

According to Americans for Insurance Reform (AIR), ''insurance companies raise rates when they are seeking ways to make up for declining interest rates and market-based investment losses.'' Mainstream media, such as The New York Times, have picked up this argument: ''The steep drop in bond yields and the stock market has also fueled the crisis.'' These arguments are both misleading and inaccurate. The root causes of the problem are quite different from what is often suggested by the media, and their resolution is far less simplistic than the pundits imply.

In this paper, we will analyze several variables to demonstrate that asset allocation and investment returns have had little, if any, correlation to the development of the current malpractice problem. The crisis is rather the result of a generally unconstrained increase in losses and, over several years, inadequate premium income to cover those losses.

Given that conclusion, we will then examine several possible solutions and attempt to gauge the magnitude of changes necessary to resolve this problem.

AIR uses the following graph to demonstrate that losses have tracked inflation and that premiums vary because of the economy. The graph attempts to compare two key trends underlying the medical malpractice controversy: premiums per doctor (DPW/MD) and paid losses per doctor (DLP/MD). Both of these variables are expressed in constant medical dollars.[1]

[1] Graphs not reproducible in the Record.

LOSS INFLATION

AIR claims this shows ''that since 1975, medical malpractice paid claims per doctor have tracked medical inflation very closely.'' In fact, the graph and the underlying data suggest exactly the opposite. First, they make an erroneous comparison. Since AIR uses real (or constant) medical dollars, they have already factored out the effect of medical inflation. So, any increase is a ''real'' increase in excess of medical inflation. One cannot compare real increases to inflation.

Second, the data show loss costs have increased significantly faster than inflation. Using data from the AIR report, we plotted medical inflation (CPI–U), premiums, and losses to show how each has grown since 1975.

One sees that the losses per doctor have grown at a much higher rate than either medical inflation or premiums per doctor. In order for losses in 2001 to have equaled the build up created by inflation in medical care during the period 1975–2001, companies would have to reduce the amount of paid losses by approximately 60%. Therefore, losses, not inflation, are the problem.

ECONOMIC EFFECT

The other claim made by AIR is that ''insurance premiums (in constant dollars) increase or decrease in direct relationship to the strength or weakness of the economy, reflecting the gains or losses experienced by the insurance industry's market investments and their perception of how much they can earn on the investment 'float'.'' Unfortunately, they make this claim without any supporting analysis. Using the premium data from AIR, we found no correlation between premiums and the economy.

The standard measure of the effect one variable has on another is the coefficient of determination (r^2); this value shows how consistently two variables move in the same direction. The coefficient of determination has values between 0 and 1. A value of 1 means that if the first variable moves up the second will move up at the same time; a value of zero means that there is no similarity in the movement of the two variables. The correlation coefficient has to be greater than 0.75 for us to claim the observed effect between the two variables is significant.

As a measure of the economy, we used the year-over-year change in GDP; as a measure of investment yield, we used the yield on a 5-year Treasury note. In our analysis, neither the direct premiums written nor the direct premiums per doctor showed any significant correlation to either the investment yield or GDP variable. The table lists the coefficients of determination generated by the regression analysis between the economy, investment yield, and medical malpractice premiums.

	GDP	Yield
DPW	0.0001	0.1255
DPW/MD	0.0104	0.0318

Several other analyses also failed to show a correlation between premiums and the economy. To test if the premium increases are related to the economy or bond market, we analyzed the correlation of the change in premiums to GDP and investment yield. To test whether premiums go up when the investment yield goes down, we analyzed the correlation between premiums and the change in yield as well as the correlation between the change in premiums and the change in yield.

One could reasonably claim that the premiums (or increases in premiums) are dependent not upon the company's performance this year but upon the company's performance in the previous year. To test this hypothesis, we regressed both premiums and

change in premiums to both the economy and investment yield in the previous year. For thoroughness, we also analyzed the correlation between both premiums and change in premiums with the change in yields in the prior year.

We also considered alternate measures for GDP and yield. We used industrial production as an alternate measure of the economy and the 10-year Treasury note as an alternate measure of yield. We also analyzed the effect the slope of the yield curve and the change in slope had on premiums. We performed all of the analyses above on these new variables.

In 64 different regressions between the economy, yield, and premiums, the highest coefficient of determination was 0.1505. Therefore, we can state with a fair degree of certainty that investment yield and the performance of the economy and interest rates do not influence medical malpractice premiums.

STOCK MARKET EFFECT

But what about the stock market? How did the drop in the equity markets affect insurance company performance? Are companies raising premiums because they lost money on Enron or WorldCom?

Obviously, the market decline affects insurance companies like every other investor, but the magnitude of the losses gets lost in the media hype. We analyzed the equity exposure in two stages. Stage one: Did medical malpractice companies have an unusually large amount of equities in their portfolio? Stage Two: Given their level of equity exposure, did they invest prudently in the market or did they gamble by investing in technology or telecom stocks?

Using NAIC filings, we can determine the amount of assets invested in equities.

Over the last five years, the amount medical malpractice companies have invested in equities has remained fairly constant. In 2001, the equity allocation was 9.03%. We can also compare how the medical malpractice sector compares to other P&C sectors.

This graph shows that medical malpractice companies have less invested in equities than other sectors of the industry.

Even if the equity allocation is not large relative to the industry or other insurance sectors, is 10% the correct amount for medical malpractice insurers to invest in equities? Insurance companies invest their assets as a fiduciary of the policyholders. As such, they must invest according to a ''prudent investor'' standard. This requires the company not only to consider the risk in an individual security, but also the risk to the portfolio as a whole. Prudent investors know that diversifying across asset classes can enhance return and reduce volatility. A simple analysis shows a conservative investor will have at least 10% invested in equities. Thus, a prudent insurance company should have some allocation to equities.

If the degree of equity exposure was not unusual, was the investing? Again using NAIC filing data, we can analyze the distribution of equity investments for medical malpractice companies and compare it to S&P performance.

[In percentage]

Sector	Medical malpractice companies	S&P sector return
Energy	5.6	−11.0
Materials	1.9	−5.4
Industrials	11.9	−26.2
Consumer Discretionary	15.9	−23.7
Consumer Staples	7.3	−4.3
Healthcare	14.1	−18.8
Financials	17.8	−14.5
Technology	17.9	−37.4
Telecom	6.3	−34.0
Utilities	1.4	−29.5
	100.0%	
Total Return	−22.4%	
S&P Return	−22.2%	

We see that medical malpractice companies had returns similar to the market as a whole. This indicates that they maintained a diversified equity investment strategy.

As medical malpractice companies did not have an unusual amount invested in equities and since they invested these monies in a reasonable market-like fashion, we conclude that the decline in equity valuations is not the cause of rising medical malpractice premiums.

WHERE DO WE GO FROM HERE?

In order for any form of insurance coverage to be viable, the insurance company must receive more in premium dollars and investment income than they pay in losses and expenses. A simple measure of this is the ratio of paid losses to premiums Over the last 27 years, and especially over the last 16, the paid loss ratio in medical malpractice coverage has steadily increased. Without some form of relief, this is not a good sign.

Although the paid loss ratio is a good starting point, that metric excludes other expenses such as incurred losses, loss adjustment expenses, general operating expenses, etc. as well as income from investments. A.M. Best provides the combined loss ratio (paid loss + change in reserves + expenses) for the medical malpractice industry. By subtracting the paid loss ratio, from the AIR report, from the combined ratio, we can get an estimate of the other expenses for an insurance company. The average expense ratio for medical malpractice companies was 43% when investment income is included and 74% when investment income is excluded.

Over the last 27 years, the average paid loss ratio was 47% and the minimum paid loss ratio was 16%. In 2001, the industry paid loss ratio was nearly 75%. In other words, for every dollar that comes in the door, 75 cents is paid out. When combined with the expense ratios cited earlier, it is clear that it has been extremely difficult—if not impossible—for insurance companies to earn a profit writing medical malpractice insurance. Further, at this rate of expenditure, after the company pays its losses and expenses, there is very little ''float'' on which they can earn investment income.

Medical malpractice paid loss ratio 1975–2001

	In percent
Average loss ratio	46.8
Minimum loss ratio	15.9
2001 loss ratio	74.4

To increase profitability, companies must effect one of three changes: reduce their losses, increase their premiums, or increase their investment income. As the industry, in aggregate, cannot control return on investments, they have only two choices. Using the methodology above, we can estimate the magnitude of the change required to restore profitability to the industry.

If losses are held constant—i.e., no change in loss and expense trends, then we are left with increasing premiums to restore the industry to profitability. For premiums to have kept up with medical inflation for the period 1975 to 2001, they would have to increase by 41%. For premiums to have kept up with the increases in paid losses since 1975, they would have to increase by 325%. For the industry's average loss ratio to drop back to its 27-year average, premiums would need to rise by 59%. For the loss ratio to drop to its nadir during that period, premiums would have to increase by 368%.

	Dollars	% Increase
2001 DPW/MD	$9,719	
Premium required for:		
Average Loss Ratio	15,448	59
Minimum Loss Ratio	45,478	368

Clearly, increases of this magnitude are intolerable, for both the industry and state regulators. In this regard, St. Paul's experience is noteworthy. Prior to its withdrawal from the market, the company was granted 31% less in rate increases than indicated. It is little wonder that they responded as they did!

ST. PAUL RATE FILINGS

[In percentage]

State	Date	Indicated increase	Increase filed	Difference
1	1/1/2001	76.10	25.00	40.90
2	3/7/2001	−34.30	−43.00	15.30
3	1/1/2001	54.50	35.00	14.40
4	6/1/2000	39.20	5.00	32.60
5	11/1/1999	28.70	5.00	22.60
6	1/1/2001	55.20	10.00	41.10
7	2/1/2001	18.90	−21.00	50.50
8	1/1/2001	90.80	35.00	41.30
9	1/1/1999	18.50	5.00	12.90
10	1/1/2002	73.00	35.00	28.10
11	1/1/2001	26.80	12.50	12.70
12	1/1/2002	70.20	45.00	17.40
13	1/1/2002	67.30	40.00	19.50
14	1/1/2001	49.30	10.00	35.70
15	10/1/1999	88.10	5.00	79.10
16	1/1/2002	71.00	10.00	55.50
17	1/1/2002	82.60	45.00	25.90
18	7/1/2000	12.50	0.00	12.50
19	7/15/2000	57.00	7.50	46.00
20	7/1/2000	17.10	5.00	11.50
21	1/1/2000	40.90	5.00	34.20
22	7/1/2000	58.90	8.50	46.50
23	1/1/2001	50.70	15.00	31.00
Average		48.40	13.00	31.60
Average excluding #2		52.20	15.60	32.40

St. Paul had the luxury of falling back on other lines of business. Unfortunately, many special medical malpractice companies, such as state PIAA companies, do not have other lines of business to fall back on.

RATING AGENCY RESPONSE

The reaction of rating agencies to these trends is another important ingredient in the medical malpractice landscape. Principal concerns of the agencies are ''solvency'' and the ''leverage'' built into the premium and surplus structure of the industry. While agencies usually express the benchmarks for the measurements (ratios) in ranges, trends are also important. Either level or trend can result in a downgrade in a company's rating, a serious event in the corporate life of an insurer.

In 2001, medical malpractice companies had an average premium-to-surplus ratio of 0.72. As premiums are increased, this ratio will rise. If premiums rise too quickly, we would observe a spike in this ratio as it takes time for the increased premiums to show up in surplus. Unless rating agencies account for this, a company could find they cannot raise their rates by the required amount for fear of impairing their rating. In fact, several companies have been downgraded recently, with premium leverage given as the primary reason. (The situation is exacerbated by the fact that with the industry suffering from reduced capacity as a result of the St. Paul type experiences, companies are adding to their number of insureds. This puts further strain on their leverage ratios.) Fortunately, the rating agencies seem to be aware of the problem.

TAMING LOSSES

If companies cannot increase their premiums, then they must be able to control the burgeoning increase in losses. Our analysis suggests that the level of losses would

have to decrease by 37% to achieve the average loss ratio and by 79% to obtain the minimum loss ratio observed over the past 27 years. Such reductions would require significant change in the tort environment.

	Dollars	% decrease
2001 DLP/MD	$7,232	
Losses required for:		
Average Loss Ratio	4,549	−37
Minimum Loss Ratio	1,545	−79

The paid loss number cited above includes both jury awards and settlements. Large jury awards have the pernicious effect of enticing more lawsuits, most of which are settled out of court but with an expense to the company. Prudent reforms, such as MICRA, reduce not only the jury awards but also reduce the amount of lawsuits filed.

SUMMARY

The magnitude of these changes suggests that the eventual solution to the current malpractice problem will be a blend of premium increases and tort reform. Since the financial shortfall compounds itself over time, it is imperative that the solution set be developed as quickly as possible. Without significant relief in fairly short order, the country may find itself facing an accelerating loss of available medical care.

Mr. VOINOVICH. The subject of the article is ''Did Investments Affect Medical Malpractice Premiums?'' It concluded:

. . . asset allocation and investment returns have had little, if any, correlation to the development of the current malpractice problem.

The article goes on to say:

The crisis is rather the result of a generally unconstrained increase in losses and, over several years, inadequate premium income to cover those losses.

The article also goes on to say:

We see that medical malpractice companies had returns similar to the market as a whole. This indicates that they maintained a diversified equity investment strategy. As medical malpractice companies did not have an unusual amount invested in equities and since they invested these moneys in a reasonable market-like fashion, we conclude the decline in equity valuations is not the cause of rising medical malpractice premiums.

Finally, I will finish up with a summary:

The magnitude of these changes suggests that the eventual solution to the current malpractice problem will be a blend of premium increases and tort reform. Since the financial shortfall compounds itself over time, it is imperative that the solution set be developed as quickly as possible. Without significant relief in fairly short order, the country may find itself facing an accelerating loss of available medical care.

And I contend that acceleration is well underway not only in OB/GYN but in other aspects of the medical profession.

According to a November 2000 study of the American College of Obstetricians and Gynecologists, 59 percent of responding Ohio OB/GYNs have been forced to make changes to their practice such as quitting obstetrics, retiring, relocating, decreasing gynecological surgical procedures, no longer performing gynecologic surgery, decreasing the number of deliveries, and/or decreasing the amount of high-risk obstetric care because of unaffordable and unavailable medical liability insurance. Of the respondents, 86 percent no longer practice obstetrics, which forces a potential of some 14,000 pregnant Ohio women to find new OB/GYNs to provide their obstetric care.

This is not the statistics. I have received dozens of testimonials from doctors saying they are quitting their practice because of the rising cost of medical liability insurance. A friend of mine shared with me a letter from an OB/GYN in Dublin, OH, who decided to retire from his practice.

He wrote the following to his patients:

On June 17, 2003, I received my professional liability insurance rate quote for the upcoming year, and it is 64% higher than last year's rate. I have seen my premiums almost triple during the past two years, despite never having had a single penny paid out on my behalf in twenty-seven years as a physician. Even worse, during this time the insurance company has reduced the amount of coverage that I can purchase from $5 million to only $1 million, while jury verdicts have skyrocketed, often exceeding $3–4 million. If I were to purchase this policy, I would be putting all of my family's personal assets at risk every time that I delivered a baby or performed surgery. I refuse to do that.

I have therefore decided to retire from private practice on July 31, 2003, the final day of my current liability insurance policy. This is not a decision that I take lightly, but unfortunately it has become necessary. For many of you, I have been part of your life for years. I have delivered your babies, and helped you through some of life's most difficult challenges. It has truly been an honor.

I received another letter from Dr. Ben Alvarez. He worked for Beachwood OB/GYN. He sent a letter informing his patients he was relocating to Minnesota this March. He says, in part:

The decision to leave Ohio is the direct result of the medical malpractice crisis: with a clean record, my annual premium will reach well over $100,000 this July. I cannot, and will not, in good conscience play the insurance company's game—it's just that simple. What's not simple is saying good-bye to a town and people that have given me so much. Ob/Gyn is so different from other medical specialties due to the emotional and personal relationships that exist between us. I have been blessed to have experienced with so many of you the joy of a new baby's arrival; prayed about the outcome of surgery; and also shared the painful moments.

I ask unanimous consent to have the complete letter printed in the RECORD.

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

BEACHWOOD OB/GYN, INC.,
Lyndhurst, OH, January 4, 2004.

MY DEAREST PATIENTS: It is with a heavy heart that I inform you that I shall be relocating to Minnesota in March. The decision to leave Ohio is the direct result of the medical malpractice crisis: with a clean record, my annual premium will reach well over $100,000 this July. I cannot and will not, in good conscience play the insurance company's game—it's just that simple.

What is not simple is saying good-bye, to a town and people that have given me so much. Ob/Gyn is so different from the other medical specialities due to the emotional and personal relationships that exist between us. I have been blessed to have experienced with so many of you the joy of a new baby's arrival; prayed about the outcome of a surgery, and also, shared the painful moments. Indeed, it is I who thank God for having met you, for, because of you, I have become a better, more complete, human being.

Do not despair over the continuity of your care. My colleagues in the practice will keep the ball rolling. From a practical standpoint, I would encourage you to set up follow-up appointments with any one of the doctors. Drs. Varyani and Goldshmidt have schedules that allow for more flexibility, but Drs. Bellin, Evans, Klein and Vexler are also available to continue your care. They are all excellent doctors and have my complete confidence.

Farewell, my friends, and the best to you and your families.

With sincere affection and melancholy.

BEN ALVAREZ,
MD.

Mr. VOINOVICH. After speaking at a physicians' rally in Ohio, I received a letter from a young doctor, Geoff Cly. Dr. Cly received a notice from the insurance carrier that the premiums would increase by 20 percent, $30,000, this plus the $20,000 increase from the year before, forcing him to make a difficult decision of uprooting his family and practice to go to another State. Doctor Cly was unable to make the insurance premiums and still take care of his student loan obligations and his family. He moved to Fort Wayne, IN. He said to me: Senator, I am going to Indiana. My liability insurance will be less there. But the practice has gotten so much different than what I anticipated it to be that I am seriously thinking, after I pay off my college loans, I am going to get out of medicine.

It is a tragedy what is happening today in my State and other States throughout this country. For those of my colleagues who think medical liability reform is a State issue, I ask them to read this letter and see how the medical liability crisis transcended State lines, particularly my friends from the neighboring State of West Virginia. Our Ohio physicians who practice along the border are feeling the effects of their proximity to West Virginia and its favorable plaintiffs' verdicts. They are feeling these effects in their increasing insurance premiums.

It is amazing the number of counties along the West Virginia border and eastern Ohio where they have no more OB/GYNs. They just left. These counties go bare, with no OB/GYN to provide services to protect women.

I could go on and give more and more examples of Ohio physicians who had to leave the practice of medicine. Dr. Komorowski of Bellevue stopped delivering babies after 20 years when he found out the day after Christmas last year that his liability insurance was tripling to more than—listen to this—$180,000. Dr. Komorowski, the only obstetrician in Bellevue, figured it would cost him nearly 11 months of his salary to pay the premium increase in addition to taxes and other expenses.

It is out of control. We need to do something now, not just for Ohio but

for the rest of the country as well. Obstetrics/gynecology is among the top three specialties in the cost of professional liability insurance premiums. Nationally, insurance premiums for OB/GYNs have increased dramatically. The median premium increased 167 percent between 1982 and 1998. The median rate rose 7 percent in 2000, 12½ in 2001, 15.3 in 2002, with increases as high as 69 percent according to a survey by the Medical Liability Monitor, a newsletter covering the liability insurance industry.

According to the Physicians Insurance Association of America, OB/GYNs were first among 28 specialty groups in the number of claims filed against them in 2000. OB/GYNs were the highest of all the specialty groups in the average cost of defending against a claim in 2000 at a cost of almost $35,000. In the 1990s they were first, along with family physicians, general practitioners, in the percentage of claims against them closed with a payment of 36 percent. They were second after neurologists in the average claim payment made during that same period.

Although the number of claims filed against all physicians climbed in recent decades, the phenomena do not reflect an increased rate of medical negligence. In fact, OB/GYNs win most of the claims filed against them. In 1999, an American College of Obstetricians and Gynecologists survey of its membership found that over one-half, 54 percent of claims against OB/GYNs were dropped by plaintiff attorneys, dismissed or settled without payment; 54 percent of the cases that did proceed. OB/GYNs won 7 of 10 times. Enormous resources are spent to deal with these claims, only 10 percent of which are found to have merit.

The cost to defend these claims can be staggering and often mean that physicians invest less in new technologies that help patients. In 2000, the average cost to defend a claim against the OB/GYN was the highest of all physicians.

According to the American College of Obstetricians and Gynecologists, the typical OB/GYN is 47 years old, has been in practice for 15 years and can expect to be sued 2.53 times over his or her career. Over one-quarter of the residents have been sued for care provided during their residency. And that is another problem we are seeing in this country: Many residencies are going unfulfilled because of the medical malpractice lawsuit abuse growth in this country. Medical school enrollments have been impacted by what young people are seeing happening in the medical profession in this country.

In 1999, 76 percent of the American College of Obstetricians and Gynecologists fellows reported they had been sued at least once so far in their career. The average claim takes over 4 years to resolve. I know from anyone who has been the subject of a lawsuit that 4 years is 4 years of stress as they worry about what is going to happen as a result of the outcome of that litigation.

The legislation we are debating today gets us on our way to turning these statistics and stories around. It provides a commonsense approach to our litigation problems that will help keep consumers from bearing the cost of costly and unnecessary litigation while making sure that those with legitimate grievances have recourse through the courts.

Throughout my career in public service, health care has been one of my top legislative priorities. We all want access to quality, affordable health care. We do have a problem in this country in terms of access to quality health care. In my State, I have conducted eight listening sessions. The result from all those sessions, regardless of who was there, is that the system is broken, and we need to plow new ground.

When the quality is not there, when people die or are truly sick due to negligence or other medical error, they should be compensated. We want that. But when healthy plaintiffs file meaningless lawsuits to shake the money tree to get as much as they can get, there is a snowball effect and all of us pay the price.

The last time I spoke on this subject, I had the front and back cover of the white pages and the yellow pages of the Cleveland phonebook. The front cover and back cover of both of them were advertisements for personal injury lawyers giving specific examples of encouraging people to file suits based on the information they had in their advertisement.

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

I have been concerned about this issue since my days as Governor of Ohio. In 1996, I essentially had to pull teeth in the Ohio Legislature to pass a tort reform bill. I signed it into law in October of 1996. Three years later, the supreme court ruled it unconstitutional. If that law had withstood supreme court scrutiny—and it should have; we now have what I call a balanced supreme court in Ohio—Ohioans would not be facing the medical access problems they face today: Doctors leaving their practice, patients unable to receive the care they need, and the cost of health insurance going through the roof.

During my time in the Senate, I have continued my work to alleviate the medical liability crisis. To this end, I have worked with the American Tort Reform Association to produce a study in August of 2002 that captured the impact of this crisis on Ohio's economy in order to share these findings with my constituents and colleagues. Guess what we found. What we have in this country today, in my opinion, not only in this area but in a lot of areas, is a litigation tornado that is ripping through the economy. We found in Ohio that the litigation crisis costs every Ohioan $636 per year and every Ohio family of four $2,544. These are alarming figures, and the numbers are from 2 years ago. Which family do you know that can pay $2,500 for the lawsuit abuse of a few individuals?

Next to the economy and jobs, the most important issue facing our country today is health care. In fact, it is a major part of what is wrong with the economy. We have too many uninsured, and those who have insurance face soaring premiums every year, making it less likely they can continue to pay them. In addition, employers are facing spiraling costs and in some cases don't even provide insurance.

I have talked to one employer after another. They say: I want to provide health insurance for my workers, but I cannot afford to do it at $10,000 for a family of four. I am asking my employees to pay more of the premiums. In many instances my employees cannot afford to pay the premiums so they are going without health insurance.

We have a real problem. Medical malpractice lawsuit abuse reform is having a dramatic impact on the cost of health insurance, in spite of what some of my colleagues have said. Providing the sort of commonsense approach found in the Healthy Mothers and Healthy Babies Access to Care Act is a win-win situation. The bill will help decrease the rising cost of health care. It will give patients access to care and it will curtail the rising cost of medical liability insurance for those physicians who provide prenatal delivery and postpartum care to mothers and babies.

Patients will not have to give away large portions of their judgments to their attorneys. Truly injured parties can recover 100 percent of their economic damages. Punitive damages are reserved for those cases where they are truly justified. Doctors and hospitals will not be held liable for harms they did not cause and physicians can focus on what they do best—practicing medicine and providing health care.

I urge my colleagues to vote for cloture so we can debate this issue and have an up-or-down vote on this legislation impacting on our most important patients: Pregnant women and their newborn babies.

There was some mention made of the General Accounting Office study of the medical liability crisis and access to care. I ask unanimous consent to have printed in the RECORD the response of the American Medical Association to that General Accounting Office report. It is very important.

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

MEDICAL LIABILITY CRISIS AND ACCESS TO CARE—AMA'S RESPONSE TO THE GENERAL ACCOUNTING OFFICE, SEPTEMBER 2003

The U.S. General Accounting Office (GAO) recently released two reports related to

America's medical liability crisis. [U.S. General Accounting Office, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates, GAO–03–702 (June, 2003); and Medical Malpractice: Implications of Rising Premiums on Access to Health Care, GAO–03–836 (August, 2003)]. The first report (June 2003) confirms that, since 1999, medical liability premiums skyrocketed in some states and specialties—and increasing settlements and jury awards (''paid claims'') are the primary drivers for these increases. The second report (August 2003) confirms that America's medical liability crisis is causing access to health care problems in high-risk medical specialties and in select locations throughout America.

The GAO reports also confirm what the American Medical Association (AMA) has long held to be true—tort reform works. Medical liability premiums in states with strong caps on non-economic damages grew at a slower rate than states without caps on non-economic damages.

We appreciate the GAO's efforts and recognize that it is difficult to quantify the medical liability crisis. Among its findings, the GAO confirmed that:

Increased losses on claims are the primary contributor to higher medical liability premium rates (GAO 03–702, p. 15);

Premiums were higher (GAO 03–702, p. 14) and grew more quickly (GAO 03–836, p. 30) in states without non-economic damage caps than in states with non-economic damage caps;

Physician responses to medical liability pressures in the five crisis states have reduced access to services affecting emergency surgery and newborn deliveries (GAO 03–836, p. 5);

Similar examples of access reductions attributed to medical liability pressures were not identified in the four non-crisis states without reported problems (GAO 03–836, p. 5);

Insurers are not charging/profiting from excessively high premium rates (GAO 03–702, p. 32); and

None of the insurance companies studied experienced a net investment loss (GAO 03–702, p. 25).

However, the GAO's August report fails to accurately reflect the severity of the current crisis. Numerous changes to the GAO methodology would strengthen the basic findings of this report. Among the data sources, measures, or analytical methods that could be improved:

Examine all crisis states. To date, the AMA, in conjunction with its federation of state medical associations, has identified 19 states in a medical liability crisis. The GAO investigated access problems in only five of those states. In each of those states it found examples of reduced access to care. The GAO would have found similar access problems if it had examined the other 14 crisis states. In fact, the GAO did not identify any access problems in the four non-crisis states it examined. Therefore, the GAO's conclusion that access problems are not widespread is not substantiated.

Recognize increased impact on rural areas. Health care access problems do not have to affect every part of a state to create crisis conditions. Health care by its nature is local, where a loss of just one or a few physicians or other health care providers in a community can have a traumatic impact on the availability of health care services in that community. Many rural areas suffered from physician shortages prior to the recent escalation in liability premiums. It is precisely in those areas where access is already threatened that one would first notice the impact of physician's relocation or curtailment of certain services.

Appropriately measure physician mobility. Physician counts were based on state licensure data, which do not accurately reflect the number of physicians practicing in a given location. Actual physician practice location information must be used instead.

Relying on the total number of licensed physicians is a state to track physician mobility is inappropriate. According to James Thompson, MD, President and CEO of the Federation of State Medical Boards of the U.S. (FSMB) in September 2003: ''The number of licensed physicians in a state is not an accurate measure of whether patients have adequate access to health care. Physicians may reduce their practice, stop treating high-risk patients, or stop practicing altogether and still maintain their license. Also, the number of licensed physicians is not an accurate indicator of the distribution of those physicians in underserved areas. Licensed physicians may work in administrative, academic or other settings where they may not have a clinical practice. Also, many retired physicians maintain a license. Information in the Federation of State Medical Boards' database shows that approximately 60% of physicians are licensed in more than one state which indicates that they are licensed in states where they do not maintain a full-time or part-time practice.''

Accurately count physicians by specialties and local markets. The GAO's method of measuring physician supply and potential access to care is not appropriate. Physician/population ratios that aggregate physicians across local markets and specialties obscure the significant market-specific or specialty-specific changes in the supply of physicians and availability of critically important medical services. Similarly, the number of high-risk sub-specialists that depart from any locality would likely account for only a small percentage of physicians in the state.

Use multi-payor data to accurately measure access to health care services that Medicare data alone do not capture. Utilization statistics based exclusively on data from a single payor (Medicare) exclude data for obstetric and emergency care, and fail to capture the impairment of access among other vulnerable populations, such as Medicaid patients. Medicare data are inadequate to identify changes in obstetric services because a vast majority of Medicare eligible beneficiaries are beyond reproductive age. Limitations in the data also preclude an assessment of changes in emergency room services. Therefore, the report significantly understates the impact of rising liability insurance premiums because it does not examine two clinical areas in which impairment of patient access has been the most severe—obstetric and emergency room services.

The AMA will continue to advocate on behalf of patients and physicians for national reforms similar to those already passed by the U.S. House of Representatives. America's patients are the ones who will suffer if Congress does not act soon. This is a crisis. It is not waning, and without real reforms more patients will be unable to find a doctor to deliver a baby, perform life-saving trauma surgery, or provide other critical care to high-risk patients who need it most.

Mr. VOINOVICH. I will summarize quickly some of the conclusions. It says: The GAO August report fails to accurately reflect the severity of the current crisis. Numerous changes in the GAO methodology would strengthen the basic findings. Among the data sources, measures, analytical methods that could be improved: Examine all crisis States. To date, the AMA, in conjunction with its federation of State medical associations, has identified 19 States that have a medical liability crisis.

They also suggest recognizing the increased impact on rural areas, which GAO did not do; approximately measure physician mobility. Physician accounts were based on State licensure data which do not accurately reflect the number of physicians practicing in a given location. Actual physician practice location information must be used instead.

They should accurately count physicians by specialties and local markets and use multi-payor data to accurately measure access to health care services that Medicare data alone do not capture.

I can tell you I have not completely read the GAO report, but I have read portions of it. Its connection to reality in my State is not there. I have talked to David Walker about it. I have talked to the people who did the report and encouraged them to look at some of the suggestions the AMA made and perhaps do another study that would accurately reflect what is really going on today in this country in terms of medical malpractice increases and what it is doing to access to health care.

I would like to end my remarks with the words of Dr. Evangeline Andarsio. Dr. Andarsio is an OB/GYN from Dayton, OH. I met Dr. Andarsio at a physicians rally in Ohio. I will never forget that day. It was October of 2002. It was very cold. I was freezing. In fact, when I got up, my teeth were chattering. But prior to my getting up, Dr. Andarsio started to speak. I thought to myself, this doctor is just going to go on and on and on. And I was cold. But as she started, as I listened intently to what she was saying, I was moved by her remarks. This was truly a dedicated physician who loved her patients, loved what she was doing, and who was unable to practice medicine the way she wanted to because of this malpractice lawsuit abuse problem she is confronted with in our State.

I would like to close with a quote from her speech:

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

That is what much of this debate is about. It is about physicians being able to practice medicine and do it in a way they did back when my wife Janet and I were having our four children. There is a special relationship between an OB/GYN and a family. It breaks my heart to see so many of them leaving the practice of medicine because of these malpractice costs with which they are confronted.

We do have a crisis. This Senate is going to have to face up to it. I am hoping that we will have 60 votes today on cloture on the motion to proceed. I think we need to debate this issue. This issue has to be debated and the American people who are not aware of the crisis need to be made aware of it.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized.

Mr. GREGG. Mr. President, what is the present situation relative to time?

The PRESIDING OFFICER. The Senator's side has 37 minutes and the other side has 12 and a half minutes.

Mr. GREGG. The Senator from Florida wanted 20 minutes. I ask unanimous consent that he be allowed to proceed after I speak for 20 minutes, but to the extent his time exceeds 12 minutes, it be debited against the time of the Democratic membership after we come back from the policy lunches.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. GREGG. Mr. President, I congratulate the Senator from Ohio for an excellent statement outlining the gravity of the problem we face, which is that women in this country are losing access to OB/GYN doctors, especially if they want to have babies. As a result, we are putting a lot of pressure on a lot of people—women, specifically, in their birthing years—and making it difficult, especially in rural areas, to get the type of health care we want them to get.

We are a society that is built around the concept of babies and children, and that is one of the more exciting things that happens in everybody's lifetime. Yet we are a society making it extraordinarily difficult now for doctors who practice the delivery of children and babies to practice their trade.

As I have said before, lawyers don't deliver children. Doctors deliver children. Unfortunately, the doctors are being driven out of the business by attorneys, and the cost of their malpractice premiums are going up radically. As a result, many doctors in my State are not delivering children anymore. I went through the specifics of that yesterday. I want to read a compelling letter I received from Debbie Risteen. She lives in Derry, NH. She has six children.

She wrote:

I regret I could not be here with you in person today to tell you my story myself, as it would have been quite an honor for me. Let me tell you a little about myself. I am a mother of 6 whose ages range from 12 to 8 months. I love children and I homeschool. One of my favorite things of our married life has been being pregnant and delivering our babies. What an incredible time all 6 have been!

I would like to describe to you a word picture for a moment. . . . It was a very difficult decision for me to decline coming to speak to you all today. One that took a lot thought. I need to weigh the cost at such a short notice. As much as I wanted to be here today, my family needed me more. If anything happened especially with the baby . . . I would be so far away to be able to meet the need and it would take me awhile to get to NH. In this picture, I now want you to see the importance of a pregnant woman needing the care of her OB. Someone she can depend on, trust in the decisions that lie ahead and most of all close in case of an emergency just like my family is depending on me.

You see, my heart was broken this Christmas when I learned of our dear friend, Dr. Pat Miller, would not be doing what was closest to her heart . . . delivering babies. I could not believe it, you are so wonderful at this, people need you, I would tell her.

12½ years ago we made one of the biggest decisions of our lives . . . to begin a family. When we got the exciting news, we were busy looking for the best care, a doctor who was up on the latest, one who could handle complications, a hospital close by, and the list went on. We learned of a new OB in the area . . . Pat Miller. We heard she was all the things we were looking for and more. We were thrilled to be in the care of someone as wonderful as her. Through all of our visits we became very close friends and I knew she truly cared about me, the child, and my husband. Being our first and not knowing what to expect, I knew she was right there if anything was to happen and I trusted her wisdom to do what was best for the both of us. As a matter of fact, 3 of our children were born on her day off and she spent the day at the hospital in case we needed her for any emergencies. It was a tremendous comfort not only to me through these 9 months, but also for my husband to know we were in the best care and it was close. We knew that no matter what lied ahead she was there and would make the best choices. As our family began to grow it was a huge help to have her close by, especially when bringing 1 then 2 and so on with me. I have been so fortunate through 6 pregnancies to not have any complications, but as we all know, there are no guarantees to this. Other women are not as fortunate as me, but I would love for them to be able to have the same comfort and trust that I have experienced with our OB. I love our children dearly, and I love babies, and my hearts desire in sharing my story with you, is for legislators to hear 1st hand the importance of people, like Pat Miller, to be able to continue what she loves and does best. To be able to provide an environment in which OB's can continue to deliver babies. To allow other mothers the same opportunity of trust and friendship that we still have today with our OB. Please listen to my heart . . . we need people like Pat Miller back in OB where she does what she knows best. Thank you for listening.

Sincerely,

DEBBIE RISTEEN.

That is a pretty compelling letter. It is anecdotal, but it is an anecdote happening across this country. Stories are being retold. Women are losing their OBs because these physicians are getting out of the practice of delivering babies because of the cost of their malpractice insurance. This bill will help alleviate that problem, and it is absolutely critical to give women this access and to not do things extremely discriminatory against women, and especially women who wish to become pregnant and have children.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, I rise today in support of S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act, the principal sponsors of which were Senator GREGG and Senator ENSIGN.

Much of America cannot access basic medical services because lawsuits are driving insurance premiums through the roof and driving doctors literally out of business. Seven months ago a majority of Senators voted to try to do something about this problem. Unfortunately, not a single Democratic Senator supported our effort and therefore we could not overcome a filibuster and were prevented from even considering S. 11, the Patients First Act of 2003.

In the last 7 months, the crisis has gotten no better. That is the bad news. The good news is our resolve has not waned so again we are before the American people waiting and willing to roll up our sleeves to fix this problem if our friends on the other side of the aisle will let us have a chance.

Like the bill we offered last July, the reforms we are now proposing are tried and true. They are based on California's MICRA legislation, which for a quarter of a century has stabilized insurance premiums and helped ensure access to health care for those in the Golden State. The Healthy Mothers and Healthy Babies Access to Care Act would allow plaintiffs to recover unlimited economic damages, up to a quarter million dollars in noneconomic damages, and punitive damages up to the greater of a quarter million or twice economic damages.

While the reforms in S. 2061 are similar to those in MICRA and S. 11, the scope of S. 2061 is much more narrow. The bill we are asking the Senate to begin considering today pertains only to obstetrics and gynecological services. If our friends across the aisle will not help us protect all medical professionals with MICRA-type reforms, then perhaps they will let us take this important step toward reform by protecting at least one specialty.

OB/GYNs provide some of the most critical medical services in our country. Unfortunately, OB/GYNs also suffer from some of the highest premiums. As a result, women and children across our country are placed in danger as they struggle to find, oftentimes unsuccessfully, basic obstetric care. This is a nationwide problem. Data from the American College of Obstetricians and Gynecologists illustrates the legal and financial jeopardy faced by OB/GYNs across our country today.

Obstetrics and gynecology are among the top three specialties with the highest professional liability insurance premiums. OB/GYNs were No. 1 among 28 specialty groups in the number of claims filed against them. OB/GYNs were also the highest of all specialty groups in the average cost of defending against a claim. OB/GYNs are also facing enormous increases in the average payout of claims brought against them.

For example, back in 1996, the average award against an OB/GYN was $254,495. Between 1996 and 1998, the average award went up to about $350,000—from $250,000 up to $350,000 in 2 years. By 2000, the average award against an OB/GYN had increased to about $400,000. That is an increase of almost 40 percent in 4 short years.

This phenomenon is even more striking when one looks at cases involving alleged brain injuries to newborns.

Such cases account for 30 percent of all claims against OB/GYNs but research shows physician error is responsible for fewer than 4 percent of neurologically impaired infants. Despite the rarity of physician error in these cases, the average award in these few cases where obstetricians are at fault has dramatically increased in just a few years. In 1996, the average award in these type cases was about $460,000. Two years later, the average award had doubled to $935,000.

Today, the median award in childbirth cases has risen to over $2 million. This is the highest category of award for all types of medical liability cases. American women should not be misled by these statistics. They should not worry that despite annual advances in medical technology and training there is somehow an increasingly poor level of obstetric care in this country.

No, these troubling statistics do not mean America's medical schools have lowered their standards and a rash of incompetent obstetricians has begun to practice medicine. In fact, according to the Society of Obstetricians and Gynecologists, over 80 percent of all cases that went to verdict against an OB/GYN resulted in judgments for the physician. In other words, on average eight out of 10 cases that went to trial against OB/GYNs were not meritorious.

It is the dramatic increase in awards noted above and the specter of such awards in settlement negotiations that is driving malpractice premiums through the roof, not a lowering of medical standards for practice.

Looking at my own State, the immediate result of skyrocketing liability premiums is the doctors pack up and move to a State such as California with liability reform or they just simply close their doors altogether. When this happens, the ultimate victims, of course, are the patients, the mothers and their children.

Let's take a look at the Commonwealth of Kentucky. Kentucky does not have a medical liability reform system. Not surprisingly, liability insurance rates for OBs in my State increased 64 percent in one year from 2002 to 2003. Also not surprisingly in the last 3 years, Kentucky has lost one-fourth of its obstetricians.

Moreover, Kentucky has lost nearly half its potential obstetric services during this time when one factors in those who have limited their practices.

As this chart I have shows, roughly 60 percent of the counties in the Commonwealth of Kentucky have no obstetrician at all—none. These are counties in red on this map. It is a majority of the counties in my State that have no obstetricians at all.

Other counties, such as Perry County, down in southeast Kentucky, down this way, technically have a practicing OB/GYN, but that one doctor has stopped delivering babies within the last year, so if you are in Perry County, that doesn't do you much good. Still other counties, such as Greenup, Lawrence, and Johnson Counties, in northeast Kentucky, have just one OB/GYN in each county, so if you are a woman in those counties you better hope there is not another woman having a baby when you are, or the doctor isn't out of town or busy with another patient. If that happens, you are going to have to drive through the hills on the backroads of eastern Kentucky to try to find a doctor to deliver your baby. All told, 82 of Kentucky's 120 counties have no OBs, or just have one OB.

According to Dr. Doug Milligan of Lexington, who specializes in caring for women with high-risk pregnancies, 11 OBs in eastern Kentucky have recently quit delivering babies or left the State, forcing women to drive for hours.

According to Dr. Milligan, apart from problems with delivering babies, some women are developing complications because they are not getting prenatal care.

So what should we conclude from all of this? The situation I have just described is not, unfortunately, unique to Kentucky. As you will hear from my colleagues, States across the country are in similar straits. So I commend Senator GREGG and Senator ENSIGN for trying to address this important problem.

As I have said earlier, their legislation is modeled on reforms that have stood the test of time in California, and it has been endorsed by the American Medical Association, the American College of Obstetricians and Gynecologists, and a host of other medical organizations.

I hope a dozen brave souls on the other side of the aisle will give the Senate a chance to consider this bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I understand there was an agreement for the allocation of time evenly divided between the two parties this morning, and that there has also been an agreement to divide the time during the afternoon.

I have talked with our leadership. They have indicated I could use 10 minutes of our time this afternoon, for the Democratic side, and use it at this time.

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

Mr. KENNEDY. What adjustment has to be made in the afternoon will be made.

Mr. President, I intend to speak to the issue before us, medical malpractice, in a moment. I will yield myself 6 minutes now and then I will speak on the medical malpractice in just a moment.

THE FEDERAL MARRIAGE AMENDMENT

Earlier today the President announced his endorsement of the Federal marriage amendment. By endorsing this shameful effort to write discrimination back into the Constitution, President Bush has betrayed his campaign promise to be ''a uniter, not a divider.''

The Constitution is the foundation of our democracy and it reflects the enduring principles of our country. We have amended the Constitution only 17 times in the two centuries since the adoption of the Bill of Rights. Aside from the amendment on prohibition, which was quickly recognized as a mistake and repealed 13 years later, the Constitution has often been amended to expand and protect people's rights, never to take away or restrict their rights.

By endorsing this shameful proposal, President Bush will go down in history as the first President to try to write bias back into the Constitution.

Advocates of the Federal marriage amendment claim it will not prevent States from granting some legal benefits to same-sex couples, but that is not what the proposed amendment says. By forbidding same-sex couples from receiving ''the legal incidents of marriage,'' the amendment would prohibit State courts from enforcing many existing State and local laws, including laws that deal with civil unions and domestic partnerships and other laws that have nothing to do with such relationships.

Just as it is wrong for a State's criminal laws to discriminate against gays and lesbians, it is wrong for a State's civil laws to discriminate against gays and lesbians by denying them the many benefits and protections provided for married couples.

The proposed amendment would prohibit States from deciding these important issues for themselves. This Nation has made too much progress in the ongoing battle for civil rights to take such an unjustified step backwards now.

We all know what this is about. It is not about how to protect the sanctity of marriage, or how to deal with activist judges. It is about politics, an attempt to drive a wedge between one group of citizens and the rest of the country, solely for partisan advantage. We have rejected that tactic before and I hope we will do so again.

The timing of today's statement is also a sign of the desperation of the President's campaign for reelection. When the war in Iraq, jobs and the economy, health care, education, and many other issues are going badly for the President and his reelection campaign is in dire straits, the President appeals to prejudice in a desperate tactic to salvage his campaign.

I am optimistic the Congress will refuse to pass this shameful amendment. Many of us on both sides of the aisle have worked together to expand and defend the civil rights of gays and lesbians. Together, on a bipartisan basis, we have fought for a comprehensive Federal prohibition on job discrimination on the basis of sexual orientation. We have fought together to expand the existing Federal hate

crimes law to include hate crimes based upon this flagrant form of bigotry.

I hope we can all agree that Congress has more pressing challenges to consider than a divisive, discriminatory constitutional amendment that responds to a nonexistent problem. Let's focus on the real issues of war and peace, jobs and the economy, and the many other priorities that demand our attention so urgently in these troubled times.

Mr. President, as to the issue that we will be voting on this afternoon, on the medical malpractice legislation, I spoke on this issue yesterday but there are a few additional points that I wish to make today.

How much time do I have remaining?

The PRESIDING OFFICER. The Senator has 6 minutes remaining.

MEDICAL MALPRACTICE LEGISLATION

Mr. KENNEDY. Mr. President, today's vote of S. 2061 is a test of the Senate's character. In the past, this body has had the courage to reject the simplistic and ineffective responses proposed by those who contend that the only way to help doctors is to further hurt seriously injured patients. Unfortunately, as we saw in the Patients' Bill of Rights debate, the Bush administration and congressional Republicans are again advocating a policy which will benefit neither doctors nor patients, only insurance companies. Caps on compensatory damages and other extreme ''tort reforms'' are not only unfair to the victims of malpractice, the do not result in a reduction of malpractice insurance premiums.

Once more, we must stand resolute.

We must not sacrifice the fundamental legal rights of seriously injured patients on the altar of insurance company profits. We must not surrender our most vulnerable citizens—seriously injured women and newborn babies—to the avarice of these companies.

This bill contains most of the same arbitrary and unreasonable provisions which were decisively rejected by a bipartisan majority of the Senate last year. The only difference is that last year's bill took basic rights away from all patients, while this bill takes those rights away only from women and newborn babies who are the victims of negligent obstetric and gynecological care. That change does not make the legislation more acceptable. On the contrary, it adds a new element of unfairness.

This legislation would deprive seriously injured patients of the right to recover fair compensation for their injuries by placing arbitrary caps on compensation for non-economic loss in all obstetrical and gynecological cases. These caps only serve to hurt those patients who have suffered the most severe, life-altering injuries and who have proven their cases in court.

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

A person with a severe injury is not made whole merely by receiving reimbursement for medical bills and lost wages. Noneconomic damages compensate victims for the very real, though not easily quantifiable, loss in quality of life that results from a serious, permanent injury. It is absurd to suggest that $250,000 is fair compensation for a child who is severely brain injured at birth and, as a result, can never participate in the normal activities of day-to-day living; or for a woman who lost her reproductive capacity because of an OB/GYN's malpractice.

This is not a better bill because it applies only to patients injured by obstetrical and gynecological malpractice. That just makes it even more arbitrary.

The entire premise of this bill is both false and offensive. Our Republican colleagues claim that women and their babies must sacrifice their fundamental legal rights in order to preserve access to OB/GYN care. The very idea is outrageous.

For those locales—mostly in sparsely populated areas—where the availability of specialists is a problem, there are far less drastic ways to solve it. It is based on the false premise that the availability of OB/GYN physicians depends on the enactment of draconian tort reforms. If that were accurate, States that have already enacted damage caps would have a higher number of OB/GYNs providing care. However, there is in fact no correlation. States without caps actually have 28.4 OB/GYNs per 100,000 women, while States with caps have 25.2 OB/GYNs per 100,000 women.

And that is only one of many fallacies in this bill. If the issue is truly access to obstetric and gynecological care, why has this bill been written to shield from accountability HMOs that deny needed medical care to a woman suffering serious complications with her pregnancy, a pharmaceutical company that fails to warn of dangerous side effects caused by its new fertility drug, and a manufacturer that markets a contraceptive device which can seriously injure the user? Who are the authors of this legislation really trying to protect?

In reality, this legislation is designed to shield the entire health care industry from basic accountability for the care it provides to women and their infant children. It is a stalking horse for broader legislation which would shield them from accountability in all health care decisions involving all patients. While those across the aisle like to talk about doctors, the real beneficiaries will be insurance companies and large health care corporations. This legislation would enrich them at the expense of the most seriously injured patients; women and children whose entire lives have been devastated by medical neglect and corporate abuse.

When will the Republican party start worrying about injured patients and stop trying to shield big business from the consequences of its wrongdoing?

If we were to arbitrarily restrict the rights of seriously injured patients as the sponsors of this legislation propose, what benefits would result? Certainly less accountability for health care providers will never improve the quality of health care. It will not even result in less costly care. The cost of medical malpractice premiums constitutes less than two-thirds of 1 percent—0.66 percent—of the Nation's health care expenditures each year. Malpractice premiums are not the cause of the high rate of medical inflation.

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.

A CBO report released in January of this year rejected claims being made about the high cost of ''defensive medicine''. Their analysis ''found no evidence that restrictions or tort liability reduce medical spending.'' There was ''no statistically significant difference in per capita health care spending between States with and without limits on malpractice torts.''

The White House and other supporters of caps have argued that restricting an injured patient's right to recover fair compensation will reduce malpractice premiums. But, there is scant evidence to support their claim. In fact, there is substantial evidence to refute it. In the past year, there have been dramatic increases in the cost of medical malpractice insurance in States that already have damage caps and other restrictive tort reforms on the statute books, as well as the States that do not. No substantial increase in the number or size of malpractice judgments has suddenly occurred which would justify the enormous increase in premiums which many doctors are being forced to pay.

The reason for sky-high premiums cannot be found in the courtroom.

Caps are not only unfair to patients, they are also an ineffective way to control medical malpractice premiums. Comprehensive national studies show that medical malpractice premiums are not significantly lower on average in States that have enacted damage caps and other restrictions on patient rights than in States without these restrictions. Insurance companies are merely pocketing the dollars which patients no longer receive when ''tort reform'' is enacted.

Focusing on premiums paid by OB/GYN physicians, the evidence is the same. Data from the Medical Liability Monitor shows that the average liability premium for OB/GYNs in 2003 was actually slightly higher in States with caps of damages—$63,278—than in States without caps—$59,224. It also showed that the rate of increase last year was higher in States with caps—17.1 percent—than it was in States without caps—16.6 percent.

This evidence clearly demonstrates that capping malpractice damages does not benefit the doctors it purports to help. Their rates remain virtually the same. It only helps the insurance companies earn even bigger profits. As Business Week Magazine concluded after reviewing the data, ''the statistical case for caps is flimsy.'' That was in the March 3, 2003 issue.

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

Insurance industry practices are responsible for the sudden dramatic premium increases which have occurred in some States in the past 2 years. The explanation for these premium spikes can be found not in legislative halls or in courtrooms, but in the boardrooms of the insurance companies themselves.

Insurers make much of their money from investment income. Interest earned on premium dollars is particularly important in medical malpractice insurance because there is a much longer period of time between receipt of the premium and payment of the claim than in most lines of casualty insurance. The industry creates a ''malpractice crisis'' whenever its investments do poorly. The combination of a sharp decline in the equity markets and record low interest rates in recent years is the reason for the sharp increase in medical malpractice insurance premiums. What we are witnessing is not new. The industry has engaged in this pattern of behavior repeatedly over the last 30 years.

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

Between 1991 and 2002, the Weiss analysis shows that premiums rose by substantially more in the States with damage caps than in the States without caps. The 12-year increase in the annual malpractice premium was 48.2 percent in the States that had caps, and only 35.9 percent in the States that had no caps. In the words of the report:

> On average, doctors in States with caps actually suffered a significantly larger increase than doctors in States without caps . . . . In short, the results clearly invalidate the expectations of cap proponents.

Doctors, especially those in high-risk specialties, whose malpractice premiums have increased dramatically over the past few years, do deserve premium relief. That relief will only come as the result of tougher regulation of the insurance industry. When insurance companies lose money on their investments, they should not be able to recover those losses from the doctors they insure. Unfortunately, that is what is happening now.

Doctors and patients are both victims of the insurance industry. Excess profits from the boom years should be used to keep premiums stable when investment earnings drop. However, the insurance industry will never do that voluntarily. Only by recognizing the real problem can we begin to structure an effective solution that will bring an end to unreasonably high medical malpractice premiums.

There are specific changes in the law which should be made to address the abusive manner in which medical malpractice insurers operate. The first and most important would be to subject the insurance industry to the Nation's anti-trust laws. It is the only major industry in America where corporations are free to conspire to fix prices, withhold and restrict coverage, and engage in a myriad of other anticompetitive actions. A medical malpractice ''crisis'' does not just happen. It is the result of insurance industry schemes to raise premiums and to increase profits by forcing anti-patient changes in the tort law. I have introduced with Senator LEAHY, legislation which will at long last require the insurance industry to abide by the same rules of fair competition as other businesses. Secondly, we need stronger insurance regulations which will require malpractice insurers to set aside a portion of the windfall profits they earn from their investment of premium dollars in the boom years to cover part of the cost of paying claims in lean years. This would smooth out the extremes in the insurance cycle which have been so brutal for doctors. Thirdly, to address the immediate crisis that some doctors in high risk specialties are currently facing, we should provide temporary premium relief. This is particularly important for doctors who are providing care to underserved populations in rural and inner city areas.

Unlike the harsh and ineffective proposals in S. 2061, these are real solutions which will help physicians without further harming seriously injured patients. Unfortunately, the Republican leadership continues to protect their allies in the insurance industry and refuses to consider real solutions to the malpractice premium crisis.

This legislation—S. 2061—is not a serious attempt to address a significant problem being faced by physicians in some States. It is the product of a party caucus rather than the bipartisan deliberations of a Senate committee. It was designed to score political points, not to achieve the bipartisan consensus which is needed to enact major legislation. For that reason, it does not deserve to be taken seriously by the Senate.

I withhold whatever time I have and suggest the absence of a quorum.

The PRESIDING OFFICER. Will the Senator withhold on suggesting the absence of a quorum?

Mr. KENNEDY. I withhold suggesting the absence of the quorum.

RECESS

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

Thereupon, the Senate, at 12:30 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. VOINOVICH).

HEALTHY MOTHERS AND HEALTHY BABIES ACCESS TO CARE ACT OF 2003—MOTION TO PROCEED—Continued

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. HATCH. Mr. President, what is the state of business?

The PRESIDING OFFICER. The time until 4:50 is evenly divided.

Mr. HATCH. Thank you, Mr. President.

I rise to speak in support of S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act.

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

As you will recall, we have previously tried to remedy this crisis in access to care. Most recently, we debated S. 11 which failed to receive the 60 votes necessary to invoke cloture last July. You have to have a supermajority now on these types of issues because of the opponents of this bill—and some others.

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

Defensive medicine is way out of whack. We are spending billions of dollars on unnecessary defensive medicine because doctors are terrified they are going to be sued in these frivolous lawsuits—called medical liability suits—by personal injury lawyers.

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

These numbers have been consistent in large studies done in New York, California, Colorado, and in my home State of Utah. However, the equally troubling statistic is only 2 percent of cases with actual negligent injuries result in claims, and less than one-fifth—17 percent—of claims filed actually involve a negligent injury.

This situation has been likened to a traffic cop who regularly gives out more tickets to drivers who go through green lights than those who run red lights. Clearly, nobody would defend that method of ensuring traffic safety, and we should not accept such an insufficient and inequitable method of ensuring patient safety. Numbers are a searing indictment of the current medical liability system. I personally believe we can do better for the American people, and the Healthy Mothers and Babies Act is an important step in that path.

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

Studies by both the Utah Medical Association and the Utah Chapter of the American College of Obstetricians and Gynecologists underscore the problem in my State. Over half—50.5 percent—of family practitioners in Utah have already given up obstetrical services or never practice 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 5 years.

An ACOG survey from August 2002 revealed that over half—53.16 percent—of OB/GYNs in Utah have changed their practice, such as retiring, relocating, or dropping obstetrics because of the medical liability reform crisis. This change in practice leaves 1,458 pregnant Utahns without OB/GYN care.

The medical liability crisis, while affecting all medical specialties and practices, hits OB/GYN practices especially hard, and I suspect this is true of every State in the Union. Astonishingly, over three-fourths, 76.5 percent, of obstetricians/gynecologists report being sued at least once in their career. Indeed, over one-fourth of OB/GYN doctors will be sued for care given during their residency. These numbers have discouraged Americans finishing medical school from choosing this vital specialty. Currently, one-third of OB/GYN residency slots are filled by foreign medical graduates compared to only 14 percent one decade ago. OB/GYN doctors are particularly vulnerable to unjustified lawsuits because of the tendency to blame the doctor for brain-injured infants, although research has proven that physician error is responsible for less than 4 percent of all neurologically impaired babies.

Ensuring the availability of high-quality prenatal and delivery care for pregnant women and their babies, the most vulnerable members of our society, is imperative. We simply must pass this bill.

In August 2003, a GAO report concluded that actions taken by health providers as a result of skyrocketing malpractice premiums have contributed to health care access problems. These problems include reduced access to hospital-based services for deliveries, especially in rural areas. In addition, the report indicated that States that have enacted tort reform laws with caps on noneconomic damages have slower growth rates in medical malpractice premiums and claims payments. From 2001 to 2002, the average premiums for medical malpractice insurance increased about 10 percent in States with caps on noneconomic damages. In comparison, States with more limited reforms experienced an increase of 29 percent in medical malpractice premiums.

Medical liability litigation directly and dramatically increases health care costs for all Americans. Unfortunately, a high percentage of those cases are brought in order to get the defense costs by, in many respects, lawyers who are not true to their profession, who are personal injury lawyers seeking to make a buck.

In addition, skyrocketing medical litigation costs indirectly increase health care costs by changing the way doctors practice medicine. Defensive medicine is defined as medical care that is primarily or solely motivated by fear of malpractice claims and not by the patient's medical condition. According to a survey of 1,800 doctors published in the Journal of Medical Economics, more than three-fourths of doctors believed they must practice defensive medicine. A 1998 study of defensive medicine by Mark McClellan, our current head of the FDA who has been nominated now to be head of CMS, used national health expenditure data that showed medical liability reform has the potential to reduce defensive medicine expenditures by $69 billion to $124 billion in 2001, an amount that is between 3.2 and 5.8 times the amount of malpractice premiums.

The financial toll of defensive medicine is great and especially significant for reform purposes as it does not produce any positive health results nor benefits. Not only does defensive medicine increase health care costs, it also puts Americans at avoidable risk. Nearly every test and every treatment has possible side effects. Thus every unnecessary test, procedure, and treatment potentially puts a patient in harm's way.

Seventy-six percent of physicians are concerned that malpractice litigation has hurt their ability to provide quality care to patients. What can we do to address this crisis? The answer is plenty. There are excellent examples of what works.

Last March, the Department of Health and Human Services released a report describing how reasonable reforms in some States have reduced health care costs and improved access to quality health care. More specifically, over the last 2 years in States with limits of $250,000 to $350,000 on noneconomic damages, premiums have increased an average of just 18 percent, compared to 45 percent in States without such limits.

California enacted the Medical Injury Compensation Reform Act, also known as MICRA, more than a quarter century ago. MICRA slowed the rate of increase in medical liability premiums dramatically without affecting negatively the quality of health care received by the State's residents. As a result, doctors are not leaving California. Furthermore, between 1976 and 2000, premiums increased by 167 percent in California, while they increased three times as much, 505 percent, in the rest of the country. Consequently, Californians were saved billions of dollars in health care costs, and Federal taxpayers were saved billions of dollars in the Medicare and Medicaid programs.

No one in this body, perhaps with the exception of our colleague from Tennessee, Dr. Bill Frist, our majority leader, is more keenly aware of the defects in this system than I. Before coming to Congress, I litigated several medical liability cases. I defended health care providers. I have seen the heart-wrenching cases in which mistakes were made and where judgments should have been brought. But more often I have seen heart-wrenching cases in which mistakes were not made and doctors were forced to expend valuable time and resources defending themselves against frivolous lawsuits.

I have seen a lot of cases where there was no injury at all that were brought by unscrupulous personal injury lawyers, running up the cost to all the doctors, to the whole system. A high percentage of these cases are brought merely for defense costs because it cost so much to defend these cases that even the defense costs mean a pretty good fee if you are charging 30 to 40 percent.

The recent Institute of Medicine report, ''To Err is Human,'' concluded that ''the majority of medical errors do not result from individual recklessness or the actions of a particular group. This is not a bad apple problem. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them''. We need reform to improve the health care systems and processes that allow errors to occur and to identify better when malpractice has not occurred.

The reform I envision would address litigation abuses in order to provide swift and appropriate compensation for malpractice victims, redress for serious problems, and ensure that medical liability costs do not prevent patients from accessing the care they need. We need to move ahead with legislation to improve patient safety and reduce medical errors, and we need urgently to address the medical liability crisis so that more women are not denied access to quality medical care because it has become too expensive for their OB/GYN doctors to continue their practice.

The Healthy Mothers and Healthy Babies Access to Care Act will allow us to begin ensuring women and babies get the medical care they need and deserve. Without tort reform, juries are awarding astounding and unreasonable sums for pain and suffering. A sizable portion of those awards goes to the attorney rather than to the patient. The result is that doctors cannot get insurance and patients cannot get the care they need and deserve.

All Americans deserve the access to care, the cost savings, and the legal protections that States such as California provide their residents. Today's bill will allow us to begin to address this crisis in our health care system, gives women and their babies access to their OB/GYN doctors, and enables doctors to provide high-quality, cost-effective medical care.

I strongly support this legislation and urge my colleagues to support cloture.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Nevada.

Mr. REID. Mr. President, I ask unanimous consent that during the debate this afternoon with respect to the cloture vote, any Democratic speakers be limited to 10 minutes each. The reason I propound this request is that we have less than an hour left on our side. We have a number of speakers who have a desire to speak. If we have a limited time, they will not be able to do that. I ask unanimous consent that be the order.

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

Mr. CRAIG. Mr. President, I do not object to that. I appreciate the time consideration. The Senator from California is kind enough to allow me to proceed. I ask unanimous consent that she immediately follow me.

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

Mr. CRAIG. Mr. President, first, I am here to speak on S. 2061 and ask our colleagues to support it. Many of my colleagues have already spoken of the pressing need for this legislation, so I will not repeat their words now. What I will speak about is how the medical liability crisis has played out in my region of the country, the Pacific Northwest. I believe the situation as it exists there provides clear evidence of the need for national reform.

My story is the tale of two States, my home State of Idaho and our neighbor to the west, Oregon. Idaho enacted its original tort reform legislation in 1987. This legislation limited the award of noneconomic damages in personal injury cases to $400,000. This limit was indexed to inflation. Oregon also enacted tort reform legislation in 1987. Like the Idaho law, the Oregon law limited the award of noneconomic damages in personal injury cases. Oregon's law placed this limit at $500,000.

Unlike Idaho however, where the tort reform measure withstood judicial scrutiny, and has since been strengthened by the Idaho State Legislature in 2003, Oregon's law was struck down by the State supreme court in 1999. Since the cap was removed, there have been 20 settlements and jury awards of more than $1 million.

As expected, the costs of these awards have been passed on to medical professionals in the form of higher medical malpractice insurance premiums. The Eugene Oregon Register Guard reported on March 19, 2003, that obstetricians who have base coverage ($1 million per claim, $3 million aggregate per year) through Northwest Physicians Mutual, a doctor-owned insurance company, have seen their premiums increase nearly threefold, from $21,895 in 1999 to $61,203 in 2003. The same article referred to a statewide survey conducted by researchers at Oregon Health and Science University which found that since 1999, 125 doctors have quit delivering babies in Oregon—representing about 25 percent of doctors providing obstetric care. Nearly half of these physicians, 48 percent, cited insurance costs and 41 percent said they feared lawsuits.

The article goes on to tell the story of an Oregon physician who is abandoning his practice in Eugene, in order to establish a new practice in Coeur d'Alene, ID. The physician stated that he was attracted to Idaho because the State has safeguards in place for doctors. These safeguards have helped keep malpractice premiums down in Idaho. Indeed, the Idaho Medical association reports that physicians in Idaho for some high-risk specialities, such as obstetrics and gynecology, pay about half of what their counterparts in Oregon pay.

While I welcome any healthcare providers who wish to practice in Idaho, I do not wish to see women of a neighboring State, or any State, suffer from lack of available health care because medical providers cannot afford to purchase malpractice insurance in their home State.

Now as a firm proponent of our Federal system, I have always believed that it is preferable to solve problems at the level of government closest to the people. And my preference here would have been for State governments to address this issue, as indeed many have. However, many other States have either not enacted reform legislation, or as in the case of Oregon, have found their efforts at reform sidetracked by overzealous judges. And, as the medical liability crisis in the 19 States identified by the AMA now threatens to overwhelm the entire Nation's medical liability system, I feel that now is the time to address this issue at the national level.

A Federal law is required to ensure that reforms will be effected in all States. Furthermore, the language of S. 2061 will protect States with existing caps. At the same time it will protect health care providers by establishing a Federal standard for noneconomic damages limits, even if such caps are barred by a State constitution, such as in Oregon. By allowing State autonomy in the setting of liability limits, this bill respects our tradition of federalism.

Since this body refused to vote for cloture on a related bill last July, the general accounting Office has issued a report assessing the effects that rising malpractice insurance premiums have had on the public's access to health care. This report, released in August of last year, confirmed instances in the five ''crisis'' States studied where actions taken by physicians in response to malpractice pressures have reduced access to services affecting emergency surgery and newborn deliveries. No instances of reduced access to heath care were identified in the four ''non-crisis'' States studied.

The August report follows an earlier GAO report that examined the causes of the dramatic increase in malpractice insurance rates. That earlier report found that ''losses on medical malpractice claims—which make up the largest part of insurer's costs—appear to be the primary driver of rate increased in the long run.''

Together these two studies provide strong evidence that: (1) Rising claims costs are driving up the cost of malpractice insurance; (2) the rising cost of insurance is causing medical service providers to take actions which have limited access to health care; and (3) the imposition of noneconomic damages caps, as well as the other reform measures included in this bill, are effective in constraining the rise of insurance premiums.

From the Pacific Northwest to the Florida Keys, the problem is clear and the solution is clear. The only question awaiting clarification is whether this body possesses the resolve to pass this much-needed legislation.

Mr. President, to reiterate, I want to tell the story of two States as it relates to this issue and the bill, Healthy Mothers and Healthy Babies Access to Care Act, addressing that problem. The States are Idaho and Oregon. In 1987, Idaho and Oregon passed identical laws—or relatively identical laws. In the State of Idaho, we capped our personal injury cases at $400,000. Oregon capped them at $500,000. Unlike Idaho, the Oregon Supreme Court, in a period of time immediately following that, struck down the Oregon action. Idaho did not.

Idaho not only held its law but then strengthened that law in 2003. Here is the rest of the story. Idaho strengthened its law in 2003. Oregon struck down its law in 1999. But they both started in the same place. Since the cap was removed in Oregon, there have been 20 settlements for injury awards of well over a million dollars.

As expected, the cost of these awards has been passed on to the medical professional in the form of higher medical malpractice insurance premiums. The Eugene, Oregon Register Guard reported on March 19, 2003, that obstetricians who have base coverage—that is, $1 million per claim, $3 million per aggregate per year—through Northwest Physician Mutual, a doctor-owned insurance company, have seen their premiums increase nearly threefold, from $21,895 in 1999, to 61,203 in 2003. The same article referred to a statewide survey conducted by researchers at Oregon Health and Science University, which found that since 1999, 125 doctors have quit delivering babies in Oregon—representing about 25 percent of the doctors providing obstetric care. Nearly half of these physicians, 48 percent, cited insurance costs, and 41 percent said they feared lawsuits.

The article went on to talk about one Eugene, OR, physician who moved to Coeur d'Alene, ID. The reason he moved to Idaho is because in our State of Idaho, their insurance premiums are substantially less because the cap we placed in the law has held the test of the courts.

The reality is that we are trying to set the stage nationwide. We are all aware—and many colleagues have come to the floor of the Senate to talk about it—of the studies done, the GAO report, the high-cost States, and the OB/GYN doctors fleeing from those States, and as a result making it very difficult in some instances for pregnant women to receive the kind of health services they need and, in fact, upon time of delivery, to know they have a doctor waiting at their side to help them.

As medical liability crises in these 19 identified States loom, it is time we speak with uniformity across the Nation. That is exactly what this bill does. I hope that our colleagues can support cloture and we can move to a final vote on this bill. Clearly, the American people are now expecting us to speak out.

Last week, I held a health care conference in Boise. One of the primary concerns was the rapidly rising cost of health care. One of the components of that escalation in cost is the very thing we are attempting to address today. So I hope the Senate can stand with reasonable unity. Myself and others understand the politics of the trial bar. When is enough enough?

If we don't, by this action, deny access to the courts by those who are truly injured—and we don't—then why are we allowing a certain segment of our society, in the litigious manner they have chosen, to line their pockets. Who is the beneficiary? The patient? In many instances, they are not. Yet costs go up simply because of the risk involved.

We ought to be protecting the patient and, in this case, the average citizen of this country on both sides of that equation by making sure they can gain true access to the courts when true injury results and, at the same time, making sure we are wise enough to hold down the increasing costs of health care, assisted by the dramatic increase in premium costs to our physician. This is a step toward that kind of a solution.

I yield the floor.

The PRESIDING OFFICER. The Senator from California is recognized.

Mrs. FEINSTEIN. Mr. President, I thank the distinguished Senator from Idaho for his courtesy. I cannot support this bill. I don't believe it reflects compromise. I don't think it is materially changed from the bill that failed to get 50 votes last July. The major difference, as I see it, in this bill is that the liability restrictions apply to only one medical specialty group, obstetricians and gynecologists.

This bill sets a national cap of $250,000 for noneconomic damages. The cap applies not only to suits against doctors but to suits against HMOs and to manufacturers of gynecological or obstetric products as well.

So, under this bill, the Dalkon Shield contraceptive device would be shielded by this $250,000 cap regardless of the harm caused.

Moreover, this bill severely limits the availability of punitive damages against OB/GYNs and manufacturers of related products. The bill would also immunize manufacturers or sellers of gynecological products approved by the FDA from punitive damages.

The FDA exemption sets, in a way, a downward course. If a company has an FDA-approved product on the market and then learns of dangerous complications, the company must remove the product from the marketplace immediately. To provide an exemption for products with FDA approval may well be a disincentive to prompt removal from the shelf.

I am one who believes there needs to be a solution to rising malpractice insurance premiums. I want to talk to that solution in just a moment. But, it is correct that obstetricians and gynecologists are reeling under exorbitant medical malpractice premiums.

Obstetricians and gynecologists had more claims against them and paid out more money to plaintiffs than any other medical specialty between 1985 and 2000.

Prior to the State of Florida passing medical liability caps last year, OB/GYNs in Florida paid over $200,000 annually for malpractice insurance.

OB/GYNS in California, a State with liability caps, pay an average in malpractice insurance of $57,000, which is about a quarter of what it is in Florida.

According to the American College of Obstetricians and Gynecologists, 20 percent of obstetricians and gynecologists in Nevada are leaving their practice due to rising malpractice insurance costs. Twenty percent of OB/GYNs in West Virginia and Georgia have been forced out of their practice. I could go on and on and on.

I want to talk for a moment about California, and then I want to talk about what I think is a logical solution to this. But up to this point, the AMA and my own medical association, the California Medical Association, won't buy it. Congress can and should provide some legislative relief.

MICRA, the Medical Injury Compensation Reform Act, took place 29 years ago in California. MICRA set a precedent in the ensuing years for reform measures in several States. The MICRA law provides a model.

Last year, I spent several months reviewing MICRA to see what could be transferred to the national level.

I have come to believe it is possible that reasonable caps on liability can lead to affordable premiums.

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

MICRA has kept costs down. In 1975, California's doctors paid 20 percent of the gross costs of all malpractice insurance premiums in the country. Today, it is 11 percent.

California's premiums grew 167 percent over the past 25 years compared to 505 percent in other States. So the growth in California is just about less than a third of what it is in the rest of the United States.

In California, patients get their money faster. Cases in California settle 23 percent faster than in States without caps on noneconomic damages.

MICRA allows patients to obtain health care costs, recover for loss of income, and receive the funds they need to be rehabilitated. And California's malpractice premiums are now one-third to one-half lower on average than those in Florida and New York.

The proposal I would put out for people to study today takes those parts of MICRA which I thought could serve as a national model. For example, a schedule of attorney's fees; a strict statute of limitations requiring that medical negligence claims be brought within 1 year from the discovery of an injury or within 3 years of the injury's occurrence; the requirement that a claimant give a defendant 90 days' notice of his or her intent to file a lawsuit before a claim can actually be filed; allowing defendants to pay damage awards in periodic installments; and allowing defendants to introduce evidence at trial to show that claimants have already been compensated for their injuries through workers' compensation benefits, disability benefits, health insurance, or other payments; and permitting the recovery of

unlimited economic damages. All of these points are now in play in California. I believe they are applicable nationally.

The differences from the California MICRA that I would propose would be in two key areas. The first is noneconomic damages, and the second would be punitive damages. The California MICRA law has a $250,000 cap on noneconomic damages. That is what is proposed in the pending bill. In contrast, I would propose a national $500,000 flex cap, a general cap on noneconomic damages. This cap would allow a State to impose a lower or a higher limit, but it would be pivotal for those States where the State laws do not currently allow a State to set a cap. This would allow in those States for the cap to be $500,000.

In catastrophic cases where a victim of malpractice was subject to severe disfigurement, severe disability, or death, the cap would be the greater of $2 million or $50,000 times the number of years of life expectancy of the victim. This handles the situation of a very young victim who was really the victim of egregious malpractice.

In addition, my proposal would have less onerous punitive damages standards than California law. California law would require a plaintiff to prove punitive damages under the very high standard of fraud, oppression, or malice. Under this standard, I am not aware of a single case where a plaintiff has obtained punitive damages in California over the past 10 years. However, if the State wanted to keep that—any State—they could under my proposal. But I would offer a four-part test where a plaintiff would have to show by clear and convincing evidence that the defendant (1) intended to injure the claimant unrelated to the provision of health care; (2) understood the claimant was substantially certain to suffer unnecessary injury, and in providing or failing to provide health care services, the defendant deliberately failed to avoid such injury; (3), acted with a conscious, flagrant disregard of a substantial and unjustifiable risk of unnecessary injury which the defendant failed to avoid; or, (4), acted with a conscious, flagrant disregard of acceptable medical practices in such circumstances.

I firmly believe a variant of this type could lead to a compromise in the Senate, but the AMA and my own medical association, the California Medical Association, both flatly rejected this proposal last year. They refused any cap for noneconomic damages above $250,000 even in catastrophic cases. To me this makes little sense because a $250,000 cap in 1975, which was when the cap was put in play in California, adjusted for inflation, was worth $839,000 in 2002. If $250,000 was adequate in 1975, why wouldn't a figure of a half a million dollars—$500,000—which is lower than the cap adjusted for inflation, be acceptable in 2004? If a victim receives $250,000 today, it is the equivalent of $40,000 in 1975 dollars.

There are many specific instances of why a $250,000 noneconomic damage, especially today, remains too low. Let me just give you one case. I happened to meet this woman, and it is a case that I think makes my argument irrevocably. It is the case of Linda McDougal. She is 46. She is a Navy veteran, an accountant, and a mother. She was diagnosed with an aggressive form of cancer and underwent a double mastectomy. Two days later, she was told that a mistake was made. She didn't have cancer, and the amputation of her breasts was not necessary. A pathologist had mistakenly switched her test results with another woman who had cancer.

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

I remain a supporter of malpractice insurance reform. If at any time there would be physician support, I believe then the necessary 60 votes in this body could be generated for a plan such as I have just enumerated.

In conclusion, I will vote against this bill but stand ready to participate in a solution along the lines I have mentioned.

I thank the Chair, and I thank the Senator from Delaware.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. CARPER. Mr. President, before Senator FEINSTEIN leaves the Chamber, she has laid out what may well be a very reasonable alternative for this body and our colleagues in the House to consider with respect to medical malpractice. She has played a vital role as we have worked over the last several years to craft a compromise on class action reform and offered maybe the critical amendment to the bill.

What I would like to do in the 10 minutes I am going to speak is compare and contrast, if I can, the approach in bringing this medical malpractice bill to the Senate today with the approach that has been followed as we have tried to bring class action reform legislation to the Senate floor.

Let me step back for a moment. For those who may be listening to this discussion, class action reform seeks to address the issue of when a class of people are harmed what kind of redress do they have to seek compensation? I think most of us would agree that if a person were harmed by a product, good, or service that they had come in contact with or acquired that that person should be made whole. I think we would also agree if a whole class of people were somehow damaged by a product, good, or service that they came in contact with that the class of people should be made whole.

The question is, In what forum should those damaged persons, the damaged class, the plaintiff class—where do they turn to for redress to gain compensation for their injury or for their harm?

In my view, and I think it is a view probably shared by a majority of my colleagues, we believe that if the plaintiff class happens to be in a State different from the State that the defendant is from, our Constitution would suggest that maybe in those cases that rather than the case being litigated in the State where all of the plaintiffs are located, if the defendant is from another State, that the fair thing to do to both the defendant and the plaintiff is to litigate that matter in Federal court. That has been a subject of some debate.

It is not an issue that involves limits on punitive damages, economic, noneconomic damages, pain and suffering. The debate does not lie there. Rather, the debate lies in the area of in what court, in what jurisdiction should those kinds of questions be resolved.

I have been in the Senate for a bit more than 3 years. During that course of time, there have been any number of hearings in the Senate Judiciary Committee and in the House Judiciary Committee to bring before the respective panels in both bodies those who believe that we need to change the status quo with respect to class action litigation and those who think that what we have is just fine.

Proponents and advocates have had the opportunity to speak their points of view and to testify repeatedly in the Senate and in the House. In fact, over the last couple of years, this is what has happened in the Senate: Legislation has been developed in committee, it has been debated in committee, it has been amended in committee, and it has been brought to the floor in an effort to try to have it debated, amended, and voted on.

Last fall, we were able to get 59 votes to proceed to the bill, to take it up and offer amendments on the floor, but on class action we fell just short of the 60 that we needed to invoke cloture. So we went back and we did some more work. Those of us who think changes are necessary worked with some of our Democrat colleagues, three of them especially, and others as well, to come up with changes that would make the bill better, fairer, and more defensible. Hopefully, within the next several weeks we will have the opportunity to debate that on the floor and to offer further amendments to class action reform legislation.

It has been a long process, some would say too long. What happens is we start off with a reasonable proposal, debate it in committee, improve it in committee, report it out of committee, and then we are going to have the opportunity to bring the bill to the floor and it will be altered, I think improved, when that same bill comes to the floor.

Once the bill is on the floor, we will have the opportunity for full and open debate to consider what people like about it and do not like about it. They can offer their changes and we will have an up-or-down vote at the end of

the day when we have amended the bill. That is what we call regular order. That is the way an issue of this nature should be decided.

To my knowledge, maybe in the last 3 years there has been one hearing in one committee in the Senate on the issue of medical malpractice. If there have been others, I am not aware of them. A year ago, there was one hearing in one committee on this issue. I do not believe the bill has been marked up in that committee.

They did not vote on that bill in that committee. They did not seek to amend this medical malpractice bill in that committee. Instead, we simply find a related bill appearing on the Senate agenda with no opportunity to offer amendments, to improve it as maybe Senator FEINSTEIN, Senator DURBIN, or others would like to do but, rather, to have to kind of take it or leave it. That is not regular order and that is not the way to build consensus, particularly on an issue as difficult and as contentious as this one.

Another issue we have been dealing with, which involves litigation reform, is the subject of asbestosis. We all know that for many years people used asbestos. It was used in all kinds of projects, construction, automobiles, brakes, ship construction. Asbestos was commonly used. We later found out that it kills people. It causes asbestosis, mesothelioma, and other diseases. We now have been working for years to try to figure out how do we compensate the victims of asbestos exposure to make them whole. That process is one that has gone on for any number of years, too. The process we followed there is the opportunity to fully debate the issue in committees, to hold hearings in committees, where people who are for and against it have a chance to express their views. There are a lot of interested parties such as insurance companies, manufacturers, labor unions, the trial bar, and others that have had the opportunity to add their input. I hope what we now have coming to the Senate floor sometime later this spring is legislation that says maybe the way we handle asbestos litigation in this country can be improved on so we make sure people who are sick and dying of asbestos exposure get the help they need, and make sure people who are not sick will not ever be sick and do not siphon off money from those who truly need it. We need to come up with a fair system and one, frankly, that will stem the loss of companies, corporations, and businesses that are going bankrupt by the scores of asbestos exposure.

If we compare the way this body has approached class action reform legislation, in a very deliberate and thoughtful fashion, with plenty of opportunity for debate and changes, and compare that with what is before us today, it is night and day. There is really very little similarity.

I suggest to our friends on the other side of the aisle that on this particular issue if they are interested in finding a fair and reasonable solution, there are a number of us on this side of the aisle who would be willing to engage with them to find that. In the meantime, I would suggest they take a look at what States are doing.

Senator FEINSTEIN talked about her own State. In Delaware, the Governor put together a group, not a partisan group but a group that includes the trial bar, health providers, hospital representatives, folks within government and outside of government, to try to figure out if we needed to make any changes in our own State with respect to medical malpractice.

In the end, they said: We do not think we have a problem in Delaware with physicians being unable to get the coverage at a reasonable price. We do not have out of control jury awards. This is not a huge Delaware problem. Rather, they did suggest one change which I think is instructive. What they did was said why do we not provide for the certification of medical malpractice litigation to certify that it is not a frivolous lawsuit. If someone wants to bring a suit before it ends up in court, there will be a panel of knowledgeable people within that area of health care who will look at the assertion of the plaintiff and decide whether or not this is a frivolous lawsuit. If it is, the litigation does not go forward. That is what one State is doing, as a temporary measure.

I close by saying this: Unlike asbestos litigation reform, which needs a national solution, unlike class action litigation reform, which I believe needs a national solution, for the most part States can deal with on a case-by-case, State-by-State basis issues revolving around medical malpractice. I think for the most part we are better off pursuing that. Not everybody will agree with me on that point, but I think most people in this body will agree on this point, and that is the right way to legislate on these contentious issues is the approach we have taken with respect to class action reform and the approach we are taking with respect to asbestos litigation reform, where all sides have the opportunity to be heard, Members get to offer their amendments in committee and on the floor and then we go forward. That is the way to do business, and if we do business on those bases and in that accord, on a more consistent basis, we will be able to not only talk about doing something that needs to be done but actually accomplish it.

I yield the floor.

The PRESIDING OFFICER (Mr. TALENT). The Senator from New Jersey.

CHICKEN HAWKS

Mr. LAUTENBERG. Mr. President, I rise to discuss a troubling issue that has plagued our political debate for many years and now has come to a head. I cannot stay silent any longer.

We so much admire the eagle, the bird of strength, the bird that portrays the courage of America, the willingness to support our country no matter what the cost. That is what the eagle says to me. At times it has been an endangered species. But there is another bird I want to talk about today. That bird is called, in my view, the chicken hawk. There is such a bird, but usually it is the hawk chasing the chicken. But now I want to talk about the chicken that really chases the hawk.

Those of us who answered our Nation's call for military service at wartime have not grandstanded on that issue. We served our country and, frankly, many of my colleagues who answered the call are not always willing to talk about their experiences.

But now I see a disturbing trend from the other side of the political aisle. More and more, Senators in this body are tagged as lax on national security or homeland security or support for the military because of votes they took against problematic defense bills over the years. For years the charge coming from across the aisle is that Democrats are somehow or other less patriotic, less supportive of defense, and it is a shameful and grotesque charge. In my view these charges typically come from people I would simply call chicken hawks.

My definition of a chicken hawk is someone who talks tough on national defense and military issues, casts aspersions on others who might disagree on the vote, but when they had a chance to serve, they were not there. Now they are attacking the Senator from Massachusetts for opposing bloated or poorly designed defense bills. Is it known how much courage it takes to vote against a bad Defense authorization or appropriations bill? We all know it takes a lot of political courage, because even if the bill contains wasteful and damaging provisions, the vote can be twisted by your opponents. But when faced with a bad defense bill, what do the chicken hawks do? They take the easy road. They fly the easy route. They always vote for it, no matter what it says. How much courage does it take to vote for a bad defense bill? None. Zero. It is the easy thing to do.

Our colleague, the distinguished junior Senator from Massachusetts, is being attacked this week by the other side of the aisle as being weak on support for the military and compromising the defense of our country. I say shame on those who impugn the patriotism of those who supported their country's call for duty and paid for it with injuries resulting from their obedience to that call.

In my view, that is the cry of the chicken hawk who has no idea what it means to have the courage to put your life at risk to defend your country and its ideals. But the Senator from Massachusetts knows it all too well. When our country went to war in southeast Asia, the Senator from Massachusetts enlisted in the Navy. He requested to be sent to Vietnam to fight for his country, and he did that. For his heroic

service in Vietnam, the Senator from Massachusetts won the Silver Star, the Bronze Star, three Purple Hearts—that means he was wounded three times; it is a miracle he is still alive—the Combat Action Ribbon, the Navy Presidential Unit Citation, the Navy Unit Commendation Ribbon, the National Defense Service Medal, the Vietnam Service Medal, and the Vietnam Campaign Medal. How dare they challenge his commitment to our defense? His patriotism?

The Senator's action took courage. It is the same courage the Senator showed when he refused to vote for defense bills merely because they were defense bills. As a man who has seen a battlefield, he has a keen understanding of military needs and military policy and he voted accordingly. He actually did what his constituents sent him here to do: evaluate legislation on its merits and vote with your conscience and your obligation to our citizens.

Did it take courage? Of course. Integrity? Of course. Was it an easy thing to do? Absolutely not. The easy thing to do would be to simply vote for all the defense bills, no matter what they say, and pretend these votes are the real measure of patriotism. That is what the chicken hawks do. That is the easy road.

It is the same easy road we see when someone files for five student deferments and then claims an old football injury should prevent him from fighting for his country. Only a chicken hawk would attack a political rival who lost three limbs in Vietnam as being soft on defense.

So I say to my colleagues on the other side of the aisle, we are not going to put up with these insinuations that attack our patriotism, our support for our troops, anymore. Because real patriotism and real support for our Nation's defense should not be judged on whether we ignore our constitutional duty and rubberstamp legislation. Real patriotism and support for the defense of this country has to do with answering the call. In my view, as a fellow veteran, the Senator from Massachusetts not only answered the call to fight for his country, but also to perform his duty and judge legislation on its merits.

I served in the Army. It doesn't mean I should approve $1,500 toilet seats or poorly designed military equipment that is being procured simply because of political influence. In fact, I believe because I served, I have the duty to the men and women who are now in the military to make sure our military is strong and is as free from waste and corruption as possible, and our military men and women are protected to the fullest extent possible during their service and, when they are veterans, to provide for their health care needs and other services without question.

Our job is to think as Senators and not to bow to everything defense contractors or Pentagon officials want. The Senator from Massachusetts has voted for plenty of defense spending increases, but he has also voted to prevent bad programs from moving forward. He does his duty to his country and to his constituents.

The way I see it, the President and his proxies are attempting to bring American politics back to the days of dirty tricks. We saw it in 2000, not against just Al Gore but also against the most serious Republican challenger, the Senator from Arizona. The Bush campaign coordinated attacks on the Senator from Arizona that questioned his commitment to our troops. Outrageous. An attack on a man who not only fought for this Nation but spent years as a prisoner of war. They didn't stop there. They even attacked the Senator's family. It was a new low in modern American campaigning.

I want the administration and its allies in Congress to know we are not going to put up with these despicable insinuations and dirty campaigning. From now on, they question our commitment to our troops and the defense of this Nation at their own peril.

We saw it just the other day, I think it was yesterday. In a speech that was publicly televised, those members of the NEA, the National Education Association, who stick up for the quality of our teachers, for their ability to earn a living, for the ability to take the courses they need—to talk about them as terrorists? That is no different than the chicken hawk line I just talked about.

With that, I will yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, it is my understanding we are considering S. 2061, with 10-minute allocations of time for each Senator who is recognized?

The PRESIDING OFFICER. The Senate is debating the motion to proceed to that measure. An order has been entered limiting Democratic Senators to 10 minutes each.

Mr. DURBIN. Mr. President, I rise pursuant to that order to speak for 10 minutes about S. 2061. This bill which is pending before the Senate addresses a very serious national issue of medical malpractice. Medical malpractice insurance premiums have increased in my State of Illinois and across the Nation. Because of those increases, a lot of good doctors have been forced to a position where they have to retire or relocate their practices. I have met with those doctors. I understand the problems and dilemmas they face. I think we need to address that here in the Congress. This point is dramatized by the fact that the bill before us is unfortunately not a bill which has been the product of any effort to find compromise or common ground or bipartisan answer to this national challenge.

This bill without referral to committee was sent to the floor of the Senate. It is a bill which, frankly, was introduced by Senator GREGG of New Hampshire, a bill which ordinarily would have been referred to the Senate Judiciary Committee. The bill did not go to that committee. Senator GREGG does not serve on that committee. The bill was sent to the floor. I am afraid what this bill is all about is trying to make certain we make a record rollcall on this issue so that those who are supporting this bill will go back to some members of the medical committee and say all Senators who voted against it don't want to help you with increasing medical practice premiums. That couldn't be further from the truth for this Senator.

I have strong feelings about what we need to do. I believe we need to be doing something. We need to address the issue in a comprehensive way. We shouldn't be afraid to look at all aspects of this challenge.

The first aspect of this challenge is that there are too many medical errors today in hospitals and doctors' offices across America. Don't take my word for it. The Journal of the American Medical Association reached that conclusion and said medical errors are of epidemic proportions across America. The Institute of Medicine estimated that in any given year, 24,000 to 98,000 Americans lose their lives because of medical negligence. This bill doesn't even address that issue. It addresses medical malpractice in a courtroom. It doesn't address it in a doctor's office or in a hospital.

The first thing we should do is see how can we work with the medical community and the hospitals to reduce errors, reduce negligence, and reduce the incidence of these grievous injuries and death that occur as a result.

Currently, when you look at the universe of possible medical negligence and the lawsuits filed as a result of it, a tiny fraction—some 2 percent or less—end up in court. It means that 98 percent or more of the medical negligence that is committed in America does not result in a lawsuit.

If we want to make certain we have fewer cases going to court, let us start at the beginning. Let us make the practice of medicine safer. This bill does not even address that issue.

Second, if you are worried about the cost of medical malpractice premiums, isn't it reasonable to ask whether the insurance companies are treating doctors and hospitals fairly? This bill doesn't have a word in it about insurance companies and their responsibilities. Why are we afraid to even ask? Why wouldn't we have all the books open to find out whether what is happening to doctors' medical malpractice insurance is a result of some insurance practices which should be changed?

The third element is tort reform. I used to practice law. I was a trial lawyer. I defended doctors for many years and hospitals—and I sued them. I have been on both sides of the table. I understand those lawsuits, or at least how they were conducted in Illinois 20 years ago. So I have at least a passing experience with this issue. I think in my

practice I would never have considered taking a so-called frivolous lawsuit forward. It costs too much money. It takes too much time. You wouldn't want to put your plaintiff client through it, you wouldn't want to waste your time and money, and you would not want to run the risk at the end of the day that you would lose—or worse, be sanctioned by the court for raising a frivolous lawsuit. I think there are ways to stop it. A small percentage of lawsuits shouldn't be filed against doctors. This bill doesn't deal with frivolous lawsuits, and it should.

The last element it should address in tort reform is one that I think is essential; that is, to make certain, while we try to reduce the likelihood of frivolous lawsuits, we don't close the courthouse door for those innocent patients who are the victims of medical negligence. That is what this bill does. This bill says that instead of a jury in your hometown deciding what your injury is worth, instead of your peers in the community, your neighbors sitting in the jury box considering the evidence and the law and deciding what the value of your child's life is, or your child's health, we instead will make that decision here on the floor of the Senate. We will say that no matter what lawsuit you have filed for medical malpractice relating to OB/GYN, you cannot recover under any circumstances, regardless of what happened to you or the baby, any more than $250,000—$250,000 for pain, suffering, and disfigurement.

Two-hundred and fifty-thousand dollars may sound to some like a lot of money. Let me give you a few specific examples of cases I know of, and you decide whether $250,000 is a lot of money.

A settlement was reached last Friday in Chicago—a city I am honored to represent—in the case of Evelyn Arkebauer who gave girth to a quadriplegic son, Andrew ''A.J.'' Arkebauer, on October 4, 1998. Evelyn went into labor at 5:30 in the morning with her second child. She had her first child by Cesarean section, so there was a risk for uterine rupture. Early in the afternoon, the doctor began to administer Pitocin to speed up labor.

At 6:15 p.m.—more than 12 hours later—the doctor cut off the Pitocin and told Evelyn to start pushing. Evelyn pushed for more than an hour and a half and was rolled from her back to her side as the baby's heart rate fluctuated during this labor.

At 7:53 p.m.—more than 12 hours into labor—the doctor decided an emergency C section was necessary and paged the anesthesiologist to come to the delivery room. The anesthesiologist failed to return the page and numerous pages after that.

Finally, an hour after the doctor had decided on an emergency C section, the anesthesiologist showed up and the procedure began. The doctor discovered that the uterus had already ruptured. The baby had been without oxygen for 10 to 15 minutes. This baby is quadriplegic and spastic. He cannot walk, talk, or feed himself and will require full-time care for the rest of his life on Earth. This baby had no injury to his cerebrum, so he has normal cognitive thought, meaning he thinks like a normal child but is trapped in a body he cannot use.

During the trial, a nurse working the night of Andrew's birth testified that the anesthesiologist was with her in a private room on the hospital's fourth floor and that he ignored three different pages to respond to this emergency C section before going to the fifth floor delivery room where Evelyn was. This baby—quadriplegic and spastic for the rest of his life with a mind that is functioning—has a body that cannot be used.

This bill, S. 2061, says the jury of the Senate will decide the cases exactly like this—that that baby and that baby's family can recover no more than $250,000 for a lifetime of pain and suffering. That is not fair. It is not just. It is not reasonable. It may reduce medical practice premiums but at the cost of justice.

Gina Santoro-Cotton was 29 years old and pregnant with her first child. Her prenatal course was normal. She was admitted to the hospital 1 week after her due date to induce labor. The drug Pitocin was used. Within a few hours of starting Pitocin, deceleration of the baby's heart rate was noted. The Pitocin was not stopped, which is normally done when there are signs that the baby is in distress.

By early afternoon, the fetal monitor strips showed signs of oxygen deprivation to the baby—a clear warning sign. The Pitocin was still not stopped. At 2:45 p.m., the baby had a prolonged drop in his heart rate. The Pitocin was finally stopped and the baby was resuscitated in its mother's womb.

Within hours, the Pitocin was restarted, and decelerations and other signs of poor oxygenation to the baby appeared. Rather than stopping the Pitocin, the dose was increased.

At 7:30 p.m., there were still severe decelerations on the fetal monitor strips. Pitocin was increased.

At approximately 9:45 p.m., Pitocin was finally stopped and the baby was delivered. The baby was near death at the time of delivery.

Today, that baby is 6 years old and permanently disabled. He has severe cognitive dysfunction and is partially paralyzed in all four of his extremities. He has motor problems, and he can't walk. His speech is not understandable. He is fed through a tube in his stomach because he cannot feed himself. He has paralysis of the vocal cords. He requires care 24 hours a day and extensive therapy.

There are Senators who come to the floor and talk about cases just like this and call it jackpot justice, arguing, I guess, that the parents of that little baby, who will be functionally impaired for his entire life, will never be able to express himself, will never be able to feed himself or walk—that the parents of that baby, if they recover a verdict in court, have somehow won a jackpot. How many of us would want to buy a ticket for that jackpot? How many of us would sacrifice the health of any child, let alone our own children, with the prospect of recovering a verdict?

This bill before the Senate has said that in cases just like this, no matter how serious, no matter how long that baby lives, no matter what conditions that baby faces, the rest of its natural life, the sum total and value of the pain and suffering of that baby and its family can never, ever, be worth more than $250,000. And if that baby, who is now 6, lives 20 years, is it worth $10,000, $12,000, $1,000 a month for what that family will go through? I don't think so.

Let me discuss one last case. Terri Sadowski was pregnant with her second child. At 34 weeks, she went into preterm labor and had a rupture of her membranes. Medication was not successful in stopping her labor so she was transferred from a community hospital to a high-risk referral center, to the care of a perinatologist, a specialist in high-risk pregnancies.

The perinatologist decided to let Terri proceed with labor and deliver normally even though the baby was in a breech position. The doctor also decided to administer Pitocin, a medication to bring on contractions. Within 3 hours of starting the Pitocin, the fetal heart rate began to show signs that the baby was in distress. A normal heart rate for a baby in the mother's womb is 120 to 160 beats per minute. This baby's heart rate was dropping in the 70s. By the time Terri was ready to start pushing, the fetal monitor strips showed significant fetal heart rate decelerations with a consistent heart rate in the 60s and 70s. Despite the overwhelming evidence that the baby was in severe distress, a decision to perform a C section was not made for 40 minutes.

An emergency C section was done but the baby had no movement and was unresponsive. She developed seizures shortly after birth. She sustained severe brain damage due to lack of oxygen in labor in delivery. Had the perinatologist performed a C section, the baby could have been a normal, healthy baby.

The baby lived for 1 year in a vegetative state. During her short life, she had multiple hospital admissions for pneumonia, bowel obstructions, unable to suck, and she required tube feedings and constant suctioning to keep her airways clear. At the time of death, she had frequent seizures.

Think about this for a moment. Think about the happiness each of us has been lucky enough to experience in life from a family and children. And think about something going wrong in that delivery room, something that results in a baby facing a lifetime—long or short—in a terrible situation.

The parents were not at fault. They were not at fault in any of these cases. Eventually they went to court and asked for compensation for what they would face for medical bills, what they would face for pain and suffering, and a jury from their community decided what it was worth.

This bill says it really should not be a decision of a jury, it should be a decision of the Senate, a one-size-fits-all, one solution for every problem, $250,000, take it or leave it. That is not right.

I say to my friends in the medical profession, I know you are not perfect, you are humans; you do make mistakes. Quite honestly, those who have dealt with doctors and have great respect for them know that the overwhelming majority of doctors are good men and women, well trained, dedicated to their profession, who make sacrifices every single day way beyond those called on by Members of the Senate.

Having said that, doctors I have spoken to understand that even giving it their best, occasionally they make a mistake in judgment—they do not know enough, they did not do the right thing—and terrible things occur. And most of them, under those circumstances, say yes, in those cases, people who are the victims of that kind of a circumstance should be compensated. I certainly believe that. It is not fair to establish an artificial limit and say that no matter what happens to that baby or that mother, there will never be another nickel beyond $250,000; a lifetime of pain and suffering limited to $250,000 in recovery.

To my friends in the medical profession who have a genuine concern, as they should, about the increase in medical malpractice premium rates, let me say you are not going to get any favor with this bill. This bill is being offered for reasons I cannot explain. It is being offered in the name of OB/GYNs across America who certainly do need help and need it now. But it is a bill that also includes immunity and relief from liability for pharmaceutical companies and medical device companies. I am sorry, but I have not heard anyone with a hue and cry about a crisis when it comes to these companies dealing with medical malpractice claims. But, naturally, they are included here because most bills that come through have to have a provision to help drug companies. They are the poster kids when it comes to this Congress. We are always going to find ways to help them.

For once, why don't we try to help the families who are the victims? And why don't we try to help the good doctors who need a helping hand?

I will make this statement in closing before I yield the floor: I want to work with those Members of the Senate on both sides of the aisle who in good faith want to address this issue. We can do things to deal with this. We must do them. We should do them now. This bill is not the way. This bill is a bad start. It is better to come together, off the Senate floor, try to find common ground and compromises on a bipartisan basis to protect the medical profession, on whom we all rely so much. We want to give the men and women in that profession, who have given their lives to serving us, a chance to practice medicine without skyrocketing premiums, but to also say to the families and patients who come to these doctors and these hospitals, we will not abandon you in the process.

There is reason to believe we can find this common ground. This bill is a bad start. It is likely to be defeated today. Once defeated, I hope Senators who believe, as I do, that we should address this issue will come together to try to find that common ground.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mr. DURBIN. Mr. President, I ask unanimous consent that when the Senate goes into a quorum call, the time for the quorum call be equally divided between both sides.

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

Mr. DURBIN. 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.

THE BIRTH OF SENATOR BYRD'S FOURTH AND FIFTH GREAT-GRANDCHILDREN

Mr. DASCHLE. Mr. President, later this afternoon, many of us will have an opportunity to see one another after the recess. I will make a prediction that we will notice a special twinkle in Senator BYRD's eye as we visit with him this afternoon. There is good reason. Actually, there are two very good reasons.

In the last month, Senator BYRD became a great-grandfather for the fourth and fifth times. Hannah Byrd Clarkson was born 4 weeks ago today, on January 27, weighing 10 pounds 3 ounces.

Hannah is the second child of another member of our Senate family, Mary Anne Clarkson, of the Bill Clerk's Office, and her husband James Clarkson. She joins her older sister Emma.

Hannah's cousin, Michael Yew Fatemi, was born on February 11. Michael is Senator BYRD's fifth great-grandchild, and his first great-grandson. He is named in honor of his uncle John Michael Moore, Senator BYRD's beloved grandson, who died in a car accident. Michael is the first child of Senator BYRD's grandson Fredrik Fatemi, and his wife Jinny.

Few people live long enough to see and hold even one of their great-grandchildren. To be able to welcome five of them into the world is a rare blessing, indeed.

I was deeply touched by Senator BYRD's kind words to me and my family on the births of my grandchildren, Henry and Ava.

I am sure I speak for the entire Senate family—and people throughout America—in wishing Senator BYRD and his wife Erma many happy hours with Hannah, Michael, and all of their family members.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BOND. 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. BOND. Mr. President, going to the doctor for a checkup is hard enough these days between juggling family and work schedules. Few of us get all the checkups and screenings we need. Making matters worse, more and more doctors are closing their practices or limiting the services they offer.

They are doing so because they cannot afford the increasing costs of medical malpractice insurance which they are required to carry.

According to the American Medical Association, 19 States are in a full-blown medical liability crisis, including the home State of the occupant of the chair and mine.

In Missouri, physicians' average premium increases for 2002 was 61 percent on top of increases the previous year of 22 percent. What happens? Well, 31 percent of the physicians surveyed by the Missouri State Medical Association said they were thinking about leaving their practice altogether.

Almost one in three physicians in Missouri considered leaving their practice because they cannot afford the exorbitant medical malpractice insurance cost caused by the lawsuits brought—some frivolously, and many of them, I assume, against doctors. Doctors who have practiced for years in Missouri are closing their doors.

But this is not just a problem for doctors. They are well educated. They can move elsewhere and resume their practice, as difficult and unfair as that is. The real damage and pain is being felt by the patients.

Last summer we considered a comprehensive bill, S. 11, the Patients First Act. Unfortunately, the motion to proceed was not successful. Because this issue is so critical to the health care of all Americans and because the crisis continues to grow, inaction

should not be an option because the outcome of considering the same comprehensive reform bill again is clear.

Today we have narrowed our focus on the health care needs of women and babies.

The American College of Obstetricians and Gynecologists last year said:

> An ailing civil justice system is severely jeopardizing patient care for women and their newborns. Across the country, liability insurance for OB/GYNs has become prohibitively expensive. Premiums have tripled and quadrupled practically overnight. In some areas, OB/GYNs can no longer obtain liability insurance at all, as insurance companies fold or abruptly stop ensuring doctors. When OB/GYNs cannot find or afford liability insurance, they are forced to stop delivering babies, curtail surgical services or close their doors. The shortage of care affects hospitals, public health clinics, and medical facilities in rural areas, inner cities and communities across the country.

It is a real problem in Missouri. A survey conducted by the American College of Obstetricians and Gynecologists in August of 2002 said 55 percent of their members from Missouri have been forced to change their practice, retire, relocate, decrease surgery, stop practicing obstetrics, decrease the number of deliveries, and decrease the number of high-risk obstetric care.

Last year, Missouri lost a total of 33 obstetricians. I want to share with you a few examples.

A St. Joseph, MO, practice, the only practice in Northeast Missouri to accept Medicaid, lost one-third of its doctors after the insurance company would no longer offer insurance to OB/GYNs. St. Joseph now has only seven OB/GYNs serving its population.

A Missouri doctor who has been in private practice for 3 years experienced a 400 percent increase in his liability premiums over the past 3 years and received a quote for $108,000 in 2004. This OB/GYN is considering quitting obstetrics in order to find affordable insurance.

A gynecological oncologist in Missouri left a group practice and eliminated a rural outreach clinic because of rising professional medical liability premiums. ''Women with gynecologic cancers in Ste. Genevieve, Carbondale, and Chester now have to drive over 100 miles to see a gynecologic oncologist and receive the care they deserve,'' said the doctor.

An OB/GYN in St. Ann, MO, was forced to close his practice last year because of medical liability costs that rose 100 percent. The practice had delivered about 400 babies a year.

Twelve doctors at the Kansas City Women's Clinic used to serve women in both Missouri and Kansas. But, because of rising medical liability insurance rates, the clinic could not find a single company that would offer them a medical malpractice insurance policy they need for their office in Missouri.

I should say parenthetically, I have been approached by some lawyers who practice medical malpractice plaintiff cases, and they said: The problem is the insurance companies are making too much money. It is not the lawyers. That is strange when the insurance companies can't even stay in business. They can't stay in business because of the lawyers.

As a result at the end of 2002 they closed their doors to their Missouri patients. There were over 6,600 visits a year in their Missouri office. Now, these women must either travel to Kansas to see their OB/GYN or find a new doctor elsewhere in Missouri.

Two Kansas City, inner city OB/GYNs who serve low-income, high-risk patients had to sell their practices to their hospital in order to continue to see patients in Missouri. Excessive litigation has created an environment that forced two doctors—committed to serving some of the most vulnerable women in Kansas City—out of business. They are no longer in independent practice.

One OB/GYN practice in Missouri had to take a $1.5 million loan to pay the malpractice insurance for this year. That does not even include the cost of the tail coverage.

Other doctors in Missouri are considering going without insurance for their tail coverage because they simply can't afford the premiums.

Women are having a hard time getting the care they need and communities are losing their trusted doctors. We have a health care system that is in crisis in Missouri.

The bill before us today, the Healthy Mothers and Healthy Babies Access to Care Act is narrowly crafted to protect access to prenatal, delivery, and postnatal care for women and babies by reducing the excessive burden the liability system places on the delivery of OB/GYN services.

This bill will protect the right of an injured patient to recover fair compensation while at the same time prevent clear lawsuit abuse.

The bill protects the right of injured patients to receive full economic damages that cover the out-of-pocket expenses that a victim might incur due to a doctor's negligence, such as hospital costs, doctor bills, long-term care, other medical expenses, and lost wages. This bill also includes a $250,000 cap on noneconomic damages, with deference to existing and future State caps.

This bill maximizes the amount of awards received by injured patients by limiting attorney's contingency fee to a reasonable, sliding scale.

Too often large percentages of an injured patient's award go to attorneys, leaving the patient with less money for their medical care and other needs. Injured patients are entitled to an overwhelming amount of their award after settling or winning a lawsuit.

Currently, lawyers in many States can take up to 40 percent of all awards and settlements, robbing the injured patients of their award. We think by protecting injured patients by limiting lawyers to 15 percent of any payment over $600,000 makes good sense.

These are just a few of the many vital reforms contained in this bill.

I urge my colleagues to protect access to quality health care for women and babies and support the Healthy Babies, Healthy Mothers Access to Care Act.

We cannot afford to have OB/GYNs to continue closing their practices, reducing the number of babies they deliver or eliminating care for high-risk patients, the uninsured, and the underinsured because of excessive frivolous lawsuits brought by plaintiff attorneys.

Ms. MIKULSKI. Mr. President, I oppose S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act. It should be called the ''Insurance Companies First Act.'' This is extreme legislation that puts the interests of the insurance industry ahead of the interests of women, their families and their doctors. It applies only to women seeking obstetrics and gynecological services—that's it. Every other patient can recover full damages. But under this bill only women will be limited in what they can recover for a doctor's medical error. This bill penalizes patients, while doing nothing to prevent doctors from being gouged by insurance companies.

This bill is legislative malpractice. First of all, the procedure for considering this bill is seriously flawed. The bill was brought to the full Senate without hearings, without consideration by the Judiciary Committee. There was no chance for patients, doctors or others affected by this bill to testify. There was no Committee Report to analyze the effects of the extremely complex and controversial legislation.

The result is a bill that targets some of the most serious cases of medical error, restricts the rights of women and infants, while doing too little to protect doctors from the high cost of insurance. It is the same broad brush legislation that we defeated in July, only this time they limit it to obstetrical and gynecological services and by design only restrict the rights of women patients. Proponents of the bill say they wanted to streamline the bill, to address the area of medicine with one of the highest premium rates and they claim that the beneficiaries will be women who will have improved access to health care. But since when has limiting one's rights improved anything? And how does restricting a woman's right to full recovery and only her rights provide her a benefit?

The real beneficiaries of this bill are the insurance companies. They get to see their profits soar while mothers who take care of infants who suffer because of medical error will face unfair caps in the remedies they receive. These are often stay at home mothers who need resources to care for their families and their infants who may need constant care, but the cap on noneconomic damages will prevent them from getting those resources. It's unfair to penalize these women because

they can't recover economic damages. I think the Senate can do better.

I oppose this legislation for three reasons:

As a Senator from Maryland, I cannot support legislation that gives Marylanders a worse deal. This legislation would override the Maryland law and place a $250,000 cap on non-economic damages. Maryland law strikes an important balance, providing a much higher cap on non-economic damages. The cap increases each year to offset inflation. It started at $500,000 and is now $635,000. It also has no caps on punitive damages. The Maryland law is supported by both physicians and patient advocates.

Yet the Republican bill would preempt Maryland law. It would put women and infants in Maryland at a disadvantage. It would severely limit their ability to get relief for the death, physical impairment or disfigurement that they suffer as a result of serious medical error.

This legislation shuts the court house door. It denies justice to women and women only. It denies justice to those who must care for a mentally disabled child for his or her whole life because of a doctor's mistake during prenatal or post-natal care. It denies justice to women who needlessly lost a child during delivery because of a serious medical error. It does this by imposing arbitrary caps instead of enabling juries to determine damages. I have faith in juries made up of members of the community to reach a fair verdict.

Who would be hurt by this legislation?

Someone like the mother from Baltimore whose newborn baby suffered brain damage because an emergency c-section was not performed in time. His mother had gone to the hospital reporting that there was decreased fetal movement. She knew something was wrong. Tests were performed. Yet the doctor misdiagnosed the problem. After several days, an emergency c-section was performed. It was too late. The baby suffered severe brain damage. He died 13 months later.

It is impossible to put a price on the loss of a child. Imagine if that death is the result of carelessness. Parents who suffer the unbearable pain of losing a child deserve the right to use the courts to seek full accountability.

Instead of penalizing patients, we need legislation to help doctors who are facing skyrocketing insurance costs. A doctor's number one priority is the care of his or her patients. We should make sure that it is easy for them to do so, knocking down the roadblocks to practice that excessive insurance premiums create. S. 2061 won't do that. It won't provide doctors with real relief today.

That's why the Senate should consider alternatives such as that proposed by Senator DURBIN, which focuses on solving the problems where they start. Senator DURBIN addresses the root of the problem, creating greater accountability for doctors through a voluntary error reporting database, economic help for those who face growing premiums, punishment for frivolous lawsuits, grants to provide physicians in areas where malpractice insurance has led to a shortage of doctors, and critically, an end to the immunity that insurance companies face from anti-trust regulations.

Yet instead of helping patients and doctors, the Senate is again caught up in a political game. It doesn't have to be this way. We have worked together in the past to pass legislation that helps victims and lowers insurance costs. The terrorism insurance legislation is a prime example. We passed it because there was a national will and the urgency to do something that provided real solutions.

Today, we are faced with the same national will. And I urge my colleagues to work toward a sensible compromise. One that does not unfairly target women and their infants. One that addresses all forms of medical error, not just those affecting women and puts the rights of all patients first. The public is demanding that we do something, as more Americans are suffering from serious medical mistakes and more doctors are unable to treat patients because of rising premiums. We now need the political will to help doctors without harming patients.

I urge my colleagues to vote no on cloture. We need to send this bill back to the Judiciary Committee for full consideration of the issue of medical liability as well as the impact of limiting women's rights to recovery on their health and well-being and that of their new born infants.

Mr. LAUTENBERG. Mr. President, I rise to talk about the bill that is the subject of today's cloture vote on the motion to proceed.

We must not be fooled by the seemingly friendly title of this bill. The Healthy Mothers and Healthy Babies Access to Care Act of 2003 does nothing to promote the health of mothers or babies. This bill will devastate the rights of parents and children, but it will help neither patients nor doctors. The real beneficiaries will be insurance companies, HMOs and large medical corporations. Sponsors of this bill insult us by calling it a Healthy Mothers and Healthy Babies Act. How can shielding from accountability an entire medical specialty area result in healthy babies? Less accountability will never lead to better health care.

This bill discriminates against women and infants by restricting their right to hold physicians, hospitals, insurance companies, HMOs, and even drug and medical device manufacturers fully accountable for injuries resulting from the provision of obstetrical and gynecological care. Although proponents of the legislation say the bill is necessary to increase access to women's health care, nowhere does the bill make liability insurance for doctors more available or affordable. And nowhere does it provide access to health care for women who are uninsured. What it does do is greatly limit the ability of women and children with the most devastating injuries to hold the wrongdoer accountable.

It is another example of what I call the ''maleogarchy'' that prevails around here placing a higher value on a man's worth than a woman's. The bill cynically devalues the worth of pregnant women injured by medical negligence. Men's injuries are given full value. For example, if a woman is inappropriately prescribed blood pressure medication during pregnancy that causes blood clots, her recovery is limited under the bill's provisions. If a man is prescribed the same defective blood pressure medication by his internist, he may recover against the drug manufacturer in accordance with available State law remedies.

The legislation unfairly reduces the amount of time that an injured woman has to file a lawsuit. Under the bill, a suit would have to be filed no later than 1 year from the date the injury was discovered or should have been discovered, but not later than 3 years after the ''manifestation'' of injury. Thus, a pregnant woman who contracted HIV through a transfusion but only learned of the disease 4 years after the transfusion would be barred from filing a claim. In addition, the bill limits the rights of injured newborns by requiring that actions on their behalf be brought within three years from the date of the manifestation of injury. This is in direct contradiction to the laws of many States, which preserve the rights of minors to seek legal redress upon the age of majority.

The bill limits non-economic damages to $250,000 in the aggregate, regardless of the number of parties against whom an action is brought. Noneconomic damages compensate patients for very real injuries such as the loss of fertility, excruciating pain, and permanent and severe disfigurement. They also compensate for the loss of a child or a spouse. These are very real damages, and juries are able to calculate them fairly. How do you calculate the economic damages to infants who sustain life-long injuries during childbirth or stay-at-home mothers who lose their fertility due to a defective drug taken during the course of pregnancy? Their injuries may be almost completely non-economic and this bill would have a devastating impact.

This bill is an appallingly cynical attack on the rights of mothers and their babies. In many ways, it is even more insidious than the bill that failed in the Senate last July. It is almost as if the proponents of that bill, having failed to eliminate the rights of all patients injured by negligence, decided they would simply target the rights of the most vulnerable: pregnant mothers and their babies.

Mrs. MURRAY. Mr. President, today the Senate is voting on a political gimmick that will punish women and children and do nothing to address the real medical malpractice crisis that is crippling healthcare throughout our State.

Doctors are facing escalating costs that are unsustainable, but instead of addressing this problem with a common-sense and immediate fix, the majority is engaging in a blame game. We don't have time for the blame game. Instead, we should be debating the bipartisan bill I support to provide immediate relief to doctors, stop frivolous lawsuits, and fix the broken insurance market.

But this bill doesn't just fail to address the real crisis in malpractice insurance; it actually undermines the rights of women and children in the name of helping them.

As a woman, a mother, and a Senator who has fought for the safety and welfare of mothers and infants, I am disturbed that the U.S. Senate would single out women and babies for different treatment than everyone else in America if they are injured through no fault of their own. This bill tells women that if we are injured, we don't deserve the same legal protections as men.

The sponsors of this bill have spoken about the health and well-being of women and babies in hypothetical terms. But I have to tell you, the injuries and crimes that continue to plague female patients are all too real.

Currently, in my State of Washington, we are following a high-profile case in which an OB/GYN has been accused of raping or molesting dozens of female patients under his care. This doctor is also accused of providing substandard care, ranging from performing unnecessary medical procedures to failing to prescribe prenatal vitamins to a pregnant patient with low iron levels.

In one case, this doctor even performed a surgery despite the fact that his office was not licensed for surgery and did not have a supply of blood available in case of complications.

I ask my colleagues to consider this case. If your wife or daughter or sister had been hurt, molested or worse by this doctor, would a $250,000 cap seem like a reasonable solution?

These cases are not hypothetical. They are not frivolous. And this bill will not protect the health or increase the wellbeing of any of these patients.

I find some sad irony in being told by this bill's sponsors that if I want to help women and babies, I should strip away their rights. I take a backseat to no one when it comes to standing up for women and children.

I wish that the people who are pushing this bill today had shown the same interest when I was fighting to ensure women could get direct access to an OB/GYN during the Patients Bill of Rights debate, but instead, they killed that effort. I wish they had shown the same interest in 1999 when I offered an amendment to end drive-through mastectomies, but they killed that effort as well. I wish this bill's sponsors had showed the same concern when I was fighting to improve drug labeling for pregnant women, but instead, they killed that proposal as well. They weren't on the side of women during all those fights, but here they are today, using the real shortage of OB/GYNs and the real malpractice crisis as an excuse for punishing women and babies without giving doctors or patients the help they desperately need.

If the sponsors of this bill are now serious about helping ensure healthy women and babies, I say ''Come on over!'' I've got a long list of legislation that they can sign onto today to really help women—like extending Family and Medical Leave, boosting the federal Medicaid match for OB/GYNs, and expanding Medicaid and the Children's Health Insurance Program, CHIP, for low-income pregnant women. The single most important step to ensure a healthy pregnancy and a healthy baby is prenatal care. Fully-funding and expanding CHIP would provide this care to low-income women who would otherwise go without.

The saddest part of this exercise is that we should be spending this time discussing a real solution, like the bipartisan bill I am cosponsoring with Senators GRAHAM and DURBIN, the Better HEALTH Act, S. 1374. If the Senate leadership really wants to help doctors and patients, they will bring up the widely-supported Graham-Durbin bill for a vote and stop playing games at the expense of women and babies. Every day they deny a vote on this bipartisan bill speaks volumes about their interest in a real solution.

The Graham-Durbin bill would give doctors an immediate 20 percent tax rebate on their malpractice premiums, provide federal help for a broken insurance market, and block frivolous lawsuits. That's the type of comprehensive, immediate and effective solution our doctors, patients and communities deserve.

My action plan to fix the malpractice crisis has four steps. The first thing we have to do is get doctors and hospitals some immediate relief—because the clock is ticking. Even if proposals to cap non-economic and punitive damages were passed this year, it is impossible to predict when—if ever—doctors and hospitals would see relief. That is not good enough for me, and it is not good enough for the doctors in my community. I want doctors and hospitals to get immediate relief.

Under the Graham-Durbin bill, doctors in high-risk specialties would be eligible for a tax credit that's 20 percent of their malpractice premium. Doctors in lower-risk specialties would get a 10 percent tax-credit. For-profit hospitals would get a 15 percent tax credit, and non-profit hospitals would get new grants. Immediate financial relief directly to doctors and hospitals must be part of any solution to the malpractice crisis.

Second, we have to cut down on frivolous lawsuits. Under the Graham-Durbin bill, every plaintiff attorney that files a medical malpractice case would be required to include an affidavit by a qualified health care professional verifying that malpractice has occurred. No more launching lawsuits that don't have merit. And anyone who violates this affidavit is going to be punished with strict, and increasingly harsh, civil penalties. We are not going to tolerate frivolous lawsuits, and that's the second part of the Graham-Durbin bill.

Third, we need to provide additional protections for doctors who are doing the right thing and serving patients through Medicare, Medicaid and S–CHIP. Doctors with a 25 percent caseload of Medicare, Medicaid, and State Children's Health Insurance Program, SCHIP, patients would be protected from punitive damages under the Graham-Durbin bill. Exemptions would only be allowed for cases involving sexual abuse, assault and battery, and falsification of records. Other than that there will be no punitive damages for doctors who are doing the right thing and serving Medicare, Medicaid and SCHIP patients.

Finally, the Graham-Durbin bill says the Federal Government should underwrite some of the risk in malpractice insurance—just as we have with terrorism and flood insurance. Doctors and hospitals should not have to shoulder the burden of a broken insurance market.

If the Senate leadership is serious about helping doctors and patients, it will bring up the bipartisan Graham-Durbin bill. It provides immediate and direct financial relief to doctors and hospitals. It cuts down on frivolous lawsuits. It limits liability for doctors with high Medicaid caseloads, and it provides Federal help for a broken insurance system.

As I have done for the past 10 years, I will continue to advocate for the policies that truly help women and infants and I will continue to stand up for my doctors, patients and communities who deserve an immediate, comprehensive solution to the malpractice insurance crisis. I welcome the support of any Senator who wishes to sign onto the legislation I have outlined today.

Mr. ALEXANDER. Mr. President, I express my concern once again with the rising cost of medical liability insurance. Last July we debated this issue in the Senate, and unfortunately did not reach cloture on this important issue. Today we are limiting our debate on the issue to care for mothers and babies. We must protect a woman's access to obstetric and gynecological care to ensure healthy mothers and babies. The increasing cost of medical liability insurance is creating a patient access crisis because doctors are leaving the practice of medicine.

At Hardin County General Hospital in Savannah, TN, the OB/GYN left the hospital to go practice in another state because the insurance premium was

too high. High medical liability insurance is one more reason it is difficult to recruit specialists to rural areas.

In 2002, the average net medical liability premium for an OB/GYN in Tennessee was $33,600. In 2003, the premium increased to $41,980, and in 2004, it increased again to $49,408. This is a 47 percent increase over the past 3 years. This sort of increased cost is not sustainable. I continue to be worried about who will deliver babies in my state.

I believe that S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act of 2004, will help protect access to care for mothers and babies in Tennessee. This bill will still allow unlimited economic damages, but it places a sensible cap on non-economic damages. I hope we reach cloture on the motion to proceed so that we can consider this very important legislation.

Mr. BYRD. Mr. President, I am concerned about the increasing costs of malpractice insurance and a lack of access to medical providers in West Virginia and other States. The current challenges facing the medical malpractice system are complex and require a multifaceted solution.

Unfortunately, this issue has become highly politicized with powerful interests pitted against each other. Patients and their doctors are being squeezed in the middle. It is long past time to give some peace of mind to patients and doctors alike who are caught in this political tug of war. We ought to have a wide-ranging debate in the Senate on how to best reform the medical liability and insurance system and also prevent medical errors.

I am disappointed that the administration and the Senate leadership have adopted a take-it-or-leave-it and one-size-fits-all approach to this issue.

Especially in more rural areas of this country, there is a serious shortage of doctors and a lack of access to quality medical care close to home. Too often, families must travel long distances to see a physician, and even farther if specialized care is required. I hope that, by proceeding to the medical malpractice bill, the Senate can have a constructive debate and reach a commonsense concensus on this important issue.

Mr. CHAFEE. Mr. President, today I will vote in favor of invoking cloture on the motion to proceed to S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act. My vote is not an endorsement of S. 2061 as it was introduced in the Senate. In fact, I have concerns about various aspects of the bill including the $250,000 cap on noneconomic damages and I anticipate supporting amendments to S. 2061 if the Senate has an opportunity to fully debate this legislation.

However, I do believe that reform of the medical liability system should be considered as part of a comprehensive response to surging medical malpractice premiums that endanger Americans' access to quality medical care by causing doctors to leave certain communities or cease offering critical services, such as obstetrical care. For this reason, I will vote for cloture on S. 2061 in an effort to move the debate forward.

Mr. FEINGOLD. Mr. President, once again we are faced with an ill-advised medical malpractice bill coming to the Senate floor without any committee consideration. Some argue that we have a malpractice insurance ''crisis'' that is driving doctors from the practice of medicine, particularly in the field of obstetrics and gynecology, or OB/GYN. But we have not yet explored that issue in the Senate at all. No committee has held hearings or marked up a bill on this topic. Instead, an extreme proposal has been brought directly to the floor and Senators are expected to vote for it because there is a crisis. That is not how the legislative process should work on an issue of importance to so many people.

I would like very much for Congress to address the problem of malpractice insurance premiums once we understand the seriousness of the problem and the effectiveness of the proposed solutions. But by bringing this bill directly to the floor, the majority shows that it is not serious about addressing the problem. It just wants to play a political card. To the extent that there really is a malpractice insurance problem, what is going on here is a cynical exercise, designed only to fail and to provide fodder for political attacks. I will vote ''no'' on cloture.

Ms. CANTWELL. Mr. President, I will not be voting for S. 2061, a bill that imposes very low damage caps on noneconomic damages in cases involving obstetrical services. I cannot support the bill before us today because I do not believe it would be effective in reducing the very serious problem that we have with rising medical malpractice premiums for doctors and hospitals in my State of Washington.

The fundamental premise of the bill is that by placing a very low cap on the amount persons injured in obstetrics cases could receive for noneconomic damages, insurers would respond by reducing premiums for physicians and hospitals. However, multiple studies have now shown that premiums for physicians in States that have already imposed limits on damages continue to increase. According to the Medical Liability Monitor, overall, premiums are 6.8 percent higher for OB/GYNs in States with caps than States without caps, and premium increases last year were slightly higher in States with caps on damages, than in States without them. That is why the Seattle Times, the Seattle Post Intelligencer, The Tacoma News Tribune, The Everett Herald and the Bellingham Herald have all come out in opposition to $250,000 caps in the last 2 weeks. As the editorial board of the Spokane Spokesman wrote last June 4 about proposals to cap damages, ''No doctor would prescribe radical surgery based on anecdotes or conflicting data.''

In the process of educating myself about this issue over the past year, including meeting with hundreds of Washington State physicians and hospital administrators, touring 29 rural hospitals, and reviewing the claims history of Physicians Insurance, Washington State's leading provider of malpractice insurance, I have asked many of these individuals what they believed the cap on damages should be. The fact that I have received answers ranging from zero to $5 million illustrates the difficulty in determining what a damage limit should be without reference to specific facts. I believe that juries made up of Washington State residents are better positioned to make a determination of appropriate compensation after hearing the facts of an individual case, than are Senators trying to find a one-size-fits-all solution. Washington State has the third best tort system in the country according to the Chamber of Commerce. Our State has long banned punitive damages, and as a result, capping noneconomic damages, without the knowledge of the jury, could lead to very unfair results for Washington State residents.

Imposing a $250,000 cap on noneconomic damages is radical. The $250,000 cap is based on a California law that was enacted in 1975 and has never been adjusted for inflation. While I wish that it were not true, Washington residents are sometimes harmed by negligent care in the course of obstetrics cases, and they suffer genuine damages. Despite efforts to create an exception for the most serious and egregious cases, there is no exception in the bill before the Senate for even the worst cases. Noneconomic damages compensate patients for real injuries including the loss of fertility, loss of a child, or loss of a spouse, as well as for excruciating pain and permanent and severe disfigurement. Caps on noneconomic damages disproportionately affect women and children because they lack the work history to make economic damages very meaningful.

That is not to say that we do not have a very serious problem in our State. Individual physicians have experienced premium increases of up to 75 percent and hospitals have suffered even greater increases. Increases have hit specialists, including obstetricians, particularly hard. This adds to pressure already being felt by physicians and hospitals in our State as a result of our abysmal Medicare reimbursement rate. Washington currently ranks 41st in the Nation and receives only $4,303 per beneficiary. Physician practices are small businesses, and many of our hospitals are nonprofit entities. They cannot be expected to absorb these huge increases without help.

That is why I support many measures that would actually help deal with the problem of rising insurance costs. I believe that we should be exploring the creation of best practices for physicians, which, if followed, would protect

physicians from law suits. I also believe that specialized malpractice courts could be a useful tool in curbing abuses of the system.

I also support legislation introduced by Senators LINDSEY GRAHAM and DICK DURBIN. Unlike S. 2061, which relies on damage caps to reduce future premiums, the Graham-Durbin bill provides tax credits to physicians and hospitals to help offset the increases in malpractice insurance. It would also create a medical mistake database, repeal the current law that prevents Federal regulators from examining whether the insurance industry is engaging in anticompetitive behavior and price manipulation to artificially inflate premiums, and impose stricter standards to demonstrate that a malpractice case has merit before it proceeds.

I am committed to finding solutions to these problems to ensure that Washingtonians continue to have access to quality affordable care throughout every city and county in our State. The bill on the floor unfortunately is not part of that solution. Hopefully, the debate doesn't stop today and these other alternatives will be considered.

Mr. FRIST. Mr. President, today we will be voting on a cloture motion to allow the Senate to proceed to debate S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act. I strongly urge my colleagues to vote for the cloture motion on the motion to proceed.

We have had a good discussion over the last few days, and it is clear that our medical litigation system is failing the American people. It is failing our communities, our hospitals, our doctors, our families and, most importantly, our patients. OB/GYNs and the women and babies they serve have been uniquely affected. Reform of this broken system is desperately needed, and we must act.

The upcoming vote will allow us to fully debate this critical issue. If action is delayed, we know what will happen: patients will suffer, women will suffer, and babies will suffer. OB/GYNs will continue to flee their practices and drop obstetrical services, and more States will be added to the AMA crisis list, a list that already has 19 States.

I have received letters from doctors all over America, including from my home State of Tennessee, demonstrating the devastating effect of the crisis. Premiums in Tennessee have gone up 68 percent over the last 4 years, and Tennessee is not even considered a crisis State by the AMA—yet.

One doctor from Paris, TN, writes:

> As a reproductive health physician I have provided a wide range of obstetrical and gynecologic services to west Tennessee for 13 years. I am one of only two physicians practicing in this area and do a significant amount of high risk procedures. My malpractice insurance premiums have increased from $30,000 to $60,000 in just two years. This is without a claim being filed against me. . . . I am strongly considering terminating my obstetrical practice to leave this area markedly undeserved.

Another doctor from Athens, TN, writes:

> As an obstetrician in East Tennessee whose liability insurance premiums increased 23 percent in the year 2003, it is becoming progressively difficult and risky for me to continue to deliver babies. Many of my colleagues have either retired or quit doing obstetrics. This is going to severely limit what is already excellent care in this country for the obstetrical patients especially in this part of the State.

As these real life stories show, this health care crisis is real, spreading and uniquely affects OB/GYNs. The current medical liability system is costly, inefficient and hurts all Americans. In addition to damaging access to medical services, the current medical litigation system creates problems throughout the entire health care system:

It indirectly costs the country billions of dollars every year in defensive medicine. The fear of lawsuits forces doctors to practice defensive medicine by ordering extra tests and procedures. Though the numbers are hard to calculate, well researched reports predict savings from reform at tens of billions of dollars per year.

It directly costs the tax payers billions. The CBO has estimated that reasonable broad reform will save the Federal Government $14.9 billion over 10 years through savings in Medicare and Medicaid.

It impedes efforts to improve patient safety. The threat of excessive litigation discourages doctors from discussing medical errors in ways that could dramatically improve health care and save hundreds or thousands of lives. I am a strong supporter of patient safety legislation which I hope we will pass this year. But in addition to patient safety legislation, we need to address the underlying problem—our liability system.

We must reform this broken liability system. That is why I strongly support the Health Mothers and Healthy Babies Access to Care Act. I thank my colleague, Senator GREGG, who skillfully led this debate, and I thank Senator ENSIGN, a leading proponent of reform, who has seen the current crisis close up in his own State of Nevada.

This legislation will protect women's access to care and ensure that those who are negligently injured are fairly compensated. Again, I encourage my colleagues to move this legislation forward. We cannot afford further delay.

Mr. President, I ask unanimous consent that a list of groups that support S. 2061 be printed in the RECORD.

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

GROUPS THAT SUPPORT S. 2061—HEALTHY MOTHERS AND HEALTHY BABIES ACCESS TO CARE ACT

American Medical Association
American College of Obstetricians and Gynecologists
American College of Emergency Physicians
American College of Cardiology
American Association of Neurological Surgeons
American Academy of Dermatology Association
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Surgeons
American College of Radiology
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Urological Association
Congress of Neurological Surgeons
National Association of Spine Specialists
Society of Thoracic Surgeons
American Academy of Family Physicians
American Society of Anesthesiologists

I thank the Chair, and I suggest the absence of a quorum.

The PRESIDING OFFICER. Without objection, the clerk will call the roll.

The assistant bill clerk (Ms. Stacy Sullivan) proceeded to call the roll.

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

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

Mr. SPECTER. Mr. President, I support legislation which would address the serious problems faced today by doctors, hospitals and other medical professionals who provide obstetrical and gynecological services and at the same time provide balance to treat fairly people who are injured in the course of medical treatment.

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

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

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

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

Further savings could be accomplished through patient safety initiatives identified in the report of the Institute of Medicine.

On November 29, 1999, the Institute of Medicine, IOM, issued a report entitled: To Err is Human: Building a Safer Health System. The IOM report estimated that anywhere between 44,000 and 98,000 hospitalized Americans die each year due to avoidable medical mistakes. However, only a fraction of these deaths and injuries are due to negligence; most errors are caused by system failures. The IOM issued a comprehensive set of recommendations, including the establishment of a nationwide mandatory reporting system; incorporation of patient safety standards in regulatory and accreditation programs; and the development of a nonpunitive culture of safety in health care organizations. The report called for a 50 percent reduction in medical errors over 5 years.

The Appropriations Subcommittee on Labor, Health and Human Services and Education, which I chair, held three hearings to discuss the IOM's findings and explore ways to implement the recommendations outlined in the IOM report. The fiscal year 2001 Labor-HHS appropriations bill contained $50 million for a patient safety initiative and directed the Agency for Healthcare Research and Quality, AHRQ, to develop guidelines on the collection of uniform error data; establish a competitive demonstration program to test best practices; and research ways to improve provider training. In fiscal year 2002 and fiscal year 2003, $55 million was included to continue these initiatives. We are awaiting a report, which has been delayed after being scheduled for issuance in September, 2003, by the Department of Health and Human Services, which will detail the results of the patient safety initiative.

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

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

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

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

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

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

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

Consideration of the many complex issues on the Senate floor on the pending legislation will obviously be very difficult in the absence of a markup in committee or the submission of a committee report and a committee bill.

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

Mr. President, I yield the floor.

Mr. ENSIGN. Mr. President, we had a debate today—sort of a debate, because we are only debating whether to proceed to a debate on the issue of whether we are going to continue to allow obstetricians and gynecologists and nurse-midwives to be able to practice in this country because of the runaway cost of medical liability insurance. The Democrats are not even allowing us to proceed to the bill, just like last year, when we tried to pass a more comprehensive reform. If they don't like the bill, let's amend the bill. But to have no debate on the bill, it seems to me, they are completely turning their backs on the women and children of this country, and those babies yet to be born.

I had a discussion this afternoon with the President of the American College of Obstetricians and Gynecologists. I was talking to her about the numbers of students going into the field of obstetrics and gynecology. At the Nevada School of Medicine, the lowest number ever of students have applied to go into obstetrics and gynecology. She pointed out a statistic in the State right next door, Utah. That number actually was zero. Zero have decided to go into obstetrics and gynecology. Let me repeat—in Utah, there are no new physicians this year who decided to go into obstetrics and gynecology. That is an alarming figure for the future.

For those people who are saying it is a problem but it is not that bad—the problem is bad today and it is going to get much worse in the future.

There have been statistics bantered about as to why this happened and why that happened. However, the bottom line is shown pretty well in this picture. This building is located in a very busy thoroughfare in Las Vegas. This is a picture taken last week . The sign says, ''OB/GYN—For Lease.'' The represents what is going on in many places in Nevada and other parts of the country—OB/GYN practices are shutting down.

There are obstetricians and gynecologists leaving my State. It is the fastest growing State in the country by far, yet we have OB/GYNs leaving. They are stopping their practices. Some of them are retiring early. Some of them are limiting their practices to only the practice of gynecology. For others to get coverage from the insurance companies, they have to limit the number of babies that they deliver each month.

My wife and I have had three wonderful children. Three of the most remarkable experiences of my life were the births of our three children. I know a husband and wife team, Joe and Kirsten Rojas, both of them OB/GYNs. They are passionate about what they do. They love to deliver babies. We have been out to dinner with them and often they get interrupted, and they have to go off and deliver a baby. Some of the hardest working people are OB/GYNs. Yet now they cannot afford to

keep practicing. They have to limit the number of deliveries.

The Rojases are our friends. We talk with them, and they have actually talked about leaving Nevada to go to California to practice their passion of delivering babies. They love Las Vegas. As a matter of fact, Dr. Joe Rojas, his father, was my mom's gynecologist. Actually, he did surgery on my wife when she had a medical condition. I graduated high school with Dr. Joe Rojas. He was born and raised in southern Nevada, and his wife now is in practice in Nevada, and they may have to leave their beloved home because they cannot afford the high costs of medical liability insurance.

I want to put up another chart that shows the comparison of the rates in States around the country compared with California. Some people are saying the insurance rates are rising or falling because of the stock market, or insurance companies are just raising the rates arbitrarily or because of some kind of actuarial tables. The bottom line is on this chart. This puts it into context.

The one State where we have had medical liability reform for any length of time, and it has been since the mid 1980s after surviving multiple court challenges, is the State of California. They enacted what is called MICRA. It is a strong medical liability reform law that, frankly, you could not get passed in the State of California today because the trial lawyers are so powerful. Over the years the trial lawyers have made so much money off of lawsuits that they are, I would argue, the most powerful political lobby in the United States today.

But in California they were able to enact a medical liability reform bill. Their rates are down here shown by the blue line. You see very little increase over the years all the way through 1999. The rest of the country is shown by this red dashed line. You can see the rates going up. This only goes through about 1999. If we took it out to the year 2004, to today, you would see another spike going up right now.

Actually the biggest increases in medical liability insurance we have seen have been in the last few years. This crisis is growing and getting worse year by year.

Let us just compare a few cities in two States that have enacted good medical liability reform versus cities in four States that have not.

Los Angeles in California: They have their MICRA law which is an effective medical liability reform law. Denver, CO: Once again, they have had a law on the books for about 10 years. They have an excellent law there.

Let us look here at OB/GYNs. There are some other specialties and the comparison is very fair, but us stay with OB/GYNs:

Los Angeles, a little over $54,000 a year; Denver, their premiums are about $31,000 a year; New York City, $89,000; Los Angeles, $108,000. By the way, this number, because this is 2002 data, is very low. In Las Vegas, it is somewhere between $140,000 and $200,000 a year, depending on how many babies they are delivering and whether they are dealing with difficult pregnancies. Looking on: Chicago, $102,000; and Miami, $201,000 per year in medical liability premiums.

Some people say these are rich doctors. Has anybody talked to an OB/GYN and asked them how much money they make these days? In Maryland, they get paid $1,400 for a delivery—not just a delivery but all the precare, the delivery, and the aftercare—$1,400 for all of those visits, including the hospital time. In the State of Nevada, Medicaid pays $1,200. That is about what managed care pays in the State of Nevada as well. These are not rich doctors.

By the way, we are not just talking about doctors; we are talking about nurse-midwives as well. When was the last time you talked to a rich nurse-midwife? They are in a crisis as well. A lot of them are having to leave their practices. In 2 States, legislators they have enacted excellent reforms, in too few states, nothing has been done.

That is the simplest evidence we can give as to why it is so desperately needed to enact the bill we have on the floor today. It will protect people involved in the delivery of babies and those involved in the practice of gynecology.

We have heard anecdotal stories about women delivering babies literally on the side of the road because they had to drive too far because their obstetrician left town. This is happening in my State, in Arizona, in Mississippi, in West Virginia—there are 19 States currently in crisis. Of the States that are left, all but five are showing signs of heading into crisis. The one thing we know, unless this problem is fixed, is that all of those States showing signs of crisis will head into the crisis as well.

How bad does the situation have to get before this body and those who defend the trial lawyers finally say enough is enough? How bad does it have to get? How many women have to be denied the care they need?

In the State of Nevada, sometimes politics drives this argument. Sometimes it drives many pieces of legislation around here. In the State of Nevada, our level I trauma center closed a few years ago. Just prior to its closing, the Democrat leaders in our State said there was no way they would pass medical liability reform—no way—it would never see the light of day. Our level I trauma center closed. What happened? Because of that closing, 3 weeks later a medical liability reform bill was passed in the State of Nevada. That medical liability reform bill is not a good one—it does have some good components, but it certainly does not go far enough. In the State of Nevada, we are trying to close the loopholes that were left open by that bill.

The politics that can be generated out of debating the bill and going forward can be a positive thing for actually getting this bill passed. The level I trauma center that closed in my State is the same level I trauma center where Roy Horn—the famous entertainer from Siegfried and Roy who was attacked by the tiger this last year—was treated. Had that level I trauma center not been reopened, Roy Horn would probably not be with us today.

The reason it is so apparent that this legislation would work is because we have the numbers here to show that in the States who have strong medical liability laws, much of the costs have been constrained. Case in point, the reason our level 1 trauma center was allowed to reopen was that our Governor stepped in and said: We will cover the level I trauma center under the State's liability protection.

What does the State of Nevada have for liability protection? It has a $50,000 cap for total damages, which is much more severe than we have in this bill. We have only a $250,000 cap on noneconomic damages. You can get as much as you want out of economic damages, and you can get as much as a jury says. Whatever your medical costs, you can get all of those. But on pain and suffering, with some of the most outrageous runaway jury awards, we limit it to $250,000.

Some say you are limiting the access to courts when you do that. In the State of California, once again, there have been tens of millions of dollars awarded in loss of income. For instance, a child was injured, and in one case $84 million was awarded by a jury. We are not limiting the access. We are trying to get rid of the frivolous lawsuits that are plaguing this Nation and leading to this crisis. There is a direct correlation.

Senator DASCHLE stood on the floor earlier today and said this bill would not help doctors. I question that statement because the doctors are supporting this bill. Virtually every medical association in this country is supporting this bill today. If it is not providing relief to the doctors, why are they supporting this bill? The answer is obvious. The answer is, it will help. It will help our entire system, and it will help those women and children who are being denied access to care right now. Unfortunately, if we don't do something, this situation in the future is only going to get worse and worse and worse.

The bill we have before us today, Senator GREGG and I introduced. I appreciate all of the great work he has done on this bill, which is a narrowed down version of what we tried to pass last year. What we tried to pass last year was a comprehensive bill. If we are not able to move to this bill today, we are going to try to do emergency room and trauma care and a good samaritan bill packaged together. If we can't get that done, we are going to do inner-city and rural health care areas—underserved areas.

We are trying to drive this issue home to the American people. They realize where their representatives stand.

Some have said you are trying to get a rollcall vote. You are darned right we are. We are trying to let people know who stands with patients and who stands with women and children with this bill and who stands with the trial lawyers.

Mr. ENSIGN. Another friend of mine in southern Nevada, whom I was talking to about 6 months ago, is one of the best OB/GYNs we have in southern Nevada. He focused his practice on difficult pregnancies, on the high-risk pregnancies, pregnancies with complicating factors. Maybe there is diabetes involved. That is a very common problem. One of my goddaughters who babysits our children has gestational diabetes. It is not an uncommon problem among women. During that time, there can be complications develop because of diabetes. It can be a very serious problem, but if handled by highly trained physicians, usually you do not end up with any problems.

Because my friend is in the high-risk category—by the way, he has never had a lawsuit against him—his insurance company this past year said he had to severely limit the number of babies he could deliver. This is his passion, and now he has to limit the number of high-risk deliveries. That means some other OB/GYN who is not as highly trained is going to have to deliver those babies.

If you are getting ready to deliver and you have a high-risk pregnancy, you would want the best possible medical care you could get. You would want the most highly trained physician. If you were told that because of our medical liability crisis in this country—I am sorry, you cannot go see your doctor—the one you have come to trust, because they had to limit the number of babies they could deliver in this month, imagine how that whole family would feel—the father, the mother, the grandparents. It puts an unnecessary risk on that delivery we should not be facing.

While no one wants to have medical malpractice cases, there are mistakes that occur in medicine. I am a veterinarian by profession. There are human mistakes. There is gross negligence. Those people should have the right to access a courtroom. They should have the ability of a remedy. I argue that our legislation actually gets them the remedy faster. It limits the attorney's fees so more of the money goes to the victim. It also gets the money to the victim faster. Right now it can take 6, 7, 8, 9, 10 years. A lot of times the patient may have already died. Our bill gets them the compensation they need much more quickly and in a fair manner.

I have heard it described that this bill discriminates against women. That would be like saying the whole State of California and the whole State of Colorado discriminates against women. That is ridiculous. California and Colorado are the two best examples of medical liability reform having been enacted and have been enacted for enough time to see it work. The patients who are injured actually get the compensation they deserve and we do not have the proliferation of frivolous lawsuits we see in the rest of the country in the healthcare field. There are many areas of tort reform we need to address. This happens to be one of them.

Anyone who has delivered or seen their child's birth knows the anxiety that builds up; it is a tense time. Every time one of our babies comes out of the birth canal, we are hoping and praying everything is going to be all right. The biggest fear of any parent is for something to go wrong. We want to know the best possible health care and the best possible health care provider is going to be there. That is not happening in too many cases. That is not happening because, I believe, the trial lawyers have been too powerful in the United States. We have to break that power base if we really want to care about the mothers who are expecting or about the level of gynecological care they have come to expect and deserve in this country.

This legislation is critical to the future quality of life in the United States. It is critical that we put special interests aside and the interests of patients at the forefront. That is what we are debating today. Are we going to put expectant mothers, midwives, OB/GYNs first? Or are we going to put the trial bar first?

I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. With the attention of my friend from Nevada, I ask unanimous consent I be allowed to speak as in morning business for 6 or 7 minutes. I think there are a couple of other speakers on the majority side who want to be here. When they come over, I will wrap up my remarks to give them time to be heard on the matter.

Mr. ENSIGN. I agree to the unanimous consent request with the caveat that if a Member of the majority comes over and seeks recognition, they will be recognized.

Mr. DODD. I am happy to do that and I thank my friend from Nevada.

The PRESIDING OFFICER (Mrs. DOLE). Without objection, it is so ordered.

GROWING ANARCHY IN HAITI

Mr. DODD. Madam President, I come this afternoon to express my deep concern over the growing anarchy and lawlessness in Haiti. This ominous situation, only miles off our own shores, threatens to overwhelm the elected government of Haiti in a number of days, and unless our country, the United States, along with other members of the international community, acts to stop it, it will get worse and pose far many more serious problems for us.

In my view, 3 years of neglected, mixed signals and inertia by the present administration—and the international community, for that matter—have brought a country already steeped in misery and poverty to the brink of uncontrollable violence and chaos. With respect to our own administration, which has sought to remake the political landscape of the Middle East, it is profoundly disturbing and unsettling that it seems incapable or unwilling to act to fortify a struggling democracy in our hemisphere.

I will not defend every action of the Aristide government in Haiti. There have been major problems there. I accept that and understand that. But no one denies this government was duly elected by the people of Haiti and it is being threatened today by a group of thugs and rebels, many of them who come from the previous death squads and ousted armed forces members which ruled that country with a brutal hand, who make up the majority of the people holding the second and fourth largest cities in Haiti today.

I am not standing here as some political defense of a specific administration, but I do stand here as someone who believes that if we are going to defend democracy, we have to be willing to stand up when fragile democracies, such as this desperately poor country, are being threatened by a group of people who do not have the interests of democracy at heart and have no right to be threatening this democratically elected government.

While I cannot discuss the administration's classified briefing of this morning, I can say that I was stunned by the lack of any coherent administration strategy for addressing the violence that may unseat the elected government. It is no secret that Haiti's long history of authoritarian governments as well as political and social upheaval have made it ripe to destabilize. The Haitian people continue to be the principal victims of this instability. The statistics are devastating.

Eighty percent of Haitians live in abject poverty; that is, 8 out of 10 people. By 1998, the World Bank reported that the per capita income in Haiti was $250 a year, less than one-tenth of the average in all of Latin America. In addition, only half of Haitian children attend school. Only 45 percent of the Haitian population can read or write and only marginally so. That is less than the people of Iraq.

The scarcity of resources have contributed to a public health crisis in that nation. Fifteen percent of children don't live past the age of 5. The average life expectancy is under 50 years of age. Haitians suffer from the highest rate of HIV/AIDS in the Western Hemisphere, roughly 6 percent of the population.

I note the presence of the Presiding Officer who, in a former life and occupation, knew these numbers and statistics as well as anybody. I appreciate her listening to this because she understands better than many what goes on in these impoverished nations.

Equally important are the intangible effects of this instability in this little country. Chief among them is the growing chaos in civil society. Indeed, the very fabric of Haitian society is at risk as pro and antigovernment factions armed with every imaginable weapon are increasingly clashing in the streets. Just in the last 2 weeks, more than 50 people have been killed in politically charged street protests. This violence took a new and disturbing turn when a group of armed gangs seized the towns of Cap Haitien and Gonaives, Haiti's second and fourth largest cities. They burned police stations and homes of supporters of Haitian President Jean Bertrand Aristide.

The year 2004 was to be a year of rejoicing and celebration for the people of Haiti as they were expected to proudly celebrate 200 years of independence. Instead they are forced to flee from their communities to escape seemingly indiscriminate violence. There is no mystery, in my view, who is behind these armed attacks. They have audaciously identified themselves to local and international journalists. They are former members of the Haitian armed forces and former members of the so-called FRAPH, the paramilitary organizations that terrorized Haitians in the early 1990s. They were responsible for the deaths of thousands of Haitians and the flight of tens of thousands more who were prepared to risk their lives at sea coming to this country rather than bear the repression and violence that was a daily occurrence in that country. They are back in Haiti, and they are within an eyelash of taking control of Haiti again. We are going to see the effects of it here in a matter of days.

These armed thugs have publicly announced that they intend to march on Port-au-Prince within hours. In fact, within 15 minutes of my address today, a decision will be made by the so-called political opposition in Haiti on whether to accept the recommended political solution that would bring about a new Prime Minister, sort of a copresidency with the present elected government. That is the offer to be made. It has been rejected in the last several days by these gangs and the opposition.

At 5 o'clock they are going to announce whether they are willing to try it again. I hope they will try. I hope they will accept what has been offered to them by CARICOM, our Government, and others. If they don't, I am fearful that we will see a continued rise in this violence, the cost of human life, of innocent life unnecessarily.

The administration up to now has offered only words. I commend Colin Powell. He has said that we respect this elected government and we don't believe it ought to be overthrown, that we will not support any removal of this democratically elected government. But those are words. They are important words coming from an important individual, but it doesn't diffuse the growing crisis. A rejection of the political solution does not portend well for the people of this country. A violent coup that unseats the duly elected government is not an auspicious foundation for further stability in that country as the painful aftermath of the 1991 coups should remind us.

It is too late for diplomacy alone to turn the tide. The political opposition's rebuff of last weekend's diplomatic mission makes that painfully clear. The international community must act with strength and resolve to thwart these criminal elements and prevent the impending humanitarian refugee crisis that is about to explode before our very eyes. It is time for the administration to take the lead in this matter.

I am not suggesting that we send some massive force. We are talking about 200, 300, 400 gang members, thugs. It is not a large operation. It wouldn't take much of an international force to send a message that we are not going to allow this government, this crowd to overthrow the elected government.

Our position as of right now is that we won't do anything. We are not going to step up until there is some political context in which to operate.

There will be a political context when we let these thugs know that we are not going to tolerate the overthrow of this government by asking others to join us. I hope the administration would be prepared to act, particularly in light of what I anticipate to be the rejection of the offer of a political solution.

While I commend CARICOM, the Caribbean community's organization, for ongoing efforts to find a temporary solution to the political crisis, these efforts have so far been fruitless because the political opposition hopes they will be able to watch an overthrow of this elected government and then count on the U.S. Government to come in and sanction them, as if somehow they have arrived in power legitimately.

Let me say to them today: If you think for a single second you are going to get any support out of this Congress by overthrowing an elected government, you are fooling yourselves. It is not going to happen.

This government of ours needs to speak loudly and clearly to these people that this is not what the United States stands for. This is not an endorsement of every action by the Aristide government any more than we endorse every action of other governments around this hemisphere or elsewhere. But to sit back and sort of wink, in a sense, that it is OK for these gangs and thugs and literally drug dealers, some of the worst elements that that country has ever seen, come back into power and be able to overthrow this government is a huge mistake.

It is occurring on this administration's watch. To allow it to happen will be tragic. Let there be no doubt the United States will suffer, along with the Haitian people, if we permit this to go on. Haiti is located only miles from our doorstep. Lawlessness in Haiti only ripens conditions for narcotrafficking and illegal migration.

Haiti is already a major transition site for drugs coming into this country. We know that already. If we think we are going to get a better deal from these gangs that are about to overthrow this country, we are making a mistake. Engagement with the Haitian people is clearly in the best interests of both our peoples.

Not only is the lack of real leadership on the part of our own country disgraceful and disappointing, it is dangerous. Without that leadership, there will be worse violence and greater chaos.

Once security has been restored, the administration has at its disposal the tools to move both sides toward a political compromise, should it choose to utilize them. With respect to the Government of Haiti, that includes providing direct assistance to the Haitian police, assistance in the form of training and equipment in return for compliance with the CARICOM initiative.

With respect to political parties and civil society, the United States should revoke U.S. visas to any of these organization members who are unwilling to participate wholeheartedly with the diplomatic efforts to find compromise or who support or condone violence. If it takes legislation banning these people from getting visas, I will do it. These people travel to the United States all the time and then turn around and provide support to these thugs and then anticipate coming here when it gets a little dangerous. They have no right to come to America, if they participate in this action going on in Haiti as we speak.

The Dominican Republic and other Caribbean countries must take action to stop these territories from being used as a transit point for illegal arms shipments to Haiti or as staging areas for armed Haitian opposition groups. Equally important, the United States and the international community must stop ignoring the negative impact that our economic policy of withholding assistance to the Haitian people is having on Haiti's stability.

Corruption aside, the Haitian government's lack of resources would preclude anybody from effectively ruling that country. It is disingenuous of the Bush administration and the international community to cut off hundreds of millions of dollars in aid to these desperately poor people, some of the poorest people in the world. They needed just a small amount of help, and we were unwilling to give them any over the last 3 or 4 years. It is no wonder that chaos is running wild in that country today.

I hope the administration will take far more concrete steps to respond to this crisis than they have presently. My hope is that within a matter of minutes the political opposition and

others will agree to the political solution offered to them. If not, the United States and the international community need to step up and offer to send in armed forces, if necessary, to protect the overthrow of this legitimately elected government.

Mr. ENSIGN. Madam President, what is the situation regarding time?

The PRESIDING OFFICER. The time has expired.

Mr. ENSIGN. Of the 10 minutes remaining, 5 minutes is for the minority and 5 is for the majority leader, is that correct?

The PRESIDING OFFICER. That is correct.

Mr. ENSIGN. The majority leader has the last 5 minutes.

The PRESIDING OFFICER. The Senator is correct.

Mr. ENSIGN. Madam 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. REID. Madam 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. Madam President, the distinguished Senator from Nevada, my colleague, Senator ENSIGN, has been waiting for the minority leader to come. The time is here for the majority to use. If the minority leader decides to use 5 minutes, I ask unanimous consent that the majority be given the final 5 minutes to speak on this matter.

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

The junior Senator from Nevada is recognized.

Mr. ENSIGN. Madam President, I want to sum up this debate telling one story and making a few other points. Some on the other side of the aisle claim ''they want to make health care a birthright for every single child born in this country.'' Yet they are driving the very doctors who bring America's babies into the world out of their medical practices.

Let me remind you of Melinda Sellard's story. She is the unfortunate woman who went through a horrifying experience of delivering a baby on the side of the road in the middle of the night because her doctor had quit obstetrics altogether due to exorbitant insurance premiums. En route, she and her husband had to drive right past the Copper Queen Community Hospital, which closed its maternity ward 2 months earlier because of the medical liability crisis. Instead, the Sellards were forced out onto the highway to try to get to the only hospital within 6,000 square miles with obstetricians who could afford malpractice insurance.

After enduring the excruciating pains of labor without anesthesia, Melinda was forced to give her newborn infant CPR, since the baby was not breathing immediately after delivery. She finally got her newborn breathing, wrapped him in a sweater she was wearing, and drove the rest of the way to the hospital where the emergency staff cut the umbilical cord in the parking lot.

I urge my colleagues to think of Melinda and the other mothers in this country who have lost their doctors and to stand up to the trial lawyers and support cloture on this bill. The ''objects in your rear view mirror that are closer than you think'' should never be a woman and her newborn child on the side of the road.

I yield the floor.

The PRESIDING OFFICER. The Democratic leader is recognized.

Mr. DASCHLE. Madam President, I know that time is close to having the vote. I will use my leader time. I want to make a couple of additional remarks about the bill.

We have had a great deal of discussion today and comments made by some of our Republican colleagues about the hardships malpractice insurance premiums place on doctors. There is no difference of opinion in that regard. Both Republicans and Democrats agree this is a real challenge and it certainly demands our attention. But I think we have to reject cloture this afternoon for the simple reason this bill does nothing to solve it. As we have heard most of the day, every piece of available evidence shows capping damages has no impact on the cost of malpractice insurance.

Reports from the General Accounting Office, the Congressional Budget Office, Weiss Ratings, and the Medical Liability Monitor all confirm malpractice awards are not the primary factor driving the cost of malpractice insurance higher. Even the insurance industry admits caps won't protect doctors from higher insurance premiums. Just last year, Bob White, president of the largest medical malpractice insurer in Florida, stated, ''No responsible insurer can cut its rates after a [medical malpractice tort reform] bill passes.''

Doctors deserve our help. They need our help. They certainly want it. But no doctor should expect lower insurance rates as a result of this bill. It is wrong to take away the women's right in the courtroom merely to protect the profits of the insurance companies.

This bill would create, for the first time, an unjust two-tiered legal system, actually restricting the rights of women and infants who are hurt by the negligence of a doctor, HMO, drug company, or even a medical device manufacturer.

If a man is prescribed defective blood pressure medication by an internist, he can recover full damages under the bill. If a woman is prescribed blood pressure medication during pregnancy that causes blood clots, her damages will be arbitrarily capped. There may even be a constitutional question involved in this disparity between men and women.

The idea that men and women should have unequal access to the legal system offends, if not the Constitution, certainly our sense of justice. But the real problem with this bill isn't merely that it values the injuries of men and women differently, as troubling as that is. The real problem is that it presumes that somehow those of us in this Chamber are better able to determine how to compensate injured patients in a preemptive way, knowing ahead of time all of the circumstances. Knowing exactly how these people are going to be affected by the decisions we make today is something I don't think anyone could acknowledge they have the ability to do.

This morning, I spoke with Colin Gourely of Valley, NE. At his birth, he suffered complications due to his doctor's negligence. Today he has cerebral palsy and is confined to a wheelchair. He has had five surgeries to correct his bone problems that have occurred as a result of this serious misjudgment in medical care.

Politicians in Washington can't decide what is just compensation for Colin's pain or the pain of any injured patient. We shouldn't apply the one-size-fits-all remedy for the tens of thousands of women and infants who are injured each year.

The fact is, no amount of money can ever compensate a parent for their child's pain, but malpractice awards are not simply about money. They are about offering victims a sense of justice, a way of holding accountable those responsible for their injuries or the death of their loved ones.

Malpractice awards are decided by juries and approved by judges. This is the same system we rely on to decide life or death issues in capital cases. Why wouldn't we trust our citizens to fairly evaluate how to deliver justice for the victims of medical malpractice?

There are real solutions that can bring down the cost of malpractice insurance, and Democrats are eager to work with our Republican colleagues to implement them. We have talked about tax credits to offset the high cost of premiums, prohibitions against commercial insurers engaging in activities that violate Federal antitrust laws, sensible ways to reduce medical errors, direct assistance to geographic areas that have a shortage of health care providers, due especially to malpractice insurance premiums.

So if our colleagues are as concerned about the plight of doctors as they have indicated again today, I hope they will work with us to devise a real solution. Let's drop the maneuvers that protect only the profits of insurers and HMOs and pharmaceutical companies, and let's have a serious discussion about how we solve the problem for our Nation. I think we have an obligation to have that conversation and ultimately come to some solution. Doctors and patients deserve it. They deserve an answer. This bill is not it.

As a result, once again I urge my colleagues to reject cloture. I yield the floor.

CLOTURE MOTION

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

The legislative clerk read as follows:

CLOTURE MOTION

We the undersigned Senators, in accordance with the provisions of Rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on the motion to proceed to Calendar No. 429, S. 2061, a bill to improve women's access to health care services and provides improved medical care by reducing the excessive burden the liability system places on the delivery of obstetrical and gynecological services:

Bill Frist, Judd Gregg, Kay Bailey Hutchison, Lisa Murkowski, Susan Collins, Elizabeth Dole, Michael B. Enzi, James M. Inhofe, John Ensign, Craig Thomas, John Cornyn, Pat Roberts, Sam Brownback, Orrin G. Hatch, Charles Grassley, Mitch McConnell, Jon Kyl.

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

The question is, Is it the sense of the Senate that debate on the motion to proceed to S. 2061, a bill to improve women's access to health care services and provides improved medical care by reducing the excessive burden the liability system places on the delivery of obstetrical and gynecological services shall be brought to a close? The yeas and nays are mandatory under the rule. The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Utah (Mr. BENNETT) is necessarily absent.

Mr. REID. I announce that the Senator from California (Mrs. BOXER), the Senator from New Jersey (Mr. CORZINE), the Senator from North Carolina (Mr. EDWARDS), the Senator from South Dakota (Mr. JOHNSON), the Senator from Massachusetts (Mr. KERRY), and the Senator from Georgia (Mr. MILLER) are necessarily absent.

I further announce that, if present and voting, the Senator from South Dakota (Mr. JOHNSON) and the Senator from Massachusetts (Mr. KERRY) would each vote ''nay''.

The yeas and nays resulted—yeas 48, nays 45, as follows:

[Rollcall Vote No. 15 Leg.]

YEAS—48

Alexander	DeWine	McCain
Allard	Dole	McConnell
Allen	Domenici	Murkowski
Bond	Ensign	Nickles
Brownback	Enzi	Roberts
Bunning	Fitzgerald	Santorum
Burns	Frist	Sessions
Byrd	Grassley	Smith
Campbell	Gregg	Snowe
Chafee	Hagel	Specter
Chambliss	Hatch	Stevens
Cochran	Hutchison	Sununu
Coleman	Inhofe	Talent
Collins	Kyl	Thomas
Cornyn	Lott	Voinovich
Craig	Lugar	Warner

NAYS—45

Akaka	Durbin	Lieberman
Baucus	Feingold	Lincoln
Bayh	Feinstein	Mikulski
Biden	Graham (FL)	Murray
Bingaman	Graham (SC)	Nelson (FL)
Breaux	Harkin	Nelson (NE)
Cantwell	Hollings	Pryor
Carper	Inouye	Reed
Clinton	Jeffords	Reid
Conrad	Kennedy	Rockefeller
Crapo	Kohl	Sarbanes
Daschle	Landrieu	Schumer
Dayton	Lautenberg	Shelby
Dodd	Leahy	Stabenow
Dorgan	Levin	Wyden

NOT VOTING—7

Bennett	Edwards	Miller
Boxer	Johnson	
Corzine	Kerry	

The PRESIDING OFFICER (Mr. ALEXANDER). On this vote, the yeas are 48, the nays are 45. Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is rejected.

MORNING BUSINESS

Mr. FRIST. Mr. President, I now withdraw my motion and ask that there now be a period for morning business with Senators permitted to speak therein for up to 10 minutes each.

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

The Senator from Texas is recognized.

TRADITIONAL MARRIAGE

Mr. CORNYN. Mr. President, in 1996, the Congress voted overwhelmingly to pass the Defense of Marriage Act. This is a bipartisan bill, where Members of both parties in both Houses voted overwhelmingly to define marriage as an institution in traditional terms, between a man and a woman. This, as you may recall, was in part a response at the time to the Vermont decision implementing civil unions. This body, just like approximately 38 States, has now passed defense of marriage acts defining marriage in traditional terms.

Last September, the Senate Judiciary Committee's subcommittee on the Constitution held a hearing at which we elicited testimony on this issue: Is the Defense of Marriage Act in jeopardy?

The reason we had that hearing is because the U.S. Supreme Court, last year, made some pretty significant decisions, one of which was Lawrence v. Texas, which, if the rationale was going to be followed through, would seem to place the Defense of Marriage Act in jeopardy, saying that that somehow violated the Constitution, thus opening the way to marriage between same-sex couples.

At the time we had people, as you might imagine, as in every hearing, some of whom said, oh, no, the Defense of Marriage Act will stand as long as it is the will of Congress and the will of the American people. Others said more presciently, as it turns out, that if there are judges who want to use the decision of the U.S. Supreme Court in Lawrence v. Texas, and to extend that, indeed, yes, the Defense of Marriage Act could be in jeopardy—indeed, the very definition of marriage between a man and a woman that is part of the Federal law and, as I said, I believe some 38 States.

Well, of course, the day that many thought would come only remotely in the future came much more quickly, when the Massachusetts Supreme Court decided that, indeed, traditional marriage violated the Massachusetts Constitution. Now, some might say, well, since it was a matter of State constitution law, it is limited only to the State of Massachusetts. But a closer reading of that decision reveals that one of the bases upon which the Massachusetts Supreme Court decided that traditional marriage violated the Massachusetts Constitution was a U.S. Supreme Court decision in Lawrence v. Texas, interpreting the U.S. Constitution.

So as it turns out, there is a much closer relationship between the State court constitutional decision and a decision under the Federal Constitution.

Well, once the Massachusetts Supreme Court did, indeed, hold that marriage was no longer limited to men and women in Massachusetts, some said this was just a State matter and there was no reason for the Federal Government to get involved, and there was no reason for other States to be concerned. Yet over the last week or so, we have seen that individuals have moved—I saw one report in the Washington Post of people leaving Maryland and going to San Francisco and getting married—in defiance of State law, I might add—where the city of San Francisco, the mayor, and others, would issue marriage licenses, and then people would return to places such as Maryland. Or people would show up in San Francisco and, because of an act of civil disobedience by the mayor and municipal officials there, seek to get married, even though California law is consistent with Federal law and the law of other States defining marriage in traditional terms.

Indeed, we see in New Mexico and in Chicago, where the mayor said if same-sex couples sought to get married, he saw no reason not to issue them marriage licenses. Indeed, in Nebraska, a lawsuit in Federal Court is being defended by the attorney general of Nebraska under the Federal Constitution seeking to define marriage in not untraditional terms, to allow it not to be limited to just traditional marriage.

So this is not an issue that has been raised by Members of Congress initially. This is a matter that has been injected into the public arena by activist judges who have decided to radically redefine the institution of marriage in Massachusetts but the reverberations of which have resounded all across this Nation.

It is in that light I believe we in this body have a responsibility to ask what

are the implications of the Massachusetts decision in this brush fire across the country where local officials and others are in acts of civil disobedience defying State law to issue marriage licenses and what are the ramifications of the Massachusetts decision in terms of the continued viability of the Defense of Marriage Act at the Federal level.

Next Wednesday morning, March 3, under the auspices of the Senate Judiciary Committee, Chairman HATCH has graciously agreed to allow the holding of a subcommittee hearing of the Constitution Subcommittee, which I chair, to have witnesses talk about what the implications are in terms of national policy, in terms of the institution of marriage, which I believe is important. Indeed, if Congress is to be believed, on a bipartisan, overwhelming basis Congress has said it is important and, indeed, that bill itself was signed by President Clinton.

We cannot simply stand idly by, in my opinion, and let activist judges radically redefine the institution of marriage when it stands in stark relief and defiance of the will of the American people and certainly of the decision this body has made in terms of passing the Defense of Marriage Act. So we are going to have a hearing next Wednesday on that issue.

I suspect others will come to the same conclusion I have, and that is the Constitution of the United States will be amended eventually; that this decision in Massachusetts will spread to Federal courts where others will cite this Massachusetts decision as precedent for an interpretation of the Federal Constitution that will strike down the definition of traditional marriage.

I think that is important for a couple of reasons. I know there are people who are reluctant to even talk about this issue because they don't want to be painted or cast as intolerant or haters or bashers or any other term one might think of. Indeed, I think it is important to point out you can believe in the essential dignity and worth of every human being and still believe the institution of marriage is important to our civilization, to families, to providing the most stable means of establishing family life, but also to the benefit of children.

The best interest of children requires us to do everything we can to encourage stable family life and, indeed, in the course of history, not just in this Nation's history, but throughout human history, I believe it is irrefutable that traditional marriage between a man and a woman is the firmest and most stable basis to establish family life. Indeed, that is the relationship, that is the basic social unit under which children thrive and are at reduced risk.

When I was attorney general of Texas for 4 years, I had the responsibility to collect child support for some 1.2 million children. These were children who were from single-parent families. They were either born without their parents ever marrying or their parents married and then divorced and they, of course, were in the custody of one parent and the other parent would typically be ordered to pay child support. I became very much convinced, not just because of the social science, but because of what I saw as a person responsible for collecting that child support for these 1.2 million children, that children are at less risk when they have two loving parents who care about them and support them emotionally and financially; that certainly traditional families are the optimal situation in terms of children doing well and becoming productive citizens.

At that time, of course, it had nothing to do with this new and revolutionary constitutional theory that has been thrust upon us by the Massachusetts Supreme Court that seems to be picking up around the country which I think we need to address, but really we need to, as a nation, reaffirm our commitment to doing what is in the best interest of our children.

Indeed, it is irrefutable that intact families, traditional families—mom and dad providing role models for children they can then use when they grow up to then become not only productive citizens but moms and dads themselves and raise their own children—is something the Federal Government ought to be encouraging. We shouldn't be agnostic about something that is so fundamentally important to the well-being of this country and to our future. We should not stand idly by and see the constitution of one State then spread to another State and, indeed, then to the courts where the Federal Constitution is called into question that would radically redefine this basic social institution.

While I know there are those who are hesitant to talk about this issue because, as I say, no one wants to be cast as intolerant of other relationships—indeed, I think you can say and recognize there are people in loving relationships outside of marriage. But when they want to say marriage is what we redefine it to be, and there is no difference between a man and a woman and a same-sex marriage, I think, first of all, that tends to trivialize what we all have come to recognize as an institution that is a basic social good in this country. But it also is game playing.

There are others who say we want to have all the legal benefits of marriage, but maybe we won't call it marriage, which to me is game playing.

I am a little skeptical of that, especially when, as a lawyer, I know if two people of the same sex want to make contractual or other arrangements between themselves so one can inherit from the other, so one can act on the other's behalf by use of a power of attorney, either to make medical decisions, if one is disabled, or financial decisions if the circumstances arise, there is virtually an unlimited opportunity for same-sex partners to order their relationship from a legal standpoint in a way that satisfies virtually all the reasons I have heard articulated for same-sex marriage.

It is important we have a hearing. It is important for this body to defend, if necessary, its prerogative under the Defense of Marriage Act to do what we believe and I believe the overwhelming number of American people believe is in the best interest of families and children and not leave this to activist judges who consider themselves to be superlegislators, who consider their prerogative to take a social or political or some other agenda and essentially dictate that to the American people from the bench.

We know Federal judges and many State judges serve for a lifetime. There is no way for the American people, short of impeachment, to remove a Federal judge or a judge who is appointed for a lifetime who acts in such a radical fashion, so inconsistent with our norms and traditions, with our traditional understanding of the separation of powers, And yet in a way that would so radically transform this fundamental social unit that is so important to who we are as people and as families, and one that is the best and most optimal arrangement found yet in the history of mankind to have and raise children so that they will be productive citizens.

I have come to the same reluctant position as I know the President announced he has today and believe that indeed the Constitution will be amended. The question is whether we the people are going to amend it by using article V of the Constitution, which creates an admittedly difficult process but one which is important to make sure that it is not done flippantly, too fast or without adequate deliberation. It is time to consider whether we ought to invoke that provision the Framers provided in article V of the Constitution to say: Not so fast, judge. We the people ultimately have the power within our hands to decide how this institution will be defined and we think there is a positive social good to define marriage in traditional terms.

So I believe it is important, as the President has concluded in his announcement today, that we consider a constitutional amendment.

There are some who say our Constitution is a sacred document. Indeed, I think our Constitution is very important and even an inspired document, but I disagree with those who say the Constitution is sacrosanct to the extent that they say the Constitution should never be amended. Indeed, if the Founding Fathers believed the Constitution should never be amended because it was a sacred document, then they would not have provided a means within that document itself for deliberation, hearings, decisions, and ultimately a vote of this body and of the other body by two-thirds and then three-quarters of the States voting for

ratification, which is the process by which that Constitution can be amended.

In my lifetime, I never imagined I would be standing on the Senate floor having to say I believe in the traditional institution of marriage between a man and a woman. I just thought, of all the other issues we would be debating in this body, whether they are matters of war and peace, job creation, access to health care, education, all of the important issues that affect the people in this country, the last issue I ever thought we would have to address would be a redefinition of marriage, but I submit that is where we are.

Reluctantly, as many of us come to this discussion—and I think if one looks at the polls we have all followed in the news media in the last few weeks since this issue has been splashed across our TV screens, our newspapers, the Internet, and elsewhere, one sees that the American people are getting the sense that something has gone terribly wrong, that somehow their values and their traditions are being disrespected in a way that needs correction.

As more and more people find out about the way this came about, through a sort of—well, I would call it judicial lawlessness; in other words, judges who are not interpreting the law but who are taking it upon themselves to redefine what the Constitution means and indeed redefine this basic social unit in our civilization, I think they are going to be pretty upset and they are going to expect us to take up a discussion of this constitutional amendment in a reasonable, deliberate, civil sort of fashion.

I hope we can rise to that challenge. Indeed, if one looks at the vote in the Defense of Marriage Act, one sees there is an overwhelming bipartisan group in this body and in the other body who believe that the institution of marriage is a positive social good and worthy of preservation. I hope we will not be afraid to talk about it in a frank and open way, to listen to the concerns of those who maybe are not yet convinced, to take those into account and then, as a Senate, we can discharge our responsibility under article V of the Constitution to begin the process of allowing the American people to vote on the definition of marriage.

We know who is voting now and it is a handful of judges and municipal officials who are encouraging civil disobedience. They are issuing marriage licenses in violation of State law, for example, in California and elsewhere. Ultimately, if we are going to preserve something that I think is infinitely worthy of preservation—and that is government of the people, by the people and for the people—this is something we are going to have to do. This is a responsibility we are going to have to accept and we are going to have to risk the possibility that some may mischaracterize what we are trying to do as being disrespectful of other people. That is not what this is about.

I would condemn rhetoric or language which would appear to be disrespectful of other people, but that does not mean at the same time that I do not believe the institution of marriage is worthy of protection.

I look forward to the hearing we are going to have in the Constitution Subcommittee on March 3, I believe at 10 in the morning. I anticipate that perhaps later in the month, maybe the week after we come back from the March recess, we will have another hearing. Senator HATCH, the chairman of the Judiciary Committee, of course, reserves the right to make that final decision. At that time, we will begin to take up language, which we might then consider first in committee but then on this floor, that would preserve the definition of marriage for the American people and not allow ourselves to be dictated to by judges who are pursuing some other agenda, one that the overwhelming number of American people disagree with strenuously.

I yield the floor and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

HONORING BLACK HISTORY MONTH: SUPPORTING THE SICKLE CELL TREATMENT ACT

Mr. TALENT. Mr. President, I rise today to honor Black History Month by supporting the Sickle Cell Treatment Act, which is S. 874, and inviting my colleagues to join me and my chief cosponsor, Senator SCHUMER, in doing the same. I am very pleased we now have over 40 bipartisan cosponsors in the Senate for this bill. We certainly would welcome more. I invite our colleagues to look carefully at this act and to support it. It is an important measure. It deals with a disease that afflicts many hundreds of thousands of Americans and a disease that really has not received enough attention and enough visibility in the last few years.

This bipartisan, bicameral legislation is designed to treat and find a comprehensive cure for sickle cell disease which is a genetic disease which primarily affects but not exclusively African Americans. About 1 in 300 newborn African-American infants is born with this disease, but the disease also affects people of Hispanic, Mediterranean, and Middle Eastern ancestry, as well as Caucasians.

More than 2.5 million Americans, mostly but again not exclusively African Americans, have the sickle cell trait, which is not the same as having the disease.

Why focus on sickle cell disease? Because it is the most common genetic disease that is screened in American newborns. People with the disease have red blood cells that contain an abnormal type of hemoglobin. These cells have a sickle shape, hence the name of the disease, that makes it difficult for the cells to pass through small blood vessels or carry the appropriate amount of oxygen or nutrients or antibiotics, if that has been prescribed. The tissue that does not receive normal blood flow because of the disease eventually becomes damaged and can and often does cause potentially life-threatening complications.

Stroke in particular is the most feared complication for children with sickle cell disease. It may affect infants as young as 18 months. I have personally talked with a number of parents whose children have had strokes as toddlers. One of the difficulties with this disease is recognizing it—and I will talk about that in just a minute—recognizing its symptoms. Young children can have strokes without the parents even realizing it for some time.

While some patients live without symptoms for years, many others do not survive infancy or early childhood.

I became involved with this effort because of an African-American doctor from St. Louis, Dr. Michael DeBaun, who treats children with sickle cell disease. When you meet the practitioners who specialize in treating people who have this disease, you meet a series of American heroes. Dr. DeBaun is one of them. After meeting and visiting with him about a year ago, I realized the hardship this disease puts on families and especially on the children, who often have to receive blood transfusion after blood transfusion in order to avoid strokes. And, yes, in order to stay alive.

About one-third of children with sickle cell disease suffer a stroke before age 18. These children require frequent blood transfusions, sometimes 15 to 25 units of blood a year, to prevent subsequent strokes.

If you study the disease, you will also learn firsthand how it can affect the daily lives of children. I will just use one example, 9-year-old Isaac Cornell, whom I also had the privilege of meeting. He is one of Dr. DeBaun's patients and attends fourth grade at Gateway Elementary School in St. Louis. About four times a year, Isaac misses school because of severe episodes of pain, with each episode lasting about 5 to 7 days. Every 4 weeks Isaac has to go for a blood transfusion at St. Louis Children's Hospital where he's treated by Dr. DeBaun. Isaac has a permanent port installed in his upper chest to allow for the transfusions. That is one of the reasons he cannot play contact sports or join the wrestling team.

Sickle cell disease affects Isaac's decisions every day. He has to drink plenty of water to lubricate his cells, he has to be careful not to overexert himself—and that is certainly difficult for a 9-year-old boy—and he has to be careful to get plenty of rest. Because so

many patients like Isaac are struggling with this disease, in April of 2003, Senator SCHUMER and I introduced the Sickle Cell Treatment Act. Our friends, Representatives DANNY DAVIS and RICHARD BURR, introduced a companion bill, H.R. 1736, in the House, which now has 39 bipartisan cosponsors.

S. 874, which is the bill Senator SCHUMER and I introduced, has 41 bipartisan cosponsors as well as the support of dozens of prominent African-American children's and health advocates, as well as union and church groups including—I am going to read the list. This is not a complete list, but it includes the Congressional Black Caucus, the Sickle Cell Disease Association of America, the American Medical Association, the National Association of Children's Hospitals, the National Association of Community Health Centers, the NAACP, the Children's Defense Fund, the Health Care Leadership Council, United Food & Commercial Workers Union—Minority Coalition, the UFCW Faces of Our Children, United Church of Christ, and National Baptist U.S.A. These advocates, as well as the others who support this legislation, know the bill will make a difference in the lives of kids and families who are struggling with sickle cell disease.

I want to outline four key ways in which the bill makes a difference. First, it increases access to affordable, quality health care. The provision provides funding to currently eligible Medicaid recipients for physician and laboratory services targeted to sickle cell disease that are not currently reimbursed or are underreimbursed by Medicaid. Importantly, however, the bill does not increase the number of Medicaid eligibles and the Federal Medicaid match will stay the same. We have structured this bill so it is very affordable.

The bill also enhances services available to sickle cell disease patients. This is a crucial aspect of the bill. When you have this disease, you have to stay on top of it. You have to manage this disease. I mentioned Isaac Cornell before, how he drinks water and gets adequate rest and is careful not to overexert himself. You also have to know the various respects in which the symptoms of the disease can show up. This is a tricky, sneaky disease.

I was talking with another parent whose son was having considerable dental problems. This is something people with this disease struggle with, because when they get periodontal disease and some form of antibiotic is prescribed by their dentist, they can't be certain the red blood cells will carry the antibiotic to the infected point, so indeed any infections they have are particularly dangerous.

Obviously there is a whole medical side to this we have to be aware of, but in addition, people need to know about the disease. They need to receive counseling and education as well as screening, genetic counseling, community outreach. Education and other services are crucial. Currently, those kinds of services are not reimbursed under Medicaid unless they are performed by the physicians such as Dr. DeBaun. Dr. DeBaun simply does not have the time, certainly not as much as he would want to spend, the hours and hours he would need to spend with each set of parents, with each patient, in order to go over all the various ways in which this disease can affect their lives.

So it is important that Medicaid reimburse these services, even if they are done by counselors or outreach personnel who are not physicians. They are perfectly appropriate and able to do it. The bill would allow nonmedical personnel such as counselors to spend time with sickle cell disease families to discuss how they can manage the disease. That, by the way, will end up saving the Government money because it will prevent strokes and other serious episodes that then Medicaid does appropriately reimburse.

The bill creates 40 sickle cell disease treatment centers. This provision of the bill authorizes the Department of Health and Human Services to distribute grants to up to 40 eligible community health centers nationwide for $10 million for the next 5 fiscal years for a total of $50 million. That is subject to appropriation. That could mean a health center grant in almost every State. Grant money may be used for purposes including the education, treatment, and continuity of care for sickle cell disease patients and for training health professionals.

Finally, the bill establishes a sickle cell disease research headquarters. This provision of the bill creates a national coordinating center, which also would be operated by the Department of Health and Human Services, to coordinate and oversee sickle cell disease funding and research conducted at hospitals, universities, and community-based organizations. This will help ensure efficiency so we can share information about the disease, accountability to make sure the taxpayers' dollars are being used well, and also help us get best practices and monitor outcomes for the disease so we can improve services to people who have it around the country.

I cannot overemphasize the outpouring of support Senator SCHUMER and I have received for this bill. I am sure if he were here he would relate the stories he has had. I have myself received personal handwritten letters from sickle cell disease patients who expressed their gratitude for this legislation and who asked what they can do to help pass the bill since they know how many families it will help.

For example, Allyce Renee Ford of Blue Springs, MO, wrote, and I will paraphrase: I was pleased to read of your bill to increase funding for treatment of sickle cell disease. My twin sons were born with sickle sell in 1973 and suffered from this debilitating disease all their lives. They both lost the battle to painful complications in 2002. Please believe me, it is a painful life-constricting disease both for the victims and their families. Even though I do not have any other children to lose to the disease, I mourn for all the other parents who will lose their children in the future—today, tomorrow, someday they will lose them. Thank God there will be help for sickle cell disease victims—help not just in the form of additional funding—and the bill is very affordable—but help in the form of greater visibility, community support. This bill is lifting the profile of this disease which has remained in the corner for too long. The business exclusively in the past has been the business of those struggling and the small community helping them. We need to show these people that the country is with them.

In conclusion, it is critical to help this historically underserved population. Many of these people do not even know they carry the trait or they have the disease until consequences have been visited upon them that they could have lessened or mitigated in some respect had they had prior knowledge.

I ask my colleagues to join me and Senator SCHUMER to honor Black History Month by cosponsoring this Sickle Cell Disease Treatment Act. I cannot think of a better way to honor this month than to help all of the families, most of whom are African-American families, who are living and struggling with this disease.

I yield the floor.

The PRESIDING OFFICER. The majority leader.

FAILURE TO PROCEED TO S. 2061

Mr. FRIST. Mr. President, I will be closing in a very few moments, but I want to express my disappointment in not being able to proceed to the bill. We have been on the motion to proceed the last 2 days to a bill that reflects a pressing problem, a crisis in many States. It has to do with a medical liability system that is having an impact now, not just on physicians paying for their insurance, but on the quality of care, access to care throughout the United States of America.

I do not believe the full impact of the medical malpractice malignancy is truly understood by the average American. Like a cancer, this malady is eating away at the experience of our medical system in critical areas such as obstetrics.

Dr. Sean White of Kingsport is a perfect example of what is happening. Dr. White moved to Tennessee in 2002 due to the outrageous increases in medical malpractice premiums in Pennsylvania. A staggering 7-physician group increase of $210,000 forced a 30-year-old practice to utterly dissolve. Alone, Dr. White's medical malpractice premiums were estimated to increase by $30,000 to $110,000.

And this wasn't just any practice, but an OB–GYN group focusing principally on one of the most precious of

all practices, the delivery of babies. Medical malpractice malignancy ultimately claimed the two senior physicians in the practice, as they retired early, while Dr. White was forced to leave town.

''They really had to scramble,'' Dr. White said of his fellow colleagues who didn't have the option to retire early. ''They went to two local hospitals and asked them to just employ them because they couldn't afford to pay their bills anymore. And no, I don't know how hospitals afford it.'' Dr. White left the Bethlehem practice in 2002 because the bank requested a lien on his home and the co-signature of his wife, Tracy, to finance his malpractice premiums for that year.

''I could see the hand-writing on the wall,'' Dr. White said. ''But I have delivered so many babies in that community. You invest so much time and energy into the practice and develop such a rapport with people. I delivered half of my daughters' friends, the children of my own friends. It was very difficult to just pack up and leave.''

Collectively, Bethlehem's 72,000 residents lost the better part of a century of combined experience when Dr. White left for Tennessee and his two senior partners took early retirement. Let me underscore here, a better part of a century of experience claimed by exorbitant medical malpractice premium hikes.

In addition to taking a loss in order to buyout his partnership in Bethlehem, Tennessee has hardly been a refuge for Dr. White and his family. Yes, malpractice malignancy is also eating away in my own home state, where Dr. White's personal medical malpractice premiums jumped to $65,000 this year, up $20,000 from just last year in Tennessee.

Statistics indicate that as many as nine in 10 obstetric physicians have been sued in Tennessee if they're in the practice of delivering babies for more than 10 years, Dr. White said. This despite the fact that maternal death rates have plummeted to all time lows in this country.

''The trial lawyers will tell you they are trying to weed out the bad apples,'' Dr. White said. ''Obviously, with 90 percent being sued, they're not all bad apples.''

And that is the crux of the issue here.

Mr. REID. Will the Senator yield?

Mr. FRIST. I would be delighted to yield.

Mr. REID. Mr. President, through you to the distinguished majority leader, I got a call from a dear friend in Nevada today, a surgeon. He is very active in public affairs, a very close friend of our Republican Governor. He told me that in Nevada, where the Governor called a special session that we have caps, the insurance rates have not been affected at all; they are still going up. He originally had a policy with St. Paul. They pulled out. Another company came in and doctors are always concerned with what they call the ''tail,'' to make sure if something happens after their policy expires that they are covered for acts that took place in the past. He went with a new company. They pulled out after a year and a half. Now he is going to have to pay more than $100,000 for 1 year to have coverage for today and acts that took place in the past.

I say to my friend, the distinguished Senator from Tennessee, a physician, this medical malpractice is something we have to address. I don't know the best form to do it. But when we do it, we are not only going to have to deal with some of the policies outlined by both parties today, but we will have to take a look at what the insurance industry is doing to my friend and other physicians. This is not just a problem generated solely by the trial bar; the insurance industry has some culpability.

I hope the distinguished majority leader, when again we get to this issue, will help us come up with a framework and we can discuss this issue. Part of the discussion has to be directed toward the insurance industry.

Mr. FRIST. Mr. President, let me respond through the Chair that the problem has gotten so big that patients are being hurt and potential patients are being hurt. It is a crisis. It is a complex problem.

As a physician, and as one who sees patients, I recognize they are being hurt by this system, and we have to start somewhere. Part of it is being able to proceed to debate. If the timing is not right, we will come back and do it at another time. We will come back to it. This problem is not going to go away. I look forward to addressing it again.

This particular bill is not a comprehensive bill. We are not talking about all of the doctors out there. Rather, we took one specialty. I am a little perplexed how to come back to it because I want to keep the issue out there. Patients are being hurt, and we are going to come back to it. We will work together to figure out the best way to try to have an appropriate forum for what is a complex issue. Hopefully, we will bring it back in some shape or form in the next several weeks.

The PRESIDING OFFICER. The Senator from Florida is recognized.

CRISIS IN HAITI

Mr. GRAHAM of Florida. Mr. President, I wish to share a few observations and thoughts about the current circumstances, the tragic circumstances in our near neighboring country of Haiti.

Haiti was once a beautiful country. It was one of the jewels of the Caribbean. Its people, who secured their freedom from France in 1804, have suffered a long history of despair, poverty, and misrule. This country has now fallen into chaos.

Regrettably, Haiti is one of the poorest nations on Earth. It is ranked 172 out of 208 countries in per capita gross national income. It is the only country in the Western Hemisphere to be labeled a least-developed nation.

Haitians are also among the most malnourished people in the Western Hemisphere. The World Health Organization reports that the average daily caloric intake for Haitians is the lowest in the hemisphere and on a par with the poorest nations in Africa.

Violence is on the rise. At least 70 people have been killed in the recent uprising, and the number of dead and wounded grows daily.

Indeed, the country of Haiti now faces twin crises. The first is the possible collapse, if not the violent overthrow, of a democratically elected government, with no agreed-upon follow-on governmental structure. An opposition leader predicted on Sunday that the capital, Port-au-Prince, would fall to armed rebels in 2 weeks.

Second is the humanitarian catastrophe, primarily caused by the violence and the disruption that the violence has created.

The current humanitarian crisis is forcing poor Haitians to literally eat the seeds they have saved for spring planting. With nothing planted, there will be no harvest. These desperate food shortages will strike at the same time the weather improves, and a massive exodus by sea will be feasible and more likely.

The question before the United States and the world is, What should be our priorities? Tragically, it appears that our administration has taken a firm stance on the side of indifference. This may prove to be the longest running and biggest crisis of all for Haiti. The diplomatic effort this past weekend, unfortunately, has accomplished nothing to date.

Cap Hatien, the second largest city in Haiti, fell to the rebels the day after our Assistant Secretary of State left the country. We sent 50 marines to Port-au-Prince on Monday to protect our embassy. From what I can tell, there is no administration plan B.

Furthermore, I have detected very little concern for the potential impact of this crisis on the United States itself, with my State of Florida being on the front lines.

As we have seen repeatedly over the past two decades, one of the impacts of this catastrophe will almost certainly be a dramatic increase in the number of refugees risking their lives in leaky and unsafe boats to try to escape the violence.

Yet there has been little or no contact between Federal agencies and the State and local authorities, our first responders, to prepare for the potential influx of refugees. The principal agencies of the Federal Government have limited capacities to handle yet another immigration crisis. I am told the Department of Homeland Security, which includes the Bureau of Immigration and Customs Enforcement, has the capability to handle only 150 additional

refugees once they reach our shores. This is in large part because of, in my judgment, the inappropriate use of what is supposed to be a temporary holding facility as, in fact, the permanent prison for long-term detainees. But that is another story.

The Defense Department is understandably hesitant to mix Haitian refugees with the detainees from the war on terror at Guantanamo Bay, Cuba.

The Bush administration's feeling—which appears to be shared by others in the international community—is that the problem in Haiti is a political crisis, and that until these paltry and late-starting diplomatic efforts run their course, there is no basis for dealing with the humanitarian crisis.

When asked at a briefing yesterday what the administration is planning to do to halt the violence, Scott McClellan, the White House spokesman, responded:

> We remain actively engaged in these diplomatic efforts to bring about a peaceful, political solution to the situation in Haiti.

That is simply and obviously not enough. Our first priority must be the humanitarian crisis and finding a way to halt the violence which has fueled it.

A political solution should, of course, be actively pursued, but not at the cost of abandoning efforts to address the humanitarian crisis and loss of lives which are occurring daily in Haiti.

There was already a humanitarian crisis as seen by the level of malnutrition. It is now crashing to new levels with the killings and the threats of violence which have forced international aid organizations to reduce support to the poor and impoverished of Haiti.

If we wait for a political settlement, we will be tolerating more scores of people being killed and more deaths due to the meager food supply and lack of adequate health services. Sadly, most of those who are feeling this humanitarian crisis, who are dying today, are innocent women and children.

If we continue to wait for a political solution, the country will be controlled by armed gangs, drug dealers, and thugs. These conditions represent a clear threat to the national security of the United States of America and to the security of friendly allies even closer to Haiti than we are.

It is estimated, for example, that approximately 30 percent of the population of the Bahamas represents Haitian refugees. Allowing the crisis in Haiti to continue could destabilize the Bahamas and its other neighbors, such as the Dominican Republic.

What do we need to do to avoid a humanitarian tragedy? What do we need to do to make that priority No. 1? First, we need to see a sense of urgency on the part of the United States, and that sense of urgency needs to start at the White House.

Just a few days ago, I met with the top administration official who effectively said that it was the policy of the administration to stand on the sidelines and hope that someone else—France, Canada, the Organization of Caribbean Nations, CARICOM, or the Organization of American States—would take the lead in settling the problem.

This is unacceptable as American foreign policy. There is no other alternative but the use of U.S. influence. We must become engaged at a serious and sustained level or, failing to do so, be prepared to pay the cost of chaos 700 miles off our coast and on the seas which separate us from Haiti.

Second, the next step should be a police presence of sufficient scale that it can quell the violence. This can and should be done under the auspices of the Organization of American States, but the United States must be a leader and full participant.

Third, to assure the success of that police presence, the U.S. military should serve as a visible backup force. Recently, this visible backup force worked off the coast of Liberia when we sent a marine amphibious group aboard Navy ships to stand by off the coast while we put ashore a marine security team to protect our embassy. If we can provide the powerful influence of U.S. military troops 3,000 miles away, certainly we can do so in our own neighborhood.

Next, we must enhance our humanitarian presence starting with emergency deliveries of additional foodstuffs and medical supplies, and we must assure that delivery of those supplies is available throughout the countryside.

Next, given the indifference of the State Department and the National Security Council, the President should seriously consider the appointment of a high-level delegation to Haiti, such as that represented by President Carter, Senator Nunn, and General Powell in 1994, to make certain that our expectations, as well as our level of commitment, is clear.

Next, we must enhance our capacity to understand what is happening inside Haiti. In a manner which is eerily similar to the situation in the late 1980s and the early 1990s, our capacity to gather information inside Haiti is woefully inadequate to the scale and the significance of the crisis.

Among other problems, all diplomatic personnel are confined to the capital Port-au-Prince. As one senior administration official described it:

> Our intelligence is very thin.

This limited understanding, without question, has contributed to our allowing the situation to reach near anarchy without the United States assertively engaging itself. These circumstances in Haiti are part of a disturbing pattern of our current international relations. One, by its unwillingness to engage in a leadership role in the world, with the dramatic exception of Iraq, this administration is ceding its sovereignty to other nations. We have ceded to China the leadership for negotiations with North Korea over its nuclear capability. We have ceded to the French, the Canadians, the OAS, and the Caribbean leadership our sovereignty in dealing with the crisis in Haiti.

That loss of sovereignty comes at a heavy price in our ability to influence other nations and international organizations from a position of strength. How can we challenge China on its trade practices when we are relying on China to handle the most sensitive negotiations with North Korea?

Just a year ago, our fragile relations with France were center stage. How can we now rely on France and regional organizations alone to defend our national interests in the Caribbean? The current administration appears indifferent, at best, to our neighbors in the hemisphere, specifically those in the Caribbean and Latin America. This is surprising and distressing because candidate George W. Bush stated that as President George W. Bush he would pursue a policy of much greater U.S. involvement in Latin America.

On August 25, 2000, speaking at Florida International University in Miami, FL, candidate George W. Bush declared:

> This can be the century of the Americas. . . . Should I become president, I will look South not as an afterthought, but as a fundamental commitment to my presidency. . . . Those who ignore Latin America do not fully understand America itself.

After crises in Argentina, in Bolivia, in Venezuela, and now this test in Haiti, the Bush administration has yet another credibility crisis and yet another failure of intelligence. While not on the scale of missed opportunities to disrupt the plots of September 11 or the misinformation which led us to war in Iraq, again we have a failure of intelligence to inform national leadership as to the true state of an international situation or of national leadership to effectively utilize the intelligence which was provided.

Had we secured and utilized accurate and timely information on Haiti, possibly our response would not have been as impotent and retarded as it now is.

Finally, this is the latest example of the need for a United States or international capacity to respond effectively in nation sustaining, even nation building, after our military has successfully secured the territory.

In 1994, the United States effectively invaded Haiti in order to remove a military dictatorship and replace its democratically elected president. We did that with the kind of surgical precision that has come to characterize our military efforts. We then proceeded to spend almost $3 billion attempting to sustain and build the nation of Haiti. I suggest that today, 10 years later, Haiti is in worse condition than it was when we invaded in 1994. The very things that make our military so effective; recruitment, training, support, the exercises of actions, have allowed us to have such a string of successes in the military phase of dealing

with a hostile or chaotic foreign situation. Unfortunately, none of those characteristics is true of the efforts that are made after the war concludes. We need to take the leadership, either unilaterally or, I believe, preferably with other international allies, to develop a capability which has the same characteristics of recruitment, training, support. Having exercised, before actual use, the security, the development of democratic institutions, the restoration of a governmental structure, the development of infrastructure necessary to support the population and a market economy, which can be available after the bullets stop flying, assures our future investments in nation sustaining and nation building are not as ineffective as they have been in the last decade.

The failure to have such a capacity after the 1994 invasion is a primary reason why today we stand on the edge of the volcano of chaos in Haiti yet again, 10 short years later. Let us today, by our inaction and indifference, not provide as a heritage to future generations in America and to future generations in countries like Haiti, Iraq, and Somalia the heritage of a failed effort because we were not able to complete the mission that began so brilliantly with military actions to the conclusion of a stable, democratic, functioning country that gave to their people some reasonable prospect of prosperity and personal peace.

I ask that immediately after my remarks editorials from the Miami Herald, the St. Petersburg Times, the Palm Beach Post, the Washington Post, and the New York Times be printed in the RECORD.

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

[From the Miami Herald, Feb. 19, 2004]

SET THE RIGHT PRIORITIES IN HAITI; OUR OPINION: IT'S TIME FOR WASHINGTON TO TAKE A MORE ACTIVE ROLE

Now that Haiti is in flames again, an epidemic of hand-wringing is spreading from Washington to the United Nations to the Elysee Palace in Paris.

Where was everybody when the first puffs of smoke appeared years ago? When President Jean-Bertrand Aristide started relying on thugs to maintain order? When brave journalists were murdered for writing and broadcasting the truth? When peaceful protests were repressed by violent means? Today, in the belated haste to do something—anything—there is a danger of failing to adopt the right set of priorities.

PREVENT A DISASTER

The first goal should be to prevent a full-scale humanitarian crisis, and it is already late in the day. It shouldn't take an armed invasion of Haiti to put an end to the hooliganism that has made food, gasoline and medicine scarce. But if strong diplomatic pressure on all sides can't do the job, a small military force may have to be deployed before conditions worsen.

Restoring civil order on the streets is the next priority. Here the challenge is both military and, ultimately, political. Before any outside attempt to launch a police action is made, the nonviolent opposition should be given a chance to show that it is capable of doing something besides voicing demands that Mr. Aristide must go. An effort by Mr. Aristide's critics to curtail the growing insurrection would demonstrate that the opposition is a legitimate political force with clout. The opposition should be mature enough to try to reach at least a temporary accommodation with Mr. Aristide that could lay the groundwork for a political settlement.

Although the president has failed to live up to previous promises to govern in a more democratic manner, the crisis demands a suspension of political demands from his opponents because violence threatens the survival of all political factions in the country.

Mr. Aristide carries the main burden of political responsibility. A band of thugs must not be allowed to depose an elected president, but Mr. Aristide has to do more than simply insist on remaining in power. Reaching out to the opposition to form a bulwark against the forces of violence is the best way to show that he has Haiti's best interests at heart.

DEMOCRACY TAKES TIME

The fundamental problem is that Haiti is a failed state, and will remain one until democracy takes root—the ultimate goal. CARICOM and the OAS can help Haiti get there, but only the United States has the authority, or the muscle, to lead this effort. It is time for the Bush administration to take a more active role in stabilizing the situation. As Sen. Bob Graham has pointed out, if we can send a military force to Liberia to protect our interests, we can do the same in Haiti, the sooner the better.

[From the St. Petersburg Times, Feb. 21, 2004]

CRISIS IN HAITI

With violence and chaos spreading in Haiti, the world community cannot afford to just stand by and do nothing. With the police hiding in their barracks, armed thugs patrolling the street and the elected president appealing for international protection, Haiti is on the verge of another major humanitarian and political crisis. It's understandable that the Bush administration has ''no enthusiasm,'' as Secretary of State Colin Powell put it, to intervene militarily. However, there is an urgent need for an international peacekeeping effort. If ever there was a situation calling out for United Nations peacekeepers, Haiti is it.

The two-week-old uprising has killed at least 60 people. The U.S. government Thursday urged Americans to leave, and the Peace Corps began withdrawing its staff. Washington also dispatched a military team to assess security at the U.S. Embassy. As the nation that stood behind the president, Jean-Bertrand Aristide, the United States has a special obligation to help. Since American military forces restored Aristide to power in 1994, after his ouster in a coup, Aristide has cruelly turned his back on his people and promises. He has not alleviated the human misery in Haiti or reached out to his political opponents. Armed vigilantes roaming the streets terrorize in his name. Aristide has become a polarizing force and a discredited figure internationally. The rebels, however, are not any better. Many leaders are one-time death squad commanders, who have no political legitimacy or idea how to govern.

The United Nations, working with Caribbean leaders and France and Canada, should dispatch a peacekeeping force as soon as possible to try to end the bloodshed. Beyond the need to protect innocent lives and extend a humanitarian hand, the United Nations should underscore that change in Haiti must come through the democratic process. Aristide should be held to the commitments he made to his people. He needs to disarm and disband the vigilante groups, disassociate himself from their operations and bring political opponents into the governing process. The world community has an interest in protecting Aristide, but it stems from his standing as a democratically elected president and because the alternative is even worse. Far from endorsing his presidency, international intervention would be a slap at the character of a man who sold himself to the world as a champion of democratic principles and then betrayed those very principles.

Washington has a major role to play in defusing this crisis—and a big stake in the outcome. This country, after all, restored Aristide to power, and it will become the destination of any mass exodus of Haitian refugees. On Friday, diplomats from the United States, Europe and the Caribbean were preparing to present Aristide and opposition groups a plan for political reform and a return to the rule of law. It's largely the same plan that was presented to the warring parties weeks ago. Secretary of State Powell said the plan does not call for Aristide's resignation but added that the United States would not object if he decided to step down before his term ends as part of a negotiated political solution.

Even if the violence can be quelled in the coming days, a humanitarian crisis is already upon one of the poorest countries in the world. The world community should quickly unite behind an effort that offers humanitarian aid and protects both human rights and Haiti's sovereignty.

[From the Palm Beach Post, Feb. 21, 2004]

ON HAITI, U.S. CAN'T WAIT

As President Bush tries to install democracy thousands of miles away in Iraq, he no longer can remain disengaged from the moral and practical need for democracy hundreds of miles away in Haiti.

Late this week, the State Department acknowledged that Americans in Haiti should leave the ''steady deterioration of the security situation'' between an increasingly defiant President Jean-Bertrand Aristide and the loosely organized movement to oust him. But as the administration finally has become more active in trying to broker a political settlement, it has become increasingly unrealistic to think that a settlement will not require military action. Ideally, that would take place in concert with regional allies, stabilizing Haiti and bolstering the country for the long haul beyond the end of Mr. Aristide's term in 2006.

Each hour's delay only makes the problem more difficult, as the loyal opposition that Mr. Aristide calls a band of terrorists is being subordinated by gangsters returning from exile. Haiti's outnumbered and outgunned police force of fewer than 4,000 is retreating from its posts. If certain rebels take control, they will not easily give it up.

Gov. Bush was brief by the Coast Guard again this week. ''But we have the power to some degree to stop this from hitting our shores,'' said U.S. Rep. Mark Foley, R–West Plam Beach. ''We can't take the standoff position.'' Colombia, he said, is a case where the U.S. has ''used the military to try to rebuild the economy and stem the drug flow. Liberia also is an example that's on point. (Former President) Charles Taylor wasn't going anywhere until the U.S. said we're backing the nations that are liberating Liberia.''

In Haiti, Rep. Foley said, Jamaica, the Dominican Republic and the Bahamas ''need to be leading the dialogue rather than have the perception of imperial saber-rattling. We

have to have the sense that we're all in this together, With America saying, 'We're behind you.'" But it is important, as he said, "to make sure the Haitian people understand, as well as Aristide, that we are not there to prop him up."

That's the message the international delegation led by Assistant Secretary of State Roger Noriega should carry to Haiti today. There's a lot at stake for Florida and the United States, which doesn't need a failed state close to home. It is too late just to assume that things will get better.

[From the Washington Post, Feb. 9, 2004]

NO HELP FOR HAITI

Once again a poor nation with strong ties to the United States is in desperate trouble—and once again, the response of the Bush administration is to backpedal away, forswear all responsibility and leave any rescue to others. Last summer President Bush refused to commit even a few hundred U.S. troops on the ground to help end a bloody crisis in Liberia. Now he and his administration stand by as Haiti, a country of 7.5 million just 600 miles from Florida, plunges into anarchy.

Armed gangs are spreading through cities across the country in a violent rebellion against President Jean-Bertrand Aristide, whose own police force is so weak that a group of about 40 thugs was able to take over a town of 87,000 people on Tuesday. France and the United Nations have begun exploring the possible deployment of police or peacekeepers—which is probably the only way to stop the killing. But Secretary of State Colin L. Powell made clear that "there is frankly no enthusiasm" within the Bush administration "for sending in military or police forces to put down the violence." Mr. Powell rejected "a proposition that says the elected president must be forced out of office by thugs." But that, apparently, doesn't mean the United States—which has intervened repeatedly in Haitian affairs during its 200-year history—is prepared to take any action to stop it.

Nor has the administration been willing to take the lead in seeking a political settlement to the crisis. For several years it has delegated the arbitration of Haiti's mounting domestic conflict to well-meaning but powerless diplomats from the Organization of American States or the Caribbean Community, also known as Caricom. In particular, it has declined to exercise its considerable leverage on the civilian opposition parties, some of which have been supported by such U.S. groups as the International Republican Institute and which have rejected any political solution short of Mr. Aristide's immediate resignation. Apart from Mr. Powell's statement, the administration's rhetoric has mostly been directed at Mr. Aristide. "There certainly needs to be some changes in the way Haiti is governed," said White House spokesman Scott McClellan.

Mr. Aristide is guilty of supporting violence against the opposition and has cruelly disappointed those who expected him to consolidate democracy. But Haiti's mess flows in part from U.S. actions. After restoring Mr. Aristide to power in 1994 and abolishing the army that previously ruled the country by dictatorship, the United States failed to follow through. U.S. forces were pulled out after only two years—they are still in Bosnia and Kosovo eight and five years, respectively, after they arrived—and all aid to the government was suspended after Mr. Aristide's party tampered with the results of a congressional election. Some of the military's former death-squad leaders command the gangs that would seize power. But the Bush administration would rather leave the answers to Caricom or the United Nations or France. It's an inexcusable abdication.

[From the New York Times, Feb. 24, 2004]

HOUR OF THE GUNMEN IN HAITI

Rebels in Haiti were going house to house yesterday, arresting supporters of President Jean-Bertrand Aristide and looting their possessions. The capital, Port-au-Prince, remained in government hands, but the nation's second-largest city, Cap Haitien, was held by the insurgents. The situation is clearly becoming dire. The United States needs to take the lead in protecting the Haitian people from the growing anarchy around them. There is much that Washington could do.

Only the slimmest hope remains for salvaging an international mediation effort that began last weekend. If it cannot be revived, there is a strong likelihood that the country's raging political crisis could ultimately be resolved by brute force. Abrupt and violent changes of government have been a regular feature of Haitian politics over the years and are among the main reasons that Haiti has never developed stable democratic institutions.

Mr. Aristide is no beacon of democratic principles, but he was freely elected to a five-year term that is not scheduled to run out until February 2006. It would have been better if all sides had accepted the proposed compromise that would allow him to stay in office while sharing power with the opposition.

Most, but not all, of the responsibility for the failure to reach an agreement lies with the leaders of Haiti's nonviolent political opposition. They argued that with popular anger against Mr. Aristide running so high, they could accept no compromise that did not cut short his presidency.

That public anger is largely Mr. Aristide's fault, because of a succession of betrayals of his original democratic promises. By failing to end a long impasse over flawed parliamentary elections, he has effectively shut down Parliament and now rules by decree. He has politicized the police and courts and uses special police brigades and armed gangs of his supporters to terrorize civilians and break up opposition demonstrations.

Yet the opposition's unwillingness to stand up to the former army leaders and opposition thugs now demanding Mr. Aristide departure—and their failure to back a compromise that would have been strongly supported by Washington and other mediating countries—is a troubling sign. It suggests that these politicians may not have the toughness needed to make sure that any armed ouster of Mr. Aristide does not lead to a rapid restoration of the same discredited forces that ruled Haiti before he came to power. These include thuggish leaders of the country's officially disbanded army and the murderous paramilitary groups that supported military rule. Some of these elements have already re-entered Haiti from the neighboring Dominican Republic.

There is still time for the political opposition to reconsider its rejection of compromise before the armed rebels impose their own new tyranny.

Whether or not the opposition comes to its senses, Haiti's people deserve protection. More than 70 lives have already been lost. The United States should quickly offer to build up the current force of 50 marines who arrived Monday to protect the American Embassy and make it the core of a multinational stabilization force that would also include soldiers from France, Canada and Latin America. Haiti's army was dissolved in 1994, and a modest international military force could go a long way. It should be in place before armed rebel elements grab power for themselves.

Once a stabilization force is established, an American-led international effort should be mounted to train professional, politically independent police officers and judges. It was the absence of such institutions that allowed Mr. Aristide to create a new authoritarianism behind a democratic shell. American police training programs during the Clinton administration did not reach far enough or last long enough to succeed. Washington should also make it easier for Haiti to earn its way out of poverty by eliminating the American rice subsidies that have contributed to pricing poor Haitian rice farmers out of the market.

Developing a durable democracy in this deeply impoverished country, which has no history of strong, independent civic institutions, will take plenty of time and effort. Failure to begin that effort now will surely result in future revolts, future dictators and future tides of desperate refugees headed for American shores.

Mr. LAUTENBERG. Mr. President, I rise today to express my concern about the violent political crisis engulfing Haiti. We dare not remain silent when faced with such a widespread insurrection in our backyard. I believe that we, members of Congress and the Bush administration, must make an honest reckoning regarding our history of often inconsistence and sometimes even negligent U.S. policies toward this neighboring country, the poorest in the western hemisphere. If the current vicious cycle of resistance and violent reaction to the resistance continues, the resulting instability will have a substantial impact on democracy and security in the Caribbean and will affect our entire hemisphere.

Just last month, Haiti celebrated the 200th anniversary of its independence; it was only the second country in the western hemisphere after the United State to throw off the yoke of foreign domination and to declare independence from a European colonizer. Unfortunately, Haiti's long experience with democracy and self-rule has been impeded by successive waves of military coups—over 30 since its independence—and power consolidation by elites. Poverty and disease are pervasive and government corruption rampant. In its October 2003 survey, Transparency International labeled Haiti the third most corrupt country out of 133 countries in the world and the most corrupt of the 30 countries in the Americas and the Caribbean.

Prior to Jean-Bertrand Aristide's election to his first term in 1990, Haiti had been ruled by successive military dictators, many of whom were anointed by foreign leaders. In 1990, the U.S. government and we, the members of the U.S. Congress, felt optimistic about democratic prospects under Aristide's leadership. The subsequent U.S.-backed restoration of Aristide to power derived from an American hope, perhaps even a naive idealism, that he could rebuild viable democratic institutions and further democratic progress as a legitimate head of state. This American idealism, I believe, led the Clinton administration to deploy 20,000 American troops to support Aristide. Since this time, however, Aristide and his political party have made poor economic

choices; they have consolidated power, eviscerated the role of the parliament, and allowed corruption and cronyism to corrode the government.

Indeed, over the past few years, as our foreign policy attention has shifted eastward, towards hotpots in the Middle East and Southeast Asia, we have been dangerously negligent of Haiti's continuing political dissolution and Aristide's failed leadership.

I believe that the current violent expression of political opposition, which has taken the lives of over 40 Haitians in the past two weeks, derives directly from the Haitians' frustration with their government. Haitian political rights have been chipped away since Aristide's 2000 re-election, based on only five percent voter turnout, created a political stalemate. The Haitian parliament has since stopped functioning, prompting international aid donors to block millions of dollars in needed economic aid.

The resulting economic situation is bleak. Most of Haiti's 8 million people live on less than $1 per day and it ranks 150th out of 175 countries on the United Nations Human Development Index.

But Aristide's government has exacerbated Haiti's economic crisis. The U.S. State Department classified the country's current situation as ''economic stagnation'' caused by ineffective economic policies, political instability, environmental deterioration, the lack of a functioning judiciary, and the migration of skilled workers.

On the other hand, we know that this month's violent outburst is not the only means for Haitians to express political opposition. For years, legitimate opposition groups have opposed Aristide's government and most of them do not condone today's violence. Instead they endorse new elections and a peaceful transition of power.

We have a unique obligation to stand up for the people of Haiti. Our two countries are inextricably linked—by the virtue of our similar histories, because of our involvement in Aristide's return to power, and as a result of the influx of Haitians who have come to our shores seeking refuge from the economically and politically ravaged country. These Haitian Americans have contributed greatly to American life and I am proud to have a talented young man of Haitian origins on my staff and to represent nearly 60,000 Haitian Americans in my State.

The Bush administration has advocated for a negotiated political solution to the crisis. Yesterday, Southern Command has dispatched a small military team to Haiti to provide the ambassador and the embassy staff with an enhanced capability to monitor the current situation. Secretary of State Colin Powell recently met with regional officials and the Canadian and Haitian ambassadors to discuss a possible Caribbean-Canadian police force for Haiti. I support the State Department in its efforts to forge a negotiated political solution brought about by dialogue, negotiation, and compromise and fully support the power sharing agreement put forth by Secretary Powell and international community. I urge the opposition groups to accept this proposal to share power with Aristide until he can be replaced democratically.

I also ask my colleagues to follow this crisis closely and to join me in demanding that President Bush, Secretary Powell and other foreign policy advisors continue to play a leading role, facilitating negotiations between the Haitian government and the opposition factions.

If the opposition accepts the power-sharing agreement, Secretary Powell should enlist French, United Nations, and Caricom help to see that forceful diplomatic intervention ends the current stand-off. The next step is for the U.S., in concert with international organizations, to assist Haiti in creating a unity government, a council of advisors and the installation of a new prime minister. American diplomacy and influence can be effectively mustered to convince both Aristide and the opposition to accept these reformist measures.

U.S. hegemony, wealth, and power have, over the course of our country's history, generated myriad international obligations to resolve global conflicts and preserve peace and security. Our responsibilities emerge no clearer than when conflicts arise in our own neighborhood. It is time to break with a recent policy of U.S. dismissal and neglect regarding Haiti's self-destructive government and devastating economic situation.

I urge my colleagues to join with me in insisting that the administration, with Congressional support, rise to fulfill the responsibilities of global leadership.

HONORING OUR ARMED FORCES

SPC BILLY JESS WATTS

Mr. THOMAS. Mr. President. I express our Nation's deepest thanks and gratitude to a young man and his family from Meeteetse, WY. On February 5, 2004, SPC Billy Jess Watts was killed in the line of duty while preparing to deploy to Iraq to serve his country in the war on terrorism. While traveling in a military convoy to a final training exercise before leaving for duty in Operation Iraqi Freedom, SPC Watts died when the vehicle he was riding in hit ice and rolled over.

SPC Watts was a member of the Wyoming Army National Guard's 2–300 Field Artillery Battalion. He enjoyed the outdoors, hunting and camping, and loved watching NASCAR racing and pitching horseshoes. He loved his family and his country. SPC Watts' profound sense of duty led him to join the U.S. Army following his high school graduation, and the National Guard upon his return to Wyoming. He was an American soldier.

It is because of people like Billy Watts that we continue to live safe and secure. America's men and women who answer the call of service and wear our Nation's uniform deserve respect and recognition for the enormous burden that they willingly bear. Our people put everything on the line everyday, and because of these folks, our Nation remains free and strong in the face of danger.

SPC Watts is survived by his wife Connie and his son Austin John, as well as parents, Bill and Bertha, sisters Bonnie, Betty and Barbara, and his brothers in arms of the 2–300 Field Artillery Battalion. We say goodbye to a husband, a father, a son, a brother, a soldier, and an American. Our Nation pays its deepest respect to SPC Billy Jess Watts for his courage, his love of country and his sacrifice, so that we may remain free. He was a hero in life and he remains a hero in death. All of Wyoming, and indeed the entire Nation are proud of him.

2LT LUKE S. JAMES

Mr. NICKLES. Mr. President, you don't have to do much more than open the morning newspaper or turn on the evening news to understand that the enemies of freedom are working hard in Iraq.

They lay ambushes for our troops, set off bombs by remote control, and drive explosive-laden autos into crowds of innocent Iraqis who want nothing more than a brighter future for their country and their children.

Terrorists connected with al-Qaida, foreign interests and Baathist loyalists conspire to destroy the dream of a free Iraq before it is fully born. They will fail.

But Saddam Hussein, a one-man weapon of mass destruction who preyed on his countrymen and threatened his neighbors, is in custody. His murderous sons are dead. His lieutenants and henchmen are captured, killed, or moving nearer those fates with each passing hour.

The same fates await those who would steal the dream of liberty and replace it with a nightmare of repression, corruption and domination. America's front line in her war against terrorism is now in the fields of Afghanistan and the streets of Iraq instead of in the skies over New York and Washington, DC.

Like Americans everywhere, I was thrilled to see the statues of Saddam Hussein knocked from their pedestals. Those images reminded me that the Iraqi people needed our help, our tanks, our troops, and our commitment to topple a brutal dictator. I am proud of our military and America's commitment to make the people of the Middle East more free and secure.

Without a doubt, our military men and women will face more difficult days in Iraq, and the Iraqi people will be tested by the responsibilities that come with freedom. Everyone expects more violence. Freedom is messy—nowhere more so than in a country that has just shaken off a brutal dictatorship.

Today I rise to honor who made the ultimate sacrifice one can make for his country.

A few days ago I stood in Arlington National Cemetery to honor the memory of 2LT Luke S. James.

Lieutenant James, 24, was a native of Hooker, OK, and a graduate of Oklahoma State University. He was killed in Iraq on January 27 during a roadside ambush near Iskandariyah.

Lieutenant James was assigned to the 2nd Battalion, 505th Infantry out of Fort Bragg, NC. He'd only been in Iraq a few days.

Our prayers and debt of appreciation now go to his family. He is survived here on the homefront by his wife Molly, his 6-month-old son, Bradley, his parents Brad and Arleen James, his sister Sharla, and his brother Kirby.

''That was his dream (to serve in the Army),'' Molly James said in a recent interview. ''He wasn't afraid to go. He was able to do his duty and die with honor.''

As we watch the dawn of a new day in Iraq, we must never forget that the freedom we enjoy every day in America is bought at a price.

2LT Luke James did not die in vain. He died so that many others could live freely. And for that sacrifice, we are forever indebted. Our thoughts and prayers are with him and his family and with the troops who are putting their lives on the line in Iraq.

CONTROL AND DISPOSAL OF RADIOACTIVE SOURCES

Mr. AKAKA. Mr. President, I rise today to express my concern that the threat posed by the detonation of a ''dirty bomb'' has not been adequately addressed. Controlling access to the radioactive materials needed to fabricate such a weapon remains a challenge today, just as it did in the days immediately following the terrorist attacks of September 11, 2001. Security improvements have been slow to come. Dirty bombs continue to threaten the people and the economy of the United States.

Radioactive sealed sources are all around us. They are used widely in medicine, research, industry, and agriculture. Some of these sources are more risky than others, and Congress must take action to ensure the control and safe disposal of those sources that pose the greatest risk. These sources, known as ''greater-than-Class-C'' sealed sources, are of major concern because of their potential for use in the fabrication of a dirty bomb.

To address this risk, I introduced S. 1045, the Low-Level Radioactive Waste Act of 2003, this past May. My bill addresses the efforts made by the Department of Energy, DOE, to recover and dispose of thousands of domestic greater-than-Class-C radiological sources. This measure was developed after three different U.S. General Accounting Office reports I requested showed that the efforts being made by DOE and other Federal agencies to control and dispose of these radioactive sources, both domestically and internationally, have not gone far enough.

Provisions of S. 1045 were included in H.R. 6, the Energy Policy Act of 2003, but as debate over the energy bill continues, radioactive sources remain a threat to our country. Over the holidays, there was a serious concern about the possible detonation of a dirty bomb at one of the large open-air New Year's Eve celebrations around the country. The DOE took serious and prudent action to detect possible terrorist activities and thankfully this situation did not end in tragedy. However, next time we may not be so lucky. The lack of a safe, secure, and permanent disposal site for unwanted radioactive sealed sources places our country at risk.

Thousands of sealed sources await disposal, some requiring security measures greater than those in place at current storage facilities. The problem posed by these sources will not go away by itself. Universities and industry do not have the means or facilities to secure these materials and are seeking Federal Government assistance. In my own State, the University of Hawaii is currently seeking the assistance of the DOE to remove large unwanted radioactive sources, belonging to DOE, that are no longer useful for their research. While DOE is working on a solution, the sources remain in Hawaii awaiting disposal. My bill would require the DOE to fulfill their statutory obligation to develop a disposal facility for all of these sources, in consultation with Congress, and would also require that DOE explore Federal and non-Federal alternative disposal options to make sure that the best disposal method is chosen.

However, my concern over radioactive material does not end here. I will continue my work to improve Federal oversight of radioactive sources and devices. Just a few weeks ago in New Jersey, a gauge containing radioactive material was damaged, and its radioactive material is still missing. Creating a disposal facility for this class of radioactive waste is only the beginning of getting this problem under control. We need to improve the licensing and tracking of these widely used sources and devices, so that they will not fall into the wrong hands.

When the United States began nonproliferation efforts in the former Soviet Union, one of the first jobs was to begin consolidating nuclear weapons and fissile materials in secure facilities to await disposal or destruction. Due to worries about terrorists acquiring dirty bombs, the DOE is now working to secure radiological sources in many countries oversees. I support these efforts. A theft this month of cesium-137 in China re-emphasizes the need to work with other countries to collect and dispose of unwanted radiological materials. The cesium, stolen by scrap metal thieves, ended up being melted by a steel mill. The mill is now contaminated and will have to undergo expensive clean-up efforts. While this type of incident is less likely to happen in the U.S., we must learn from this, and take steps to protect our nation from these materials. We should take the lead in helping other nations secure their radioactive material, for the good of us all.

The bill that I introduced and which is cosponsored by Senators BINGAMAN and LANDRIEU, will give radiological sources and waste on American soil a safe and secure, permanent disposal facility. Before September 11, 2001, collecting and securing these sources was a matter of public safety, now it is a national security concern that demands the attention of Congress. I urge my colleagues to support the Low-Level Radioactive Waste Act of 2003, to ensure that our nation is better protected from the dangers of dirty bombs.

LESSONS FROM A CLEAN AIR LISTENING TOUR

Mr. JEFFORDS. Mr. President, I have spoken many times about my serious concern for our Nation's deteriorating air quality. I would like to speak today on behalf of those Americans who are working tirelessly at the regional and local levels to protect our air quality, and who have expressed their concerns to me. Many Americans across the country feel that the Clean Air Act has not done enough to protect their health and their environment. They also worry that, under the leadership of our President, things will only get worse. They are taking action at the local and State levels, and State government is responding with real leadership. We need to support these actions with strong, Federal legislation to protect our current laws and improve our air quality.

On a nationwide Clean Air Listening Tour I initiated in 2003, I heard firsthand from Americans who are tired of getting sick from breathing dirty air, and tired of putting their children's health at risk from eating mercury-contaminated fish. In Asheville, NC, and in Boston, MA, the public demands that the Federal Government work immediately to clean their air.

Asheville is situated in close proximity to the Great Smoky Mountains National Park, the most visited National Park in the Nation at nine million visitors every year. Sadly, this majestic park is also the Nation's most polluted, as reported by the National Parks Conservation Association. Its visibility is tied for the worst with Mammoth Cave National Park, at a mere 14-mile range during the summer months. Under natural conditions, the vista should average around 80-miles.

The Smokies have the highest rate of acid precipitation among the parks, at thirty-five kilograms per hectare. This is six to seven times the nitrogen pollution that local soils can process. In fact, the highest peak in the Smokies can be as acidic as vinegar.

The total number of hourly ozone exceedences in the Smoky Mountains far outnumbers other parks at over one hundred and thirty-three thousand per year. Ozone exposure in the Smokies is twice that of the region's most ozone-ridden cities—Knoxville, TN, and Atlanta, GA.

These statistics mean that in the Smoky Mountains, dozens of tree and plant species are damaged, streams are dying, aquatic wildlife populations are declining, and area residents face increased mortality and chronic lung ailments. Plus, the fish that people consume are poisoned with toxic mercury, which can cause a number of birth defects and health problems in adults.

What is causing all this dreaded pollution? While cars and industry contribute substantially to the problem, old, dirty power plants are my greatest concern. About 30,000 premature deaths occur every year due to power plant pollution alone. Incredibly, North Carolina loses 1,800 people each year because of this pollution. And, hundreds of thousands of children are born annually at risk of birth defects and neurological damage from their mothers' exposure to mercury.

These are shocking figures, and we should be responding immediately to this crisis. Power plants are still the Nation's single largest source of air pollution in this country. They are responsible for most of our Nation's smog and haze pollution, and asthma- and lung disease-causing particulate matter, by emitting 60 percent or more of national sulfur dioxide emissions, and 25 percent of nitrogen oxides. In fact, the country's oldest and dirtiest plants are responsible for 75 to 85 percent of the haze in the southwestern Appalachians. Power plants also emit more than one-third of the Nation's poisonous mercury into the air.

We should also know that power plants emit 25 percent of our country's emissions of carbon dioxid—the greatest greenhouse gas. Our Nation's utilities alone send forth 10 percent of the world's carbon dioxide emissions. They are, in part, responsible for the global warming that is occurring today and will continue into the future. Global warming will seriously affect the 130 species of trees and the 4,000 other plant species in the Smokies, as well as worsen the already dangerously unhealthy ozone pollution problem. Many local residents are not only highly concerned, but they are frustrated with our Federal Government's absent leadership.

State officials and others in Asheville and the Smoky Mountain region are tired of waiting on the Federal Government to protect their air and their climate. They are already acting to reduce this power plant pollution. The North Carolina legislature has made great strides with the passage of the Clean Smokestacks Act. Other States are quickly following suit. However, States are keenly aware that since much of the pollution they experience blows in from elsewhere, a national solution is crucial. In my listening session at the Grove Park Inn on May 19, 2003, I heard witnesses testify in compelling language how air pollution affects Smoky Mountain communities, and how citizens are banding together to protect public health.

North Carolina State Senator Steven Metcalf, Buncombe County Commissioner and Chair of the Land of Sky Regional Council David Gantt, as well as John Stanton, Vice President of the National Environmental Trust, joined me in a press conference to launch the listening session. Hugh Morton, Owner of Grandfather Mountain, which is a scenic travel attraction near Linville, NC, began the public forum with a slide show illustrating the devastation that air pollution has on his business. Slide after slide showed trees made bare by acid rain, and vistas clogged with haze. There is no doubt in his mind that such pollution threatens the environmental health and economic productivity of the mountain.

Don Barger, Senior Director of the Southeast Regional Office of the National Parks Conservation Association, Brownie Newman, Executive Coordinator of the Western North Carolina Alliance, Elizabeth Ouzts, State Director of the North Carolina Public Interest Research Group, and Michael Shore, Managing Director of the local Environmental Defense, added to the dialogue by describing how grassroots action has led to a high level of public awareness about air pollution and its effects, and how that action has resulted in State legislation to begin cleaning the air.

Dr. Clay Ballantine, an Asheville physician and medical expert on power plant-related health damage, also provided excellent testimony. Given that air pollution decreases lung function, causes pneumonia and respiratory infection, increases lung cancer rates similar to those of second-hand smoke exposure, causes asthma and asthma attacks, and leads to premature death, Dr. Ballantine is concerned about the suffering he sees first-hand. I am grateful to all of these witnesses for participating in the listening session, and for sharing their expertise with me.

Since Asheville ranks sixth in the Nation in per capita deaths caused by power plant pollution, and since North Carolina is facing millions of dollars in additional pollution-related health costs, local citizens there have every reason to be concerned, and every right to be outraged that this administration plans to do nothing to help them. The administration has worked to effectively neutralize and eviscerate nearly all major protections in the Clean Air Act. From dropping all enforcement cases against the worst violators of New Source Review, to the recent proposal to delist utilities for mandatory mercury control, this administration should make all of us angry. These actions are an insult to all Americans, and a slap in the face. From Asheville, NC to Boston, MA, Americans made clear to me their desperation and frustration at being told they have to wait a decade or more for this administration and this Congress to clean their air, while the hundreds of thousands of asthma attacks and birth defects continue across the country.

Residents of Boston, MA are especially worried about the potential dangers of mercury pollution from power plants, as the Boston economy, which is highly reliant on commercial and recreational fishing and tourism, may become affected by declining consumer confidence in the safety of local fish. Fortunately for some New England residents, states such as Massachusetts and Connecticut are already moving ahead with emission reduction plans.

I sincerely appreciate the participation and support of my distinguished colleagues Senator TED KENNEDY and Congressmen MIKE CAPUANO, JIM MCGOVERN, and BILL DELAHUNT, and Massachusetts Attorney General Tom Reilly in standing with me on September 22, 2003, at the New England Aquarium to bring attention to the serious mercury pollution problem facing New England. Also lending their support during the press conference were Ed Toomey, Aquarium President and CEO, and Armond Cohen, Executive Director of the Clean Air Task Force in Boston. The Aquarium and Task Force have been leaders in mercury and air pollution-related research, education, and advocacy.

At the public forum, Cindy Luppi, Organizing Director of Clean Water Action in Boston, and Jane Bright of HealthLink in Marblehead, Massachusetts spoke about the grassroots Northeast Clean Power Campaign, representing over 300 organizations from Maine to Connecticut that are all fighting to reduce power plant pollution in the region.

Ms. Luppi also provided compelling findings from a Tufts University study: direct costs of environmentally-attributable neurobehavioral disorders, such as those caused by mercury pollution, in Massachusetts alone total between $40 million and $150 million each year, with indirect costs totaling an additional $100 million to $400 million. Also, Ms. Luppi presented the findings of a 2002 Massachusetts Department of Environmental Protection study which determined, ''The Department believes that the removal of 85 to 90-plus percent of mercury in flue gas has been demonstrated to be technologically and economically feasible.'' In other words, there is no excuse to delay mandating tough national mercury reductions under the Clean Air Act.

Massachusetts and Connecticut are moving now to require an 85 to 95 percent reduction in mercury emissions in the next 5 to 9 years. Like in Asheville, the witnesses stressed that such State-level progress is encouraging, but that real relief from air pollution can only come from reductions made across the country.

During the listening session, Dr. Jill Stein, a physician and President of the Massachusetts Coalition for Healthy Communities, and Dr. Bill Bress, State Toxicologist for the Vermont Department of Health, detailed the serious and often life-threatening health effects of mercury exposure through consumption of contaminated fish. Nearly 10 percent of American women have high mercury blood levels above EPA's safe health threshold. Pregnant women who consume even small amounts of fish can inadvertently put their developing babies at risk of mental retardation, seizures, cerebral palsy, vision and hearing problems, abnormal gait and speech, and learning disabilities. EPA has estimated that 630,000 children are born at risk each year due to mercury exposure in the womb. This is twice EPA's previous estimate.

An astonishing 50 percent of Americans who eat fish regularly exceed the mercury health limit, and 10 percent exceed the limit by a factor of four. Adults are also susceptible to developing heart, kidney, and immune system disorders due to mercury consumption. Anglers and certain ethnic groups who eat large amounts of fish face two to five times these health risks. Clearly, dramatically curbing mercury pollution will improve all of our lives.

Dr. Steve Petron, Board Member of the National Wildlife Federation and Senior Ecosystems Scientist for CH2M Hill, demonstrated how toxic mercury pollution from power plants harms our Nation's aquatic wildlife. Those species that depend on fish for food are the most at risk. Because of this, loons, bald eagles, otters, amphibians, and other animals are already facing or could soon face decline. And lastly, Dr. Praveen Amar, Director of Science and Policy for the Northeast States for Coordinated Air Use Management, NESCAUM, represented State air quality regulators by stressing that mercury control technologies are available and affordable, and by expressing the need for smart Federal environmental laws to drive technology innovation and application. As a recent NESCAUM report found, ''Where strong regulatory drivers exist, substantial technological improvements and steady reductions in control costs follow.''

That's where Congress comes in. We are elected to serve the people of this Nation. Where people are becoming sick and are dying because of air pollution, something must be done. We must never knowingly allow such suffering to continue if we have the ability to act, and we do. Time and time again, mothers and fathers, doctors, scientists, and community members ask for our help.

At the bare minimum, we should be protecting current law. But to truly benefit the public good, we must pass tough legislation to force dirty power plants and other polluters to start behaving like good citizens. The air is not their toxic waste dump. It is not theirs to pollute for free, even though this administration is encouraging them to think that way. If it belongs to anyone, the air belongs to those children who play outdoors, or those families who go fishing and take trips to our scenic national parks, or to the poorest of us who are unlucky enough to live next to a smokestack. The air belongs to all of us. We should treat it like the most precious resource we know. Americans from around the country have learned this important lesson. Congress and this administration must now do the same.

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Enhancement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

In February 1999, Steve Garcia was returning to his home from a party wearing women's clothing and shoulder length hair. He died of a gunshot wound to the shoulder and because none of his jewelry was stolen, police suspect that he was targeted because of the way he was dressed.

I believe that Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

RETIREMENT OF TOM RYAN

Mr. SPECTER. Mr. President, March 1 marks a very special occasion—although it is with mixed feelings I report that Tom Ryan, the key Department of Labor Budget Analyst for employment and training programs is retiring following more than 32 years of a most distinguished career. As the members of the Appropriations Committee can attest, Mr. Ryan's work in this area has been extraordinary, in its breadth, its depth, and in its effectiveness. As needs arose and even when crisis has come to the lives of so many job seekers throughout our Nation, Mr. Ryan has been a pillar of strength in helping people as he worked tirelessly with us to ensure that funding for the right training opportunities were available when job seekers needed them.

On behalf of the members of the Appropriations Committee, I would like to take this opportunity to express our heartfelt thanks to Mr. Ryan for his vision which has so often guided us in formulating creative solutions to funding jobs training programs, in caring for the people we serve—many of those who are in critical need of assistance. The complexities of funding these programs during the challenging years of fiscal austerity have been met with a determination to find solutions, and the countless people receiving job training and employment assistance are well-served, due in no small measure, to Mr. Ryan's efforts and his devotion to these endeavors. For these efforts and so many more, we extend our congratulations to Mr. Ryan and wish him an enjoyable and well-deserved retirement.

ADDITIONAL STATEMENTS

TRIBUTE TO ERNIE MARX

• Mr. BUNNING. Mr. President, I take a moment today to pay tribute to Ernie Marx of Louisville, KY for his service to the people of Kentucky and his willingness to teach understanding and compassion to our Commonwealth's youth.

Mr. Marx is a survivor of the Holocaust and has used this tragic event in human history as an inspiration to educate the youth of our country about tolerance and respect. He has focused his efforts on middle and high school students, speaking about his experiences before hundreds of different groups.

One such event was on Tuesday, April 29, 2003, when Mr. Marx spoke at the annual Yom HaShoah commemoration at Fort Knox, KY. Yom HaShoah, or Holocaust Remembrance Day, is an important day of reflection for Americans and people throughout the world. His own message to our soldiers at Fort Knox was about hate and tolerance. He told the soldiers that they can prevent a Holocaust, saying, ''You are our hope and are fight for our freedom.''

This fall Mr. Marx led his 54th trip to Washington, DC to educate children and citizens about the Holocaust. He brings these groups, primarily students, to visit the holocaust Museum and teaches them about tolerance and understanding. I am certain he will continue to lead these trips in the tradition of the Holocaust Museum's mission of education.

From Atherton High School in Louisville, KY to the Henry County Middle School in New Castle, KY, Ernie Marx has had a profound impact on the youth of the Louisville region. I would like to honor his dedication, leadership and commitment to the people of Kentucky.•

MEASURES READ THE FIRST TIME

The following bill was read the first time:

H.R. 3783. An act to provide an extension of highway, highway safety, motor carrier safety, transit, and other programs funded out of the Highway Trust Fund pending enactment of a law reauthorizing the Transportation Equity Act for the 21st Century.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with

accompanying papers, reports, and documents, and were referred as indicated:

EC–6390. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to law, a report of actions taken by the President of the United States under Presidential Determination 2004–08 relating to the Russian Federation; to the Committee on Armed Services.

EC–6391. A communication from the Acting Under Secretary of Defense for Acquisition, Technology, and Logistics, Department of Defense, transmitting, pursuant to law, four quarterly Selected Acquisition Reports for the quarter ending September 30, 2003; to the Committee on Armed Services.

EC–6392. A communication from the Deputy Secretary of Defense, transmitting, pursuant to law, the report of the Office of Inspector General for the period from April 1, 2003 through September 30, 2003, along with the classified Annex to the Semiannual Report on intelligence-related or classified and sensitive subjects; to the Committee on Governmental Affairs.

EC–6393. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to law, a report relative to the Cooperative Threat Reduction Act of 1993 with respect to Ukraine; to the Committee on Foreign Relations.

EC–6394. A communication from the President of the United States, transmitting, pursuant to law, a report relative to the Trade Act of 2002; to the Committee on Finance.

EC–6395. A communication from the President of the United States, transmitting, pursuant to law, a report relative to United States assistance for the interdiction of aircraft engaged in illicit drug trafficking; to the Committee on Foreign Relations.

EC–6396. A communication from the President of the United States, transmitting, pursuant to law, a report relative to the Authorization for Use of Military Force Against Iraq Resolution; to the Committee on Foreign Relations.

REPORTS OF COMMITTEES

Under the authority of the order of the Senate of February 12, 2004, the following reports of committees were submitted on February 18, 2004:

By Mr. GREGG, from the Committee on Health, Education, Labor, and Pensions, with an amendment in the nature of a substitute:

S. 741. A bill to amend the Federal Food, Drug, and Cosmetic Act with regard to new animal drugs, and for other purposes (Rept. No. 108–226).

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. ROBERTS (for himself and Mr. BROWNBACK):

S. 2103. A bill to amend the Internal Revenue Code of 1986 to limit the deduction for charitable contributions of patents and similar property; to the Committee on Finance.

By Mr. SCHUMER:

S. 2104. A bill to designate the facility of the United States Postal Service located at 2 West Main Street in Batavia, New York, as the ''Barber Conable Post Office Building''; to the Committee on Governmental Affairs.

By Mr. LAUTENBERG (for himself and Mr. CORZINE):

S. 2105. A bill to improve the Federal shore protection program; to the Committee on Environment and Public Works.

By Mr. BUNNING (for himself, Mr. MILLER, Mr. ALEXANDER, and Mr. HATCH):

S. 2106. A bill to amend the Internal Revenue Code of 1986 to provide capital gains treatment for certain self-created musical works; to the Committee on Finance.

By Mr. DEWINE (for himself, Mr. LEAHY, and Mr. DOMENICI):

S. 2107. A bill to authorize an annual appropriations of $10,000,000 for mental health costs through fiscal year 2009; to the Committee on the Judiciary.

By Mr. HARKIN (for himself, Mr. KENNEDY, Mr. LIEBERMAN, and Ms. CANTWELL):

S. 2108. A bill to amend the Federal Food, Drug, and Cosmetic Act to ensure that consumers receive information about the nutritional content of restaurant food and vending machine food; to the Committee on Health, Education, Labor, and Pensions.

By Mrs. FEINSTEIN (for herself, Mr. WARNER, Mr. SCHUMER, Mr. DEWINE, Mr. LEVIN, Mr. CHAFEE, Mr. DODD, Mr. JEFFORDS, Mrs. BOXER, Mrs. CLINTON, Mr. REED, and Mr. LAUTENBERG):

S. 2109. A bill to provide for a 10-year extension of the assault weapons ban; to the Committee on the Judiciary.

By Mr. GRASSLEY (for himself and Mr. BAUCUS):

S. 2110. A bill to amend the Internal Revenue Code of 1986 to extend the Highway Trust Fund provisions through March 31, 2004, and to add the volumetric ethanol excise tax credit (VEETC), and for other purposes; to the Committee on Finance.

ADDITIONAL COSPONSORS

S. 98

At the request of Mr. ALLARD, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 98, a bill to amend the Bank Holding Company Act of 1956, and the Revised Statutes of the United States, to prohibit financial holding companies and national banks from engaging, directly or indirectly, in real estate brokerage or real estate management activities, and for other purposes.

S. 469

At the request of Mr. KOHL, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 469, a bill to amend chapter 44 of title 18, United States Code, to require ballistics testing of all firearms manufactured and all firearms in custody of Federal agencies.

S. 557

At the request of Ms. COLLINS, the names of the Senator from Maine (Ms. SNOWE) and the Senator from Arkansas (Mr. PRYOR) were added as cosponsors of S. 557, a bill to amend the Internal Revenue Code of 1986 to exclude from gross income amounts received on account of claims based on certain unlawful discrimination and to allow income averaging for backpay and frontpay awards received on account of such claims, and for other purposes.

S. 595

At the request of Mr. HATCH, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 595, a bill to amend the Internal Revenue Code of 1986 to repeal the required use of certain principal repayments on mortgage subsidy bond financings to redeem bonds, to modify the purchase price limitation under mortgage subsidy bond rules based on median family income, and for other purposes.

S. 664

At the request of Mr. HATCH, the names of the Senator from Kansas (Mr. ROBERTS) and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of S. 664, a bill to amend the Internal Revenue Code of 1986 to permanently extend the research credit, to increase the rates of the alternative incremental credit, and to provide an alternative simplified credit for qualified research expenses.

S. 736

At the request of Mr. ENSIGN, the name of the Senator from Minnesota (Mr. COLEMAN) was added as a cosponsor of S. 736, a bill to amend the Animal Welfare Act to strengthen enforcement of provisions relating to animal fighting, and for other purposes.

S. 1010

At the request of Mr. HARKIN, the name of the Senator from Florida (Mr. GRAHAM) was added as a cosponsor of S. 1010, a bill to enhance and further research into paralysis and to improve rehabilitation and the quality of life for persons living with paralysis and other physical disabilities.

S. 1034

At the request of Mrs. FEINSTEIN, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 1034, a bill to repeal the sunset date on the assault weapons ban, to ban the importation of large capacity ammunition feeding devices, and for other purposes.

S. 1272

At the request of Mr. CORZINE, the name of the Senator from South Carolina (Mr. HOLLINGS) was added as a cosponsor of S. 1272, a bill to amend the Occupational Safety and Health Act of 1970 to modify the provisions relating to citations and penalties.

S. 1277

At the request of Mr. BIDEN, the name of the Senator from Minnesota (Mr. DAYTON) was added as a cosponsor of S. 1277, a bill to amend title I of the Omnibus Crime Control and Safe Streets Act of 1968 to provide standards and procedures to guide both State and local law enforcement agencies and law enforcement officers during internal investigations, interrogation of law enforcement officers, and administrative disciplinary hearings, to ensure accountability of law enforcement officers, to guarantee the due process rights of law enforcement discipline, accountability, and due process laws.

S. 1298

At the request of Mr. AKAKA, the name of the Senator from South Dakota (Mr. DASCHLE) was added as a cosponsor of S. 1298, a bill to amend the

Farm Security and Rural Investment Act of 2002 to ensure the humane slaughter of non-ambulatory livestock, and for other purposes.

S. 1335

At the request of Mr. GRASSLEY, the names of the Senator from Nebraska (Mr. NELSON) and the Senator from Virginia (Mr . ALLEN) were added as cosponsors of S. 1335, a bill to amend the Internal Revenue Code of 1986 to allow individuals a deduction for qualified long-term care insurance premiums, use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long-term care needs.

S. 1374

At the request of Mr. DURBIN, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. 1374, a bill to provide health care professionals with immediate relief from increased medical malpractice insurance costs and to deal with the root causes of the current medical malpractice insurance crisis.

S. 1380

At the request of Mr. SMITH, the name of the Senator from Colorado (Mr. CAMPBELL) was added as a cosponsor of S. 1380, a bill to distribute universal service support equitably throughout rural America, and for other purposes.

S. 1392

At the request of Mr. HARKIN, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 1392, a bill to amend the Richard B. Russell National School Lunch Act to improve the nutrition of students served under child nutrition programs.

S. 1393

At the request of Mr. HARKIN, the name of the Senator from South Dakota (Mr. DASCHLE) was added as a cosponsor of S. 1393, a bill to amend the Richard B. Russell National School Lunch Act to reauthorize and expand the fruit and vegetable pilot program.

S. 1466

At the request of Ms. MURKOWSKI, the name of the Senator from Alaska (Mr. STEVENS) was added as a cosponsor of S. 1466, a bill to facilitate the transfer of land in the State of Alaska, and for other purposes.

S. 1597

At the request of Mr. ALLEN, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 1597, a bill to provide mortgage payment assistance for employees who are separated from employment.

S. 1704

At the request of Ms. COLLINS, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. 1704, a bill to amend the Public Health Service Act to establish a State family support grant program to end the practice of parents giving legal custody of their seriously emotionally disturbed children to State agencies for the purpose of obtaining mental health services for those children.

S. 1726

At the request of Mr. ALEXANDER, the names of the Senator from Alabama (Mr. SESSIONS) and the Senator from Mississippi (Mr. COCHRAN) were added as cosponsors of S. 1726, a bill to reduce the preterm labor and delivery and the risk of pregnancy-related deaths and complications due to pregnancy, and to reduce infant mortality caused by prematurity.

S. 1840

At the request of Mr. CONRAD, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 1840, a bill to amend the Food Security Act of 1985 to encourage owners and operations of privately-held farm and ranch land to voluntarily make their land available for access by the public under programs administered by States.

S. 1873

At the request of Mr. DASCHLE, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 1873, a bill to require employees at a call center who either initiate or receive telephone calls to disclose the physical location of such employees, and for other purposes.

S. 1902

At the request of Mr. REED, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 1902, a bill to establish a National Commission on Digestive Diseases.

S. 1916

At the request of Ms. LANDRIEU, the names of the Senator from South Dakota (Mr. JOHNSON), the Senator from California (Mrs. BOXER), the Senator from New York (Mrs. CLINTON), the Senator from New Jersey (Mr. CORZINE), and the Senator from South Dakota (Mr. DASCHLE) were added as cosponsors of S. 1916, a bill to amend title 10, United States Code, to increase the minimum Survivor Benefit Plan basic annuity for surviving spouses age 62 and older, to provide for a one-year open season under that plan, and for other purposes.

S. 1948

At the request of Mr. REID, the name of the Senator from New Jersey (Mr. CORZINE) was added as a cosponsor of S. 1948, a bill to provide that service of the members of the organization known as the United States Cadet Nurse Corps during World War II constituted active military service for purposes of laws administered by the Secretary of Veterans Affairs.

S. 1949

At the request of Mr. BIDEN, the names of the Senator from Connecticut (Mr. LIEBERMAN), the Senator from New Mexico (Mr. BINGAMAN), the Senator from Nebraska (Mr. HAGEL), and the Senator from New Jersey (Mr. CORZINE) were added as cosponsors of S. 1949, a bill to establish The Return of Talent Program to allow aliens who are legally present in the United States to return temporarily to the country of citizenship of the alien if that country is engaged in post-conflict reconstruction, and for other purposes.

S. 2011

At the request of Mr. HAGEL, the name of the Senator from Nebraska (Mr. NELSON) was added as a cosponsor of S. 2011, a bill to convert certain temporary Federal district judgeships to permanent judgeships, and for other purposes.

S. 2020

At the request of Mrs. BOXER, the name of the Senator from New Mexico (Mr. BINGAMAN) was added as a cosponsor of S. 2020, a bill to prohibit, consistent with Roe v. Wade, the interference by the government with a woman's right to choose to bear a child or terminate a pregnancy, and for other purposes.

S. 2056

At the request of Mr. BROWNBACK, the names of the Senator from Nevada (Mr. ENSIGN), the Senator from Kansas (Mr. ROBERTS), the Senator from Arizona (Mr. KYL), the Senator from Alabama (Mr. SESSIONS), the Senator from Nebraska (Mr. HAGEL) and the Senator from Georgia (Mr. MILLER) were added as cosponsors of S. 2056, a bill to increase the penalties for violations by television and radio broadcasters of the prohibitions against transmission of obscene, indecent, and profane language.

S. 2061

At the request of Mrs. DOLE, her name was added as a cosponsor of S. 2061, a bill to improve women's health access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the delivery of obstetrical and gynecological services.

At the request of Mr. ENSIGN, the names of the Senator from Wyoming (Mr. THOMAS), the Senator from Ohio (Mr. VOINOVICH), the Senator from Kentucky (Mr. BUNNING), the Senator from Tennessee (Mr. ALEXANDER), the Senator from Nebraska (Mr. HAGEL), the Senator from Alabama (Mr. SESSIONS), the Senator from Utah (Mr. HATCH), the Senator from Illinois (Mr. FITZGERALD) and the Senator from Wyoming (Mr. ENZI) were added as cosponsors of S. 2061, supra.

S. 2065

At the request of Mr. JOHNSON, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 2065, a bill to restore health care coverage to retired members of the uniformed services, and for other purposes.

S. 2090

At the request of Mr. DASCHLE, the names of the Senator from Indiana (Mr. BAYH) and the Senator from Maryland (Mr. SARBANES) were added as cosponsors of S. 2090, a bill to amend the Worker Adjustment and Retraining Notification Act to provide protections for employees relating to the offshoring of jobs.

S. 2092

At the request of Mr. ALLEN, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 2092, a bill to address the participation of Taiwan in the World Health Organization.

S. 2093

At the request of Mrs. HUTCHISON, the name of the Senator from Nevada (Mr. ENSIGN) was added as a cosponsor of S. 2093, a bill to maintain full marriage tax penalty relief for 2005.

S. 2096

At the request of Mr. LUGAR, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. 2096, a bill to promote a free press and open media through the National Endowment for Democracy and for other purposes.

S. 2099

At the request of Mr. MILLER, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 2099, a bill to amend title 38, United States Code, to provide entitlement to educational assistance under the Montgomery GI Bill for members of the Selected Reserve who aggregate more than 2 years of active duty service in any five year period, and for other purposes.

S. 2100

At the request of Mr. MILLER, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 2100, a bill to amend title 10 United States Code, to increase the amounts of educational assistance for members of the Selected Reserve, and for other purposes.

S. CON. RES. 8

At the request of Ms. COLLINS, the name of the Senator from Colorado (Mr. ALLARD) was added as a cosponsor of S. Con. Res. 8, a concurrent resolution designating the second week in May each year as ''National Visiting Nurse Association Week''.

S. CON. RES. 81

At the request of Mrs. FEINSTEIN, the names of the Senator from Louisiana (Ms. LANDRIEU), the Senator from Connecticut (Mr. DODD), the Senator from Missouri (Mr. TALENT) and the Senator from Alabama (Mr. SHELBY) were added as cosponsors of S. Con. Res. 81, a concurrent resolution expressing the deep concern of Congress regarding the failure of the Islamic Republic of Iran to adhere to its obligations under a safeguards agreement with the International Atomic Energy Agency and the engagement by Iran in activities that appear to be designed to develop nuclear weapons.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. LAUTENBERG (for himself and Mr. CORZINE):

S. 2105. A bill to improve the Federal shore protection program; to the Committee on Environment and Public Works.

Mr. LAUTENBERG. Mr. President, I rise to introduce the Coastal Restoration Act of 2004 for myself and Senator CORZINE. Since 1995, the Federal beach nourishment program has been a regular target of the White House Office of Management and Budget, OMB. Under two separate administrations there have been at least five efforts to radically change or terminate the program.

The 1996, Congress passed the Shore Protection Act as Section 227 of the Water Resources Development Act of 1996. That legislation was the first statement by Congress since 1946 of its intent that the Nation needed an ongoing Federal beach nourishment program. Unfortunately, that has not stopped OMB from trying to change Federal policies by making budget proposals that would cripple the program.

The Coastal Restoration Act, CRA, restates the congressional intent regarding the importance of the Federal beach nourishment program. The CRA makes it clear that changes in administration policy will not prevent feasibility and other types of studies from being processed through the Corps of Engineers and sent to Congress. The legislation emphasizes the role of Congress in determining which beach nourishment projects should be authorized for construction. It also re-states and strengthens existing law that periodic renourishment is an integral part of the ongoing construction of a beach nourishment project.

This bill states the intent of Congress that preference shall be given to areas 1, where there has been a previous investment of federal funds; 2, where regional sediment management plans have been adopted to integrate coastal beach nourishment, navigation, and environmental projects; 3, where there is a need to prevent or mitigate damage to shores, beaches, and other coastal infrastructure where that damage is caused at least in part by Federal activities; or 4, where the project promotes human health and safety as well as the quality of life for individuals and families. This recognizes that a primary purpose for establishing the Federal beach nourishment program in 1946 was the promotion of public recreation.

My bill will also raise the low priority now accorded by the U.S. Army Corps to the recreational benefits of beach nourishment, giving equal consideration to all national projects. It also establishes the cost share for beach nourishment projects whose primary net benefit is recreational at the same level of Federal cost share participation as it applies to storm damage and environmental restoration beach nourishment projects. Congress retains the prerogative to authorize the project and appropriate funds based on the Corps' report findings.

These changes are needed to protect and restore our beaches as the national treasure they are. According to a recent study, travel and tourism is the world's largest industry, contributing $3.5 trillion to the world's economy in 2001. In the United States, nearly 17 million people are employed in the tourism industry.

Beaches are the leading tourist destination in the Nation. Each year about 180 million Americans make 2 billion visits to the ocean, the Gulf, and our inland beaches. That is almost twice as many visits as those made to State and national parks and wilderness areas combined. In its ''State of the Beach 2003'' report the Surfrider Foundation states that tourist expenditures in 16 of our coastal States topped $104 billion.

My home State, New Jersey, has 127 miles of shoreline and we are proud of every mile. A significant portion of our tourism industry, which generates $10 billion a year, is due to our beaches. I know many of my colleagues in the Senate have similar situations in their States.

Our beaches also provide vital habitat for numerous species of plants, and for animals such as claims, snails, and crabs. Every time a wave hits the shore it brings nutrients and oxygen to support the tiny but necessary life forms that live there.

Not to be overlooked are the peace and relaxation that a day, or week, at the beach can provide. The poet Lord Byron put it so exquisitely nearly two hundred years ago when he wrote:

There is a rapture on the lonely shore,
There is a society, where none intrudes,
By the deep sea, and music in its roar:
I love not man the less, but Nature more.

The shore's economic, environmental, and aesthetic benefits are truly limitless. That is why I am introducing the Coastal Restoration Act of 2004. My legislation will revitalize the Federal beach nourishment program by placing beach nourishment projects on a par with other Army Corps projects, and assigning recreational benefits the same priority as storm damage protection and environmental restoration, correcting the inequities in our current practices.

Since the 1980s, when medical waste, sewage, and garbage began washing up on the Jersey shore I have been working hard to protect and nurture our beaches. I wrote the Ocean Dumping Act of 1988, which ended ocean dumping of sewage sludge and industry waste. And I have led the fight to ban oil and gas drilling off the Jersey shore. We have made a lot of progress since the 1980s, but our work is far from over.

I ask unanimous consent the text of my bill be printed in the RECORD following my remarks.

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

S. 2105

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Coastal Restoration Act of 2004''.

SEC. 2. FEDERAL AID IN RESTORATION AND PROTECTION OF SHORES AND BEACHES.

The first section of the Act entitled ''An Act authorizing Federal participation in the cost of protecting the shores of publicly owned property'', approved August 13, 1946 (33 U.S.C. 426e), is amended to read as follows:

''SECTION 1. FEDERAL AID IN RESTORATION AND PROTECTION OF SHORES AND BEACHES.

''(a) DECLARATION OF POLICY.—

''(1) POLICY.—It is the policy of the United States to promote shore and beach protection projects and related research that encourages the protection, restoration, and enhancement of shores, sandy beaches, and other coastal infrastructure on a comprehensive and coordinated basis by Federal, State, and local governments and private persons.

''(2) PURPOSES.—The purposes of this Act are—

''(A) to restore and maintain the shores, beaches, and other coastal resources of the United States (including territories and possessions); and

''(B) to promote the healthful recreation of the people of the United States.

''(3) PRIORITY.—In carrying out this Act, preference shall be given to areas—

''(A) in which there has been a previous investment of Federal funds;

''(B) where regional sediment management plans have been adopted;

''(C) with respect to which the need for prevention or mitigation of damage to shores, beaches, and other coastal infrastructure is attributable to Federal navigation projects or other Federal activities; or

''(D) that promote—

''(i) human health and safety; and

''(ii) the quality of life for individuals and families.

''(b) IMPLEMENTATION.—The Secretary shall pay the Federal share of the cost of carrying out shore and beach protection projects and related research that encourages the protection, restoration, and enhancement of shores, sandy beaches, and other coastal infrastructure (including projects for beach restoration, periodic beach nourishment, and restoration or protection of State, county, or other shores, public coastal beaches, parks, conservation areas, or other environmental resources).

''(c) FEDERAL SHARE.—

''(1) IN GENERAL.—Subject to paragraphs (2) through (4), the Federal share of the cost of a project described in subsection (b) shall be determined in accordance with section 103 of the Water Resources Development Act of 1986 (33 U.S.C. 2213).

''(2) EXCEPTION.—In the case of a project for beach erosion control the primary purpose of which is recreation, the Federal share shall be equal to the Federal share for a beach erosion control project the primary purpose of which is storm damage protection or environmental restoration.

''(3) REMAINDER.—

''(A) IN GENERAL.—Subject to subparagraph (B), the remainder of the cost of the construction of a project described in subsection (b) shall be paid by a State, municipality, other political subdivision, nonprofit entity, or private enterprise.

''(B) EXCEPTION.—The Federal Government shall bear all of the costs incurred for the restoration and protection of Federal property.

''(4) GREATER FEDERAL SHARE.—In the case of a project described in subsection (b) for the restoration and protection of a State, county, or other publicly-owned shore, coastal beach, park, conservation area, or other environmental resource, the Chief of Engineers may increase the Federal share to be greater than that provided in paragraph (1) if the area—

''(A) includes—

''(i) a zone that excludes permanent human habitation; or

''(ii) a recreational beach or other area determined by the Chief of Engineers;

''(B) satisfies adequate criteria for conservation and development of the natural resources of the environment; and

''(C) extends landward a sufficient distance to include, as approved by the Chief of Engineers—

''(i) protective dunes, bluffs, or other natural features;

''(ii) such other appropriate measures adopted by the State or political subdivision of the State to protect uplands areas from damage, promote public recreation, or protect environmental resources; or

''(iii) appropriate facilities for public use.

''(5) RECOMMENDATIONS.—

''(A) IN GENERAL.—In recommending to Congress projects for Federal participation, the Secretary shall recommend projects for the restoration and protection of shores and beaches that promote equally all national economic development benefits and purposes, including recreation, hurricane and storm damage reduction, and environmental restoration.

''(B) REPORT.—The Secretary shall—

''(i) identify projects that maximize net benefits for national purposes; and

''(ii) submit to Congress a report that describes the findings of the Secretary.

''(d) PERIODIC BEACH NOURISHMENT.—In this Act, when the most suitable and economical remedial measures, as determined by the Chief of Engineers, would be provided by periodic beach nourishment, the term 'construction' shall include the deposit of sand fill at suitable intervals of time to furnish sand supply to protect shores and beaches for a period of time specified by the Chief of Engineers and authorized by Congress.

''(e) PRIVATE SHORES AND BEACHES.—

''(1) IN GENERAL.—A shore or beach, other than a public shore or beach, shall be eligible for Federal assistance under this Act if—

''(A) there is a benefit to a public shore or beach, including a benefit from public use or from the protection of nearby public property; or

''(B) the benefits to the shore or beach are incidental to the project.

''(2) FEDERAL SHARE.—The Secretary shall adjust the Federal share of a project for a shore or beach, other than a public shore or beach, to reflect the benefits described in paragraph (1).

''(f) AUTHORIZATION OF PROJECTS.—

''(1) IN GENERAL.—Subject to paragraph (2), no Federal share shall be provided for a project under this Act unless—

''(A) the plan for that project has been specifically adopted and authorized by Congress after investigation and study; or

''(B) in the case of a small project under sections 3 or 5, the plan for that project has been approved by the Chief of Engineers.

''(2) STUDIES.—

''(A) IN GENERAL.—The Secretary shall—

''(i) recommend to Congress studies concerning shore and beach protection projects that meet the criteria established under this Act and other applicable law;

''(ii) conduct such studies as Congress requests; and

''(iii) report the results of all studies requested by Congress to the Committee on Environment and Public Works of the Senate and the Committee on Transportation and Infrastructure of the House of Representatives.

''(B) RECOMMENDATIONS FOR SHORE AND BEACH PROTECTION PROJECTS.—

''(i) IN GENERAL.—The Secretary shall—

''(I) recommend to Congress the authorization or reauthorization of all shore and beach protection projects the plans for which have been approved by the Chief of Engineers; and

''(II) report to Congress on the feasibility of other projects that have been studied under subparagraph (A) but have not been approved by the Chief of Engineers.

''(ii) CONSIDERATIONS.—In approving a project plan, the Chief of Engineers shall consider the economic and ecological benefits of the shore or beach protection project.

''(C) COORDINATION OF PROJECTS.—In conducting studies and making recommendations for a shore or beach protection project under this paragraph, the Secretary shall—

''(i) determine whether there is any other project being carried out by the Secretary or other Federal agency that may be complementary to the shore or beach protection project; and

''(ii) if there is such a complementary project, undertake efforts to coordinate the projects.

''(3) SHORE AND BEACH PROTECTION PROJECTS.—

''(A) IN GENERAL.—The Secretary shall construct any shore or beach protection project authorized by Congress, or separable element of such a project, for which Congress has appropriated funds.

''(B) AGREEMENTS.—

''(i) REQUIREMENT.—After authorization by Congress, before the commencement of construction of a shore or beach protection project or separable element, the Secretary shall offer to enter into a written agreement for the authorized period of Federal participation in the project with a non-Federal interest with respect to the project or separable element.

''(ii) TERMS.—The agreement shall—

''(I) specify the authorized period of Federal participation in the project; and

''(II) ensure that the Federal Government and the non-Federal interest cooperate in carrying out the project or separable element.

''(g) EXTENSION OF THE PERIOD OF FEDERAL PARTICIPATION.—At the request of a non-Federal interest, the Secretary, acting through the Chief of Engineers and with the approval of Congress, shall extend the period of Federal participation in a beach nourishment project that is economically feasible, engineeringly sound, and environmentally acceptable for such additional period as the Secretary determines appropriate.

''(h) SPECIAL CONSIDERATIONS.—In a case in which funds have been appropriated to the Corps of Engineers for a specific project but the funds cannot be expended because of the time limits of environmental permits or similar environmental considerations, the Secretary may carry over such funds for use in the next fiscal year if construction of the project, or a separable element of the project, will cause minimal environmental damage and will not violate an environmental permit.''.

By Mr. BUNNING (for himself, Mr. MILLER, Mr. ALEXANDER, and Mr. HATCH):

S. 2106. A bill to amend the Internal Revenue Code of 1986 to provide capital gains treatment for certain self-created musical works; to the Committee on Finance.

Mr. ALEXANDER. Mr. President, I applaud Senator BUNNING for introducing the bill to amend the Internal Revenue Code of 1986 to provide capital gains treatment for certain self-created musical works, and I am proud to be a co-sponsor of this bill.

This bill will make songwriters eligible for the capital gains tax rate when

they sell their portion of a song catalogue. It treats the taxation of songwriters fairly so that they are on equal footing with musical publishers. Many songwriters are self-employed small business owners, but they are distinguishable from other similar small business owners, such as authors, because the rate of pay for songwriters is set by the Federal Government.

Historically, almost all professional songwriters assigned their copyright to a music publisher. As a result, the songwriters did not own the song or receive any royalty payments from the song. The songwriters did not own the copyright, and therefore, were not required to participate in any expenses toward exploiting it.

Currently, songwriters and music publishers are equal, joint-venture business partners. The publisher serves as the songwriter's agent in getting songs recorded or placed, otherwise known as ''co-publishing.'' Under this scenario, the songwriter and publisher equally share expenses of, among other things, demos costs and legal fees, and they equally share in any royalty income. Alternatively, the songwriter is the music publisher and bears all of the expenses of, among other things, demo costs and legal fees. Under the first scenario, the songwriter is subject to ordinary income tax, rather than capital gains tax, despite the fact that the sale of the song catalogue was actually a capital gain and should have been taxed at a lower rate. A capital gain is the result of a sale of a capital asset. Clearly, a song catalog is a capital gain because it is an asset of the songwriter.

Under current law, music publishers are eligible for the capital gains tax rate when they sell their portion of a song catalogue, but songwriters are not. When the publishing rights or the song catalogue is sold, music-publishing companies are allowed to claim the capital gains tax rate on their portion of the sale. However, because the songwriter wrote the song, they must pay ordinary income tax on their share of the same sale even though they share in expenses toward exploiting the copyright.

I am proud to be a cosponsor of this bill because it levels the tax playing field between songwriters and music publishers.

By Mr. DEWINE (for himself, Mr. LEAHY, and Mr. DOMENICI):

S. 2107. A bill to authorize an annual appropriations of $10,000,000 for mental health courts through fiscal year 2009; to the Committee on the Judiciary.

Mr. DEWINE. Mr. President, I rise today to introduce a bill that would reauthorize America's Law Enforcement and Mental Health Project. This program addresses the impact that mentally ill offenders have had on our criminal justice system and the impact the system has had on the offenders and their special needs.

My interest in, and experience with this issue began over thirty years ago, when I was working as Assistant County Prosecuting Attorney in Greene County, OH, and then as County Prosecutor. What I learned then—and what I have continued to encounter throughout my career in public service—is that our State and local correctional facilities have become way stations for far too many mentally ill individuals in our Nation.

A recent Justice Department study revealed that 16 percent of all inmates in America's State prisons and local jails today are mentally ill. The American Jails Association estimates that 600,000 to 700,000 seriously mentally ill persons each year are booked into local jails, alone. In Ohio, nearly 1 in 5 prisoners need psychiatric services or special accommodations.

Far too many of our Nation's mentally ill persons have ended up in our prisons and jails. In fact, on any given day, the Los Angeles County Jail is home to more mentally ill inmates than the largest mental health care institution in our country. What happens is that all too often, the mentally ill act out their symptoms on the streets. They are arrested for minor offenses and wind up in jail. They serve their sentences or are paroled, but find themselves right back in the system only a short time later after committing additional—often more serious—crimes.

Throughout this destructive cycle, law enforcement and corrections spend time and money trying to cope with the unique problems posed by these individuals. Certainly, many mentally ill offenders must be incarcerated because of the severity of their crimes. However, those who commit very minor non-violent offenses don't necessarily need to be incarcerated; instead, if given appropriate care early, their illnesses could be addressed, helping the offenders, while reducing recidivism and decreasing the burdens on our police and corrections officials.

That's why, four years ago Senator DOMENICI and I introduced America's Law Enforcement and Mental Health Project, to begin to identify—early in the process—mentally ill offenders within our justice system and to use the power of the courts to assist them in obtaining the treatment they need.

This program has been a success. In pilot programs around the country, mental health courts have begun to help local communities take steps toward effectively addressing the issues raised by the mentally ill in our justice system, and these steps must continue. That's why Senators LEAHY and DOMENICI join me in cosponsoring this bill to reauthorize this important program.

America's Law Enforcement and Mental Health Project established a Federal grant program to help States and localities develop mental health courts in their jurisdictions. These courts are specialized courts with separate dockets. They hear cases exclusively involving nonviolent offenses committed by mentally ill individuals. Fundamentally, mental health courts enable State and local courts to offer alternative sentences or alternatives to prosecution for those offenders who could be served best by mental health services. These courts are designed to address the historic lack of coordination between local law enforcement and social service systems and the lack of interaction within the criminal justice system.

To deal with the separate needs of mentally ill offenders, these mental health courts are staffed by a core group of specialized professionals, including a dedicated judge, prosecutor, public defender, and court liaison to the mental health services community. The courts promote efficiency and consistency by centrally managing all outstanding cases involving a mentally ill defendant referred to the mental health court.

Mental health court judges decide whether or not to hear each case referred to them. The courts only deal with defendants deemed mentally ill by qualified mental health professionals or the mental health court judge. Similarly, participation in the court by the mentally ill is voluntary; however, once the defendant volunteers for the Mental Health Court, he or she is expected to follow the decision of the court. For instance, in any given case, the mental health court judge, attorneys, and health services liaison may all agree on a plan of treatment as an alternative sentence or in lieu of prosecution. The defendant must adhere strictly to this court-imposed treatment plan. The court must then provide supervision with periodic review. This way, the court can quickly deal with any failure of the defendant to fulfill the treatment plan obligations. The mental health courts provide supervision of participants that is more intensive than might otherwise be available, with an emphasis on accountability and monitoring the participant's performance. In this sense, the mental health courts function similarly to drug courts.

Mr. President, mentally ill persons who choose to have their cases heard in a mental health court often do so because that is the first real opportunity that many of these people have to seek treatment. A judicial program offering the possibility of effective treatment—rather than jail time—gives a measure of hope and a chance for rehabilitation to these defendants.

The successes of mental health courts are encouraging and show that we can improve the health and safety of our communities through these programs. For example, in Ohio, the Fairfield Municipal Mental Health Court began its program on January 1, 2001. Of those participating in the Fairfield program, 46 percent are bipolar, 42 percent suffer from depression, and 13 percent are schizophrenic. It recently conducted its first ''graduation'' ceremony of program participants. The program's

first graduate came to them hostile, uncommunicative, and unable to function in society due to her bipolar mood disorder. Two years later, she left the program confident, talkative, healthier, and reconnected to her family and her life.

Many jurisdictions across America have established mental health courts as a result of the program that we established four years ago. Our Nation's communities are trying desperately to find the best way to cope with the problems associated with mental illness. Law enforcement agencies and correctional facilities remain challenged by difficulties posed by mental illnesses. Mental health courts offer a solution.

Mental health courts have shown great success, and we must ensure their continuation. Our Nation has long been enriched by the dual ideals of compassion and justice, and these programs are a wonderful embodiment of both ideals. I urge my colleagues to join in support of this important legislation.

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. 2107

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. AUTHORIZATION OF APPROPRIATIONS.

Section 1001(a)(20) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3793(a)(20)) is amended by striking ''fiscal years 2001 through 2004'' and inserting ''fiscal years 2004 through 2009''.

By Mr. HARKIN (for himself, Mr. KENNEDY, Mr. LIEBERMAN, and Mrs. CANTWELL):

S. 2108. A bill to amend the Federal Food, Drug, and Cosmetic Act to ensure that consumers receive information about the nutritional content of restaurant food and vending machine food; to the Committee on Health, Education, Labor, and Pensions.

Mr. HARKIN. Mr. President, I rise to introduce a bill, the Menu Education and Labeling Act, on behalf of myself and my colleagues, Senators KENNEDY, LIEBERMAN and CANTWELL.

More than 65 percent of American adults are overweight, and more than 30 percent are clinically obese. We lead the world in this dubious distinction, which is growing worse. In the past 20 years, obesity rates have doubled among American adults and children, while they have tripled among teens. If we do not change course, kids attending school today will be the first generation in American history to live a shorter lifespan than their parents.

The issue is far from merely cosmetic. It is medical and economic. The obesity epidemic has huge consequences. Overweight people have an increased risk of diabetes, cardiovascular disease, cancers and other illnesses. Sixty percent of overweight youth already have at least one risk factor for heart disease which is the No. 1 killer of adults in the U.S. Obesity also causes or contributes to $117 billion a year in health care and related costs, more than half borne by taxpayers.

There is no single solution to the complex problem of obesity, but we must start taking meaningful steps to address this growing problem by giving people the tools necessary to live healthier lifestyles. That is why my colleagues and I are introducing this bill today to extend nutrition labeling beyond packaged foods to include foods at chain restaurants with 20 or more locations, as well as food in vending machines. This common-sense idea will give consumers a needed tool to make wiser choices and achieve a healthier lifestyle. It is a positive step toward addressing the obesity epidemic.

In 1990, Congress passed the Nutrition Labeling and Education Act, NLEA, requiring food manufacturers to provide nutrition information on nearly all packaged foods. The impact has been tremendous. Not only do nearly three-quarters of adults use the food labels on packaged foods, but studies indicate that consumers who read labels have healthier diets.

Restaurants, which are more and more important to Americans' diet and health, were excluded from the NLEA. American adults and children consume a third of their calories at restaurants at the very time when nutrition and health experts say that rising caloric consumption and growing portion sizes are causes of obesity. We also know that when children eat in restaurants, they consume twice as many calories as when they eat at home. Consumers say that they would like nutrition information provided when they order their food at restaurants, yet, while they have good nutrition information in supermarkets, at restaurants they can only guess.

Vending machine food sales also plays a large role in contributing to the diets of Americans. Over the last three decades vending machine sales have shot up eighty-five percent after inflation. Most vending machine sales include foods of low nutritional value. The Menu Education and Labeling Act will require fast-food and other chain restaurants, as well as vending machines, to list basic nutritional information clearly—so consumers can make better choices about the foods that they eat.

Let there be no doubt: obesity is indeed an epidemic, and it is continuing to grow. This is a public health crisis and we must address it. Although this bill alone will not halt rising obesity in its tracks, it provides consumers with an important tool with which to make better choices about the food that they and their children consume.

In the coming weeks I will be offering additional initiatives to give Americans the tools they need to stay healthy and address risk factors like obesity and mental health that are associated with the rising medical and financial costs of chronic illnesses. The common thread will be an emphasis on preventing unnecessary disease and illness.

By Mrs. FEINSTEIN (for herself, Mr. WARNER, Mr. SCHUMER, Mr. DEWINE, Mr. LEVIN, Mr. CHAFEE, Mr. DODD, Mr. JEFFORDS, Mrs. BOXER, Mrs. CLINTON, Mr. REED, and Mr. LAUTENBERG):

S. 2109. A bill to provide for a 10-year extension of the assault weapons ban; to the Committee on the Judiciary.

Mrs. FEINSTEIN. Mr. President, I rise on behalf of myself and Senators WARNER, SCHUMER, DEWINE, LEVIN, CHAFEE, DODD, JEFFORDS, BOXER, CLINTON, REED and LAUTENBERG to offer legislation that will reauthorize the 1994 assault weapons ban—which is now set to expire on September 13, 2004—for another ten years.

I would first like to thank my courageous colleague from Virginia, Senator WARNER, for joining me in this effort. Senator WARNER voted against the assault weapons ban in 1994.

But this year, Senator WARNER was willing to revisit his position on the issue. He saw that—contrary to the fears of many in 1994—the ban has done nothing to hurt innocent gun owners. Instead, the ban has only made it harder for criminals to get access to military style firearms. A willingness to look at issues like this with an open mind, particularly this issue, shows a courage and a commitment to making the right decisions that should be emulated by all public servants, and I want to again thank Senator WARNER for this.

Second, I would like to speak about who else supports this legislation.

Those who join us in supporting a reauthorization of the assault weapons ban include: Fraternal Order of Police; National League of Cities; United States Conference of Mayors; National Association of Counties; International Association of Chiefs of Police; National Association of Police Organizations; International Brotherhood of Police Officers; U.S. Conference of Catholic Bishops; National Education Association; Americans for Gun Safety; The Brady Campaign/Million Mom March; NAACP; American Bar Association; and the list goes on, and on.

More than ten years ago—on July 1, 1993—Gian Luigi Ferri walked into 101 California Street in San Francisco carrying two high-capacity TEC–9 assault pistols. Within minutes, Ferri had murdered eight people, and six others were wounded. This tragedy shook San Francisco, and it shook the entire Nation.

The American people saw in that incident and so many others that came before and after it the incredible destruction that could be inflicted with military-style assault weapons—weapons designed and manufactured with one goal in mind—maximum lethality.

It all started, really, on August 1, 1966, when Charlie Whitman climbed the clock tower at the University of Texas and killed more than a dozen people in an hour and a half shooting spree before he was finally killed himself.

The day Whitman climbed that tower was the first time Americans realized that they could become the random victims of gun violence no matter where they were, and no matter what they were doing.

What made the Texas shooting so terrible was the total inability of law enforcement to get to Charlie Whitman until he had been firing shots for almost 96 minutes. The tower allowed him to do this. The tower made him, at least for that amount of time, invincible.

But gunmen no longer need the protection of clock towers, because they now have assault weapons.

We saw in the Columbine shooting, in the Long Island Rail Road shooting, and so many others, that high capacity assault weapons can make those who wield them temporarily invincible to law enforcement, because it is so difficult to get close to the shooter.

It is often only when a gunman stops to reload that bystanders or the police can move in to stop the shooting. And if the gun's magazine holds hundreds of bullets, that could take a long time, and result in a lot of deaths.

This is vitally important, because grievance killings by disgruntled members of society have taken an increasing number of lives in recent years. And when those grievance killers wield high capacity weapons, the toll on lives is exponentially increased.

The grievance killings have been across the Nation, in every forum: In a San Ysidro, CA, McDonald's in 1984, when a gunman with an Uzi killed 21 and wounded 15 others. In Stockton, CA, in 1989, when drifter Patrick Purdy walked into a schoolyard with an AK–47 and killed 5, wounding 30 others. In Long Island, NY, in 1993, when a gunman killed 6 and wounded 19 others on a commuter train—he was only brought down when he finally stopped to reload. In Pearl, MS, in 1997 when 2 students killed. In Paducah, KY, in 1998 when 3 students were killed. In Jonesboro, AR, in 1998 when 5 were killed, and 10 more wounded. In Springfield, OR, in 1998 when 2 were killed, and 22 wounded. In Littleton, CO, when 12 teens and one teacher were killed in Columbine High School. In Atlanta, GA in 1999 when a troubled day trader killed his wife, 2 children and several people trading stocks. At a Granada Hills, CA, Jewish Community Center when a gunman wounded three and killed a Filipino-American postal worker—many of us remember that one touching photo of small children being quickly led across the street to escape the gunfire. No child should have to go through that. At a Fort Worth, TX, Baptist church where seven were killed and seven more wounded at a teens church event, all by a man with two guns and 9 high capacity clips, with a capacity of 15 rounds each.

Recognizing the earliest of these shootings as a problem that needed to be dealt with, Congress finally took notice in 1993. In the aftermath of the 101 California shooting, we in Congress did something that no one had succeeded in doing before—we banned the manufacture and importation of military-style assault weapons.

We were told it could not be done—but we did it. I was even told by colleagues on my own side of the aisle that I was wasting my time—that the gun lobby was just too strong. I hear many of the same arguments today. But we succeeded in 1994, and we will succeed this year. We succeeded, and we will succeed, because the American people will accept no less of us.

The goal of the 1994 legislation was to drive down the supply of these weapons and to make them more difficult to obtain, and to eventually get them off our streets. And in the years following the enactment of the ban, crimes using assault weapons were indeed reduced dramatically—in fact, the percentage of crimes using banned assault weapons fell by more than 65 percent between 1995 and 2002.

The ATF has found that the proportion of banned assault weapons used in crime has fallen from 3.57 percent in 1995 to just 1.22 percent by 2002. Now these are not big percentages—most crimes are not committed by assault weapons.

But it is important to note that crimes committed with assault weapons often result in many more deaths than crimes committed with other guns. A simple robbery with a handgun is far less likely to result in multiple deaths than a drive-by shooting with an Uzi, or a grievance killing in a school using an AK–47 with a large capacity ammunition magazine.

And contrary to the near-hysterical rhetoric coming from the NRA at the time, no innocent gun owner lost an assault weapon. No gun was confiscated as a result of the ban. The sky did not fall. And life went on—but it went on with fewer grievance killers, juveniles, and drive-by shooters having access to the most dangerous of firearms.

Despite these results, House Majority Leader TOM DELAY said last year that House Republicans will let the Assault Weapons ban die when it sunsets after ten years.

To those of us who have been in Congress for some time, this comes as little surprise—after all, the House actually voted to repeal the original assault weapons ban soon after it was signed into law.

But the good news is that the President of the United States does support reauthorizing the ban.

In April of last year, White House spokesman Scott McClellan said of the assault weapons ban, ''The president supports the current law, and he supports reauthorization of the current law.''

That is what we are doing with this legislation—reauthorizing the current law. Period.

I know the President agrees with me when I say that I don't believe that banned guns like the AK–47, the TEC–9, or the Street Sweeper should once again be manufactured or imported into the United States. These are military guns, with no purpose but the killing of other human beings. They have pistol grips and other features designed solely to allow the weapons to be more easily concealed, and more easily fired from the hip in close quarters combat—or, tragically, in places like the schoolyard in Stockton, where five children died, the McDonalds in San Ysidro, the law firm at 101 California Street in San Francisco, Columbine High School, or so many other places where maniacs with their military guns were able to shoot large numbers of people in short periods of time.

That is why I believe that Congress should reauthorize the 1994 law, which expires next September 13. And that is undoubtedly why the President also supports our efforts.

I know there will be some who will say that the current law doesn't go far enough—and frankly, I agree. I would prefer to expand the ban to California law, so that we prohibit the copycat assault weapons that manufacturers so cravenly designed following the ban.

Senator LAUTENBERG has introduced legislation to do this, and I co-sponsored that bill. Ideally, we would pass legislation that fully prevents craven manufacturers from circumventing the ban.

But in an environment where the NRA has such a stranglehold on gun legislation, we will need all the help we can get just to keep the current ban.

The current ban has been effective in limiting the supply of these most dangerous guns. Even the copycat guns are less dangerous, because they are harder to conceal, harder to fire from the hip.

And no matter whether the ban has been entirely effective or not, what is the argument for letting these banned guns back on the streets?

Who is clamoring for newly manufactured AK–47s?

Who is clamoring for new TEC–9s?

These are guns that are never used for hunting. They are not used for self defense, and if they are it is more likely that they will kill innocents than intruders.

These guns—and everyone knows it—have but one purpose, and that purpose is to kill other human beings. Why would we want to open the floodgates again and let them back on our streets? There is simply no good reason.

This debate should not be about whether the assault weapons ban is perfect. This debate should be about whether these guns need to come back—and the American people know that they do not.

With the President, law enforcement, and the American people behind us, we

can succeed. We can beat the NRA's narrow, special interest agenda and keep these guns off the streets.

I urge my colleagues to read the dozens of editorials in support of the ban, to listen to their constituents, to ask us questions, and to make the only decision that makes sense—to support this bill.

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. 2109

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Assault Weapons Ban Reauthorization Act of 2004''.

SEC. 2. 10-YEAR EXTENSION OF ASSAULT WEAPONS BAN.

Section 110105 of the Public Safety and Recreational Firearms Use Protection Act (18 U.S.C. 921 note) is amended to read as follows:

''SEC. 110105. SUNSET PROVISION.

''This subtitle and the amendments made by this subtitle are repealed September 13, 2014.''.

Mr. WARNER. Mr. President, I rise today in support of reauthorizing the Assault Weapons Ban.

Signed into law in 1994, the Assault Weapons Ban placed a 10-year prohibition on the domestic manufacture of semi-automatic assault weapons and high capacity ammunition clips. The 10-year ban ends on September 13, 2004. Consequently, unless Congress and the President act prior to September 13, 2004, weapons like Uzis and AK–47s will once again be produced in America, and more and more often, these weapons will fall into the hands of criminals who lurk in our neighborhoods.

For a number of years now, President Bush has indicated that he supports reauthorizing the assault weapons ban. To date, though, no legislation has been introduced in the Senate to accomplish the President's goal. While measures have been introduced to make the ban permanent or to even expand the ban further, no legislation has been introduced to simply reauthorize the Assault Weapons Ban for another ten years.

I am pleased today to introduce, with Senator FEINSTEIN, legislation that models exactly what the President has indicated he would sign into law: a straight 10-year reauthorization of the Assault Weapons Ban.

Not only does President Bush support this legislation—law enforcement does as well. The men and women of law enforcement know that this legislation makes communities safer. In a letter dated February 18, 2004, the Grand Lodge of the Fraternal Order of Police writes, ''It is the position of the Grand Lodge that we will support the reauthorization of current law, but we will not support any expansion of the ban.'' This endorsement comes in addition to the endorsement of just about every other major law enforcement organization, and in addition to the endorsements of chiefs of police all across Virginia.

Now, admittedly, I have not always been a supporter of the Assault Weapons Ban. When the ban legislation came before the United States Senate for a vote in 1993, I opposed it. At the time, I believed Senator FEINSTEIN's legislation would do nothing to help reduce crime in this country, and I believed it would be a back door way to take firearms out of the hands of law abiding gun-owners and hunters.

Ten years have since passed from the day of that vote. Over the course of those ten years, I have watched the bill be signed into law, and I have watched its implementation. I have studied the law and its affect on crime, and I have watched carefully to see how it affects law abiding gun-owners.

Based on the ten years of history of the Assault Weapons Ban, my thoughts on the ban have evolved.

Ten years of experience provides us with key facts. The Assault Weapons Ban has helped to dramatically reduce the number of crimes using assault weapons. It has made America's streets safer, and it has protected the rights of law abiding gun-owners better than many of us predicted. In fact, the law explicitly protects 670 hunting and recreational rifles.

Moreover, we all know that the world has dramatically changed since that Senate vote in 1993. September 11, 2001, has forever changed our country and has taught us many lessons.

No longer is America protected by the great oceans. The war on terror is not only being fought abroad, but now here at home. September 11 showed us that terrorism lurks in the shadows of our own backyard. Given the world today, now is not the time to make it easier for terrorists to acquire deadly rapid fire assault weapons and use them in our neighborhoods.

Now, over my 25 years plus in the United States Senate, I have always tried to stand up for what is right, regardless of politics. I believe that is why the good people of the Commonwealth of Virginia have given me their trust and elected me to represent them in the United States Senate for five terms.

I know that reauthorizing the Assault Weapons Ban is the right thing to do.

I am pleased to join Senator FEINSTEIN in introducing this legislation, and it is my hope that the Senate will act expeditiously and send this legislation to President Bush to sign into law.

By Mr. GRASSLEY (for himself and Mr. BAUCUS):

S. 2110. A bill to amend the Internal Revenue Code of 1986 to extend the Highway Trust Fund provisions through March 31, 2004, and to add the volumetric ethanol excise tax credit (VEETC), and for other purposes; to the Committee on Finance

Mr. GRASSLEY. Mr. President, 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:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Surface Transportation Extension Act of 2004''.

SEC. 2. EXTENSION OF AUTHORIZATION FOR USE OF TRUST FUNDS FOR OBLIGATIONS UNDER TEA–21.

(a) HIGHWAY TRUST FUND.—

(1) IN GENERAL.—Paragraph (1) of section 9503(c) of the Internal Revenue Code of 1986 is amended—

(A) in the matter before subparagraph (A), by striking ''March 1, 2004'' and inserting ''April 1, 2004'',

(B) by striking ''or'' at the end of subparagraph (E),

(C) by striking the period at the end of subparagraph (F) and inserting '', or'',

(D) by inserting after subparagraph (F), the following new subparagraph:

''(G) authorized to be paid out of the Highway Trust Fund under the Surface Transportation Extension Act of 2004.'', and

(E) in the matter after subparagraph (G), as added by this paragraph, by striking ''Surface Transportation Extension Act of 2003'' and inserting ''Surface Transportation Extension Act of 2004''.

(2) MASS TRANSIT ACCOUNT.—Paragraph (3) of section 9503(e) of such Code is amended—

(A) in the matter before subparagraph (A), by striking ''March 1, 2004'' and inserting ''April 1, 2004'',

(B) in subparagraph (C), by striking ''or'' at the end of such subparagraph,

(C) in subparagraph (D), by inserting ''or'' at the end of such subparagraph,

(D) by inserting after subparagraph (D) the following new subparagraph:

''(E) the Surface Transportation Extension Act of 2004,'', and

(E) in the matter after subparagraph (E), as added by this paragraph, by striking ''Surface Transportation Extension Act of 2003'' and inserting ''Surface Transportation Extension Act of 2004''.

(3) EXCEPTION TO LIMITATION ON TRANSFERS.—Subparagraph (B) of section 9503(b)(5) of such Code is amended by striking ''March 1, 2004'' and inserting ''April 1, 2004''.

(b) AQUATIC RESOURCES TRUST FUND.—

(1) SPORT FISH RESTORATION ACCOUNT.—Paragraph (2) of section 9504(b) of the Internal Revenue Code of 1986 is amended by striking ''Surface Transportation Extension Act of 2003'' each place it appears and inserting ''Surface Transportation Extension Act of 2004''.

(2) BOAT SAFETY ACCOUNT.—Subsection (c) of section 9504 of such Code is amended—

(A) by striking ''March 1, 2004'' and inserting ''April 1, 2004'', and

(B) by striking ''Surface Transportation Extension Act of 2003'' and inserting ''Surface Transportation Extension Act of 2004''.

(3) EXCEPTION TO LIMITATION ON TRANSFERS.—Paragraph (2) of section 9504(d) of such Code is amended by striking ''March 1, 2004'' and inserting ''April 1, 2004''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

(d) TEMPORARY RULE REGARDING ADJUSTMENTS.—During the period beginning on the date of the enactment of the Surface Transportation Extension Act of 2003 and ending on March 31, 2004, for purposes of making any estimate under section 9503(d) of the Internal

Revenue Code of 1986 of receipts of the Highway Trust Fund, the Secretary of the Treasury shall treat—

(1) each expiring provision of paragraphs (1) through (4) of section 9503(b) of such Code which is related to appropriations or transfers to such Fund to have been extended through the end of the 24-month period referred to in section 9503(d)(1)(B) of such Code, and

(2) with respect to each tax imposed under the sections referred to in section 9503(b)(1) of such Code, the rate of such tax during the 24-month period referred to in section 9503(d)(1)(B) of such Code to be the same as the rate of such tax as in effect on the date of the enactment of the Surface Transportation Extension Act of 2003.

SEC. 3. ALCOHOL AND BIODIESEL EXCISE TAX CREDIT AND EXTENSION OF ALCOHOL FUELS INCOME TAX CREDIT.

(a) IN GENERAL.—Subchapter B of chapter 65 of the Internal Revenue Code of 1986 (relating to rules of special application) is amended by inserting after section 6425 the following new section:

"SEC. 6426. CREDIT FOR ALCOHOL FUEL AND BIODIESEL MIXTURES.

''(a) ALLOWANCE OF CREDITS.—There shall be allowed as a credit against the tax imposed by section 4081 an amount equal to the sum of—

''(1) the alcohol fuel mixture credit, plus

''(2) the biodiesel mixture credit.

''(b) ALCOHOL FUEL MIXTURE CREDIT.—

''(1) IN GENERAL.—For purposes of this section, the alcohol fuel mixture credit is the product of the applicable amount and the number of gallons of alcohol used by the taxpayer in producing any alcohol fuel mixture for sale or use in a trade or business of the taxpayer.

''(2) APPLICABLE AMOUNT.—For purposes of this subsection—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the applicable amount is 52 cents (51 cents in the case of any sale or use after 2004).

''(B) MIXTURES NOT CONTAINING ETHANOL.—In the case of an alcohol fuel mixture in which none of the alcohol consists of ethanol, the applicable amount is 60 cents.

''(3) ALCOHOL FUEL MIXTURE.—For purposes of this subsection, the term 'alcohol fuel mixture' means a mixture of alcohol and a taxable fuel which—

''(A) is sold by the taxpayer producing such mixture to any person for use as a fuel,

''(B) is used as a fuel by the taxpayer producing such mixture, or

''(C) is removed from the refinery by a person producing such mixture.

''(4) OTHER DEFINITIONS.—For purposes of this subsection—

''(A) ALCOHOL.—The term 'alcohol' includes methanol and ethanol but does not include—

''(i) alcohol produced from petroleum, natural gas, or coal (including peat), or

''(ii) alcohol with a proof of less than 190 (determined without regard to any added denaturants).

Such term also includes an alcohol gallon equivalent of ethyl tertiary butyl ether or other ethers produced from such alcohol.

''(B) TAXABLE FUEL.—The term 'taxable fuel' has the meaning given such term by section 4083(a)(1).

''(5) TERMINATION.—This subsection shall not apply to any sale, use, or removal for any period after December 31, 2010.

''(c) BIODIESEL MIXTURE CREDIT.—

''(1) IN GENERAL.—For purposes of this section, the biodiesel mixture credit is the product of the applicable amount and the number of gallons of biodiesel used by the taxpayer in producing any biodiesel mixture for sale or use in a trade or business of the taxpayer.

''(2) APPLICABLE AMOUNT.—For purposes of this subsection—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the applicable amount is 50 cents.

''(B) AMOUNT FOR AGRI-BIODIESEL.—In the case of any biodiesel which is agri-biodiesel, the applicable amount is $1.00.

''(3) BIODIESEL MIXTURE.—For purposes of this section, the term 'biodiesel mixture' means a mixture of biodiesel and diesel fuel (as defined in section 4083(a)(3)), determined without regard to any use of kerosene, which—

''(A) is sold by the taxpayer producing such mixture to any person for use as a fuel,

''(B) is used as a fuel by the taxpayer producing such mixture, or

''(C) is removed from the refinery by a person producing such mixture.

''(4) CERTIFICATION FOR BIODIESEL.—No credit shall be allowed under this section unless the taxpayer obtains a certification (in such form and manner as prescribed by the Secretary) from the producer of the biodiesel which identifies the product produced and the percentage of biodiesel and agri-biodiesel in the product.

''(5) OTHER DEFINITIONS.—Any term used in this subsection which is also used in section 40A shall have the meaning given such term by section 40A.

''(6) TERMINATION.—This subsection shall not apply to any sale, use, or removal for any period after December 31, 2006.

''(d) MIXTURE NOT USED AS A FUEL, ETC.—

''(1) IMPOSITION OF TAX.—If—

''(A) any credit was determined under this section with respect to alcohol or biodiesel used in the production of any alcohol fuel mixture or biodiesel mixture, respectively, and

''(B) any person—

''(i) separates the alcohol or biodiesel from the mixture, or

''(ii) without separation, uses the mixture other than as a fuel,

then there is hereby imposed on such person a tax equal to the product of the applicable amount and the number of gallons of such alcohol or biodiesel.

''(2) APPLICABLE LAWS.—All provisions of law, including penalties, shall, insofar as applicable and not inconsistent with this section, apply in respect of any tax imposed under paragraph (1) as if such tax were imposed by section 4081 and not by this section.

''(e) COORDINATION WITH EXEMPTION FROM EXCISE TAX.—Rules similar to the rules under section 40(c) shall apply for purposes of this section.''.

(b) REGISTRATION REQUIREMENT.—Section 4101(a) of the Internal Revenue Code of 1986 (relating to registration) is amended by inserting ''and every person producing or importing biodiesel (as defined in section 40A(d)(1)) or alcohol (as defined in section 6426(b)(4)(A))'' after ''4081''.

(c) ADDITIONAL AMENDMENTS.—

(1) Section 40(c) of the Internal Revenue Code of 1986 is amended by striking ''section 4081(c), or section 4091(c)'' and inserting ''section 4091(c), section 6426, section 6427(e), or section 6427(f)''.

(2) Section 40(d)(4)(B) of such Code is amended by striking ''or 4081(c)''.

(3) Section 40(e)(1) of such Code is amended—

(A) by striking ''2007'' in subparagraph (A) and inserting ''2010'', and

(B) by striking ''2008'' in subparagraph (B) and inserting ''2011''.

(4) Section 40(h) of such Code is amended—

(A) by striking ''2007'' in paragraph (1) and inserting ''2010'', and

(B) by striking '', 2006, or 2007'' in the table contained in paragraph (2) and inserting ''through 2010''.

(5) Section 4041(b)(2)(B) of such Code is amended by striking ''a substance other than petroleum or natural gas'' and inserting ''coal (including peat)''.

(6) Paragraph (1) of section 4041(k) of such Code is amended to read as follows:

''(1) IN GENERAL.—Under regulations prescribed by the Secretary, in the case of the sale or use of any liquid at least 10 percent of which consists of alcohol (as defined in section 6426(b)(4)(A)), the rate of the tax imposed by subsection (c)(1) shall be the comparable rate under section 4091(c).''.

(7) Section 4081 of such Code is amended by striking subsection (c).

(8) Paragraph (2) of section 4083(a) of such Code is amended to read as follows:

''(2) GASOLINE.—The term 'gasoline'—

''(A) includes any gasoline blend, other than qualified methanol or ethanol fuel (as defined in section 4041(b)(2)(B)), partially exempt methanol or ethanol fuel (as defined in section 4041(m)(2)), or a denatured alcohol, and

''(B) includes, to the extent prescribed in regulations—

''(i) any gasoline blend stock, and

''(ii) any product commonly used as an additive in gasoline (other than alcohol).

For purposes of subparagraph (B)(i), the term 'gasoline blend stock' means any petroleum product component of gasoline.''.

(9) Section 6427 of such Code is amended by inserting after subsection (d) the following new subsection:

''(e) ALCOHOL OR BIODIESEL USED TO PRODUCE ALCOHOL FUEL AND BIODIESEL MIXTURES OR USED AS FUELS.—Except as provided in subsection (k)—

''(1) USED TO PRODUCE A MIXTURE.—If any person produces a mixture described in section 6426 in such person's trade or business, the Secretary shall pay (without interest) to such person an amount equal to the alcohol fuel mixture credit or the biodiesel mixture credit with respect to such mixture.

''(2) USED AS FUEL.—If alcohol (as defined in section 40(d)(1)) or biodiesel (as defined in section 40A(d)(1)) or agri-biodiesel (as defined in section 40A(d)(2)) which is not in a mixture described in section 6426—

''(A) is used by any person as a fuel in a trade or business, or

''(B) is sold by any person at retail to another person and placed in the fuel tank of such person's vehicle,

the Secretary shall pay (without interest) to such person an amount equal to the alcohol credit (as determined under section 40(b)(2)) or the biodiesel credit (as determined under section 40A(b)(2)) with respect to such fuel.

''(3) COORDINATION WITH OTHER REPAYMENT PROVISIONS.—No amount shall be payable under paragraph (1) with respect to any mixture with respect to which an amount is allowed as a credit under section 6426.

''(4) TERMINATION.—This subsection shall not apply with respect to—

''(A) any alcohol fuel mixture (as defined in section 6426(b)(3)) or alcohol (as so defined) sold or used after December 31, 2010, and

''(B) any biodiesel mixture (as defined in section 6426(c)(3)) or biodiesel (as so defined) or agri-biodiesel (as so defined) sold or used after December 31, 2006.''.

(10) Subsection (f) of section 6427 of such Code is amended to read as follows:

''(f) AVIATION FUEL USED TO PRODUCE CERTAIN ALCOHOL FUELS.—

''(1) IN GENERAL.—Except as provided in subsection (k), if any aviation fuel on which tax was imposed by section 4091 at the regular tax rate is used by any person in producing a mixture described in section 4091(c)(1)(A) which is sold or used in such person's trade or business, the Secretary

shall pay (without interest) to such person an amount equal to the excess of the regular tax rate over the incentive tax rate with respect to such fuel.

''(2) DEFINITIONS.—For purposes of paragraph (1)—

''(A) REGULAR TAX RATE.—The term 'regular tax rate' means the aggregate rate of tax imposed by section 4091 determined without regard to subsection (c) thereof.

''(B) INCENTIVE TAX RATE.—The term 'incentive tax rate' means the aggregate rate of tax imposed by section 4091 with respect to fuel described in subsection (c)(2) thereof.

''(3) COORDINATION WITH OTHER REPAYMENT PROVISIONS.—No amount shall be payable under paragraph (1) with respect to any aviation fuel with respect to which an amount is payable under subsection (d) or (l).

''(4) TERMINATION.—This subsection shall not apply with respect to any mixture sold or used after September 30, 2007.''.

(11) Paragraphs (1) and (2) of section 6427(i) of such Code are amended by inserting ''(f),'' after ''(d),''.

(12) Section 6427(i)(3) of such Code is amended—

(A) by striking ''subsection (f)'' both places it appears in subparagraph (A) and inserting ''subsection (e)(1)'',

(B) by striking ''gasoline, diesel fuel, or kerosene used to produce a qualified alcohol mixture (as defined in section 4081(c)(3))'' in subparagraph (A) and inserting ''a mixture described in section 6426'',

(C) by adding at the end of subparagraph (A) the following new flush sentence:

''In the case of an electronic claim, this subparagraph shall be applied without regard to clause (i).'',

(D) by striking ''subsection (f)(1)'' in subparagraph (B) and inserting ''subsection (e)(1)'',

(E) by striking ''20 days of the date of the filing of such claim'' in subparagraph (B) and inserting ''45 days of the date of the filing of such claim (20 days in the case of an electronic claim)'', and

(F) by striking ''ALCOHOL MIXTURE'' in the heading and inserting ''ALCOHOL FUEL AND BIODIESEL MIXTURE''.

(13) Section 6427(o) of such Code is amended—

(A) by striking paragraph (1) and inserting the following new paragraph:

''(1) any tax is imposed by section 4081, and'',

(B) by striking ''such gasohol'' in paragraph (2) and inserting ''the alcohol fuel mixture (as defined in section 6426(b)(3))'',

(C) by striking ''gasohol'' both places it appears in the matter following paragraph (2) and inserting ''alcohol fuel mixture'', and

(D) by striking ''GASOHOL'' in the heading and inserting ''ALCOHOL FUEL MIXTURE''.

(14) Section 9503(b)(1) of such Code is amended by adding at the end the following new flush sentence:

''For purposes of this paragraph, taxes received under sections 4041 and 4081 shall be determined without reduction for credits under section 6426.''.

(15) Section 9503(b)(4) of such Code is amended—

(A) by adding ''or'' at the end of subparagraph (C),

(B) by striking the comma at the end of subparagraph (D)(iii) and inserting a period, and

(C) by striking subparagraphs (E) and (F).

(16) Section 9503(c)(2)(A)(i)(III) of such Code is amended by inserting ''(other than subsection (e) thereof)'' after ''section 6427''.

(17) Section 9503(e)(2) of such Code is amended by striking subparagraph (B) and by redesignating subparagraphs (C), (D), and (E) as subparagraphs (B), (C), and (D), respectively.

(18) The table of sections for subchapter B of chapter 65 of such Code is amended by inserting after the item relating to section 6425 the following new item:

''Sec. 6426. Credit for alcohol fuel and biodiesel mixtures.''.

(19) TARIFF SCHEDULE.—Headings 9901.00.50 and 9901.00.52 of the Harmonized Tariff Schedule of the United States (19 U.S.C. 3007) are each amended in the effective period column by striking ''10/1/2007'' each place it appears and inserting ''1/1/2011''.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to fuel sold or used after September 30, 2004.

(2) REGISTRATION REQUIREMENT.—The amendment made by subsection (b) shall take effect on April 1, 2005.

(3) EXTENSION OF ALCOHOL FUELS CREDIT.—The amendments made by paragraphs (3), (4), and (19) of subsection (c) shall take effect on the date of the enactment of this Act.

(4) REPEAL OF GENERAL FUND RETENTION OF CERTAIN ALCOHOL FUELS TAXES.—The amendments made by subsection (c)(15) shall apply to fuel sold or used after September 30, 2003.

(e) FORMAT FOR FILING.—The Secretary of the Treasury shall describe the electronic format for filing claims described in section 6427(i)(3)(B) of the Internal Revenue Code of 1986 (as amended by subsection (c)(12)(C)) not later than September 30, 2004.

SEC. 4. BIODIESEL INCOME TAX CREDIT.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business related credits) is amended by inserting after section 40 the following new section:

''SEC. 40A. BIODIESEL USED AS FUEL.

''(a) GENERAL RULE.—For purposes of section 38, the biodiesel fuels credit determined under this section for the taxable year is an amount equal to the sum of—

''(1) the biodiesel mixture credit, plus

''(2) the biodiesel credit.

''(b) DEFINITION OF BIODIESEL MIXTURE CREDIT AND BIODIESEL CREDIT.—For purposes of this section—

''(1) BIODIESEL MIXTURE CREDIT.—

''(A) IN GENERAL.—The biodiesel mixture credit of any taxpayer for any taxable year is 50 cents for each gallon of biodiesel used by the taxpayer in the production of a qualified biodiesel mixture.

''(B) QUALIFIED BIODIESEL MIXTURE.—The term 'qualified biodiesel mixture' means a mixture of biodiesel and diesel fuel (as defined in section 4083(a)(3)), determined without regard to any use of kerosene, which—

''(i) is sold by the taxpayer producing such mixture to any person for use as a fuel, or

''(ii) is used as a fuel by the taxpayer producing such mixture.

''(C) SALE OR USE MUST BE IN TRADE OR BUSINESS, ETC.—Biodiesel used in the production of a qualified biodiesel mixture shall be taken into account—

''(i) only if the sale or use described in subparagraph (B) is in a trade or business of the taxpayer, and

''(ii) for the taxable year in which such sale or use occurs.

''(D) CASUAL OFF-FARM PRODUCTION NOT ELIGIBLE.—No credit shall be allowed under this section with respect to any casual off-farm production of a qualified biodiesel mixture.

''(2) BIODIESEL CREDIT.—

''(A) IN GENERAL.—The biodiesel credit of any taxpayer for any taxable year is 50 cents for each gallon of biodiesel which is not in a mixture with diesel fuel and which during the taxable year—

''(i) is used by the taxpayer as a fuel in a trade or business, or

''(ii) is sold by the taxpayer at retail to a person and placed in the fuel tank of such person's vehicle.

''(B) USER CREDIT NOT TO APPLY TO BIODIESEL SOLD AT RETAIL.—No credit shall be allowed under subparagraph (A)(i) with respect to any biodiesel which was sold in a retail sale described in subparagraph (A)(ii).

''(3) CREDIT FOR AGRI-BIODIESEL.—In the case of any biodiesel which is agri-biodiesel, paragraphs (1)(A) and (2)(A) shall be applied by substituting '$1.00' for '50 cents'.

''(4) CERTIFICATION FOR BIODIESEL.—No credit shall be allowed under this section unless the taxpayer obtains a certification (in such form and manner as prescribed by the Secretary) from the producer or importer of the biodiesel which identifies the product produced and the percentage of biodiesel and agri-biodiesel in the product.

''(c) COORDINATION WITH CREDIT AGAINST EXCISE TAX.—The amount of the credit determined under this section with respect to any biodiesel shall be properly reduced to take into account any benefit provided with respect to such biodiesel solely by reason of the application of section 6426 or 6427(e).

''(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) BIODIESEL.—The term 'biodiesel' means the monoalkyl esters of long chain fatty acids derived from plant or animal matter which meet—

''(A) the registration requirements for fuels and fuel additives established by the Environmental Protection Agency under section 211 of the Clean Air Act (42 U.S.C. 7545), and

''(B) the requirements of the American Society of Testing and Materials D6751.

''(2) AGRI-BIODIESEL.—The term 'agri-biodiesel' means biodiesel derived solely from virgin oils, including esters derived from virgin vegetable oils from corn, soybeans, sunflower seeds, cottonseeds, canola, crambe, rapeseeds, safflowers, flaxseeds, rice bran, and mustard seeds, and from animal fats.

''(3) MIXTURE OR BIODIESEL NOT USED AS A FUEL, ETC.—

''(A) MIXTURES.—If—

''(i) any credit was determined under this section with respect to biodiesel used in the production of any qualified biodiesel mixture, and

''(ii) any person—

''(I) separates the biodiesel from the mixture, or

''(II) without separation, uses the mixture other than as a fuel,

then there is hereby imposed on such person a tax equal to the product of the rate applicable under subsection (b)(1)(A) and the number of gallons of such biodiesel in such mixture.

''(B) BIODIESEL.—If—

''(i) any credit was determined under this section with respect to the retail sale of any biodiesel, and

''(ii) any person mixes such biodiesel or uses such biodiesel other than as a fuel,

then there is hereby imposed on such person a tax equal to the product of the rate applicable under subsection (b)(2)(A) and the number of gallons of such biodiesel.

''(C) APPLICABLE LAWS.—All provisions of law, including penalties, shall, insofar as applicable and not inconsistent with this section, apply in respect of any tax imposed under subparagraph (A) or (B) as if such tax were imposed by section 4081 and not by this chapter.

''(4) PASS-THRU IN THE CASE OF ESTATES AND TRUSTS.—Under regulations prescribed by the Secretary, rules similar to the rules of subsection (d) of section 52 shall apply.

''(e) TERMINATION.—This section shall not apply to any sale or use after December 31, 2006.''.

(b) CREDIT TREATED AS PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of the Internal Revenue Code of 1986 (relating to current year business credit) is amended by striking ''plus'' at the end of paragraph (14), by striking the period at the end of paragraph (15) and inserting '', plus'', and by adding at the end the following new paragraph:

''(16) the biodiesel fuels credit determined under section 40A(a).''.

(c) CONFORMING AMENDMENTS.—

(1) Section 39(d) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(11) NO CARRYBACK OF BIODIESEL FUELS CREDIT BEFORE EFFECTIVE DATE.—No portion of the unused business credit for any taxable year which is attributable to the biodiesel fuels credit determined under section 40A may be carried back to a taxable year ending on or before September 30, 2004.''.

(2)(A) Section 87 of such Code is amended to read as follows:

''SEC. 87. ALCOHOL AND BIODIESEL FUELS CREDITS.

''Gross income includes—

''(1) the amount of the alcohol fuels credit determined with respect to the taxpayer for the taxable year under section 40(a), and

''(2) the biodiesel fuels credit determined with respect to the taxpayer for the taxable year under section 40A(a).''.

(B) The item relating to section 87 in the table of sections for part II of subchapter B of chapter 1 of such Code is amended by striking ''fuel credit'' and inserting ''and biodiesel fuels credits''.

(3) Section 196(c) of such Code is amended by striking ''and'' at the end of paragraph (9), by striking the period at the end of paragraph (10) and inserting '', and'', and by adding at the end the following new paragraph:

''(11) the biodiesel fuels credit determined under section 40A(a).''.

(4) The table of sections for subpart D of part IV of subchapter A of chapter 1 of such Code is amended by adding after the item relating to section 40 the following new item:

''Sec. 40A. Biodiesel used as fuel.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to fuel produced, and sold or used, after September 30, 2004, in taxable years ending after such date.

NOTICES OF HEARINGS/MEETINGS

COMMITTEE ON INDIAN AFFAIRS

Mr. CAMPBELL. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on Wednesday, February 25, 2004, at 9:30 a.m. in Room 485 of the Russell Senate Office Building to conduct a hearing on the President's Fiscal Year 2005 Budget Request.

Those wishing additional information may contact the Indian Affairs Committee at 224–2251.

SUBCOMMITTEE ON PUBLIC LANDS AND FORESTS

Mr. CRAIG. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on Public Lands and Forests of the Committee on Energy and Natural Resources.

The hearing will be held on Wednesday, March 10th, at 2:30 p.m. in room SD–366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on the following bills: S. 1354, to resolve certain conveyances and provide for alternative land selections under the Alaska Native Claims Settlement Act related to Cape Fox Corporation and Sealaska Corporation, and for other purposes; S. 1575 and H.R. 1092, to direct the Secretary of Agriculture to sell certain parcels of Federal land in Carson City and Douglas County, Nevada; S. 1778, to authorize a land conveyance between the United States and the City of Craig, Alaska, and for other purposes; S. 1819 and H.R. 272, to direct the Secretary of Agriculture to convey certain land to Lander County, Nevada, and the Secretary of the Interior to convey certain land to Eureka County, Nevada, for continued use as cemeteries; and H.R. 3249, to extend the term of the Forest Counties Payments Committee.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send two copies of their testimony to the Committee on Energy and Natural Resources, United States Senate, Washington, D.C. 20510–6150.

For further information, please contact Frank Gladics at 202–224–2878.

COMMITTEE ON AGRICULTURE, NUTRITION AND FORESTRY

Mr. COCHRAN. Mr. President, I would like to announce that the Committee on Agriculture, Nutrition, and Forestry Subcommittee on Marketing, Inspection, and Product Promotion will meet on March 4, 2004 in SH–216, Hart Senate Office Building at 2:00 p.m. The purpose of this subcommittee hearing is to discuss the development of a national animal identification plan.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. MCCONNELL. 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, February 24, 2004, at 10 a.m. to conduct a hearing on the ''Proposals for Improving the Regulatory Regime of the Housing Government Sponsored Enterprises.''

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

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on Tuesday, February 24, 2004, at 9:30 a.m. on Voice-Over-Internet-Protocol (VOIP).

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Tuesday, February 24, 2004, at 10 a.m. to receive testimony concerning the reliability of the Nation's electricity grid. Specifically, the recommendations in the February 10th North American Reliability Council Report Regarding the August 14th blackout will be reviewed and implementation of the proposed solutions will be discussed.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Tuesday, February 24, 2004, at 2:30 p.m. to hold a hearing on The Middle East: Rethinking the Road Map.

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

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet on Tuesday, February 24, 2004, at 10 p.m. for a hearing titled ''Preserving a Strong United States Postal Service: Workforce Issues.''

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

COMMITTEE ON VETERANS' AFFAIRS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Veterans' Affairs be authorized to meet during the session of the Senate on Tuesday, February 24, 2004, for a joint hearing with the House of Representatives' Committee on Veterans' Affairs, to hear the legislative presentation of the Disabled American Veterans.

The hearing will take place in room 216 of the Hart Senate Office Building at 2:00 p.m.

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

SELECT COMMITTEE ON INTELLIGENCE

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Intelligence be authorized to meet during the session of the Senate on Tuesday, February 24, 2004, at 10 a.m. to hold a hearing on intelligence matters.

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

SELECT COMMITTEE ON INTELLIGENCE

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Tuesday, February 24, 2004, at 2:30 p.m. to hold a hearing on intelligence matters.

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

SPECIAL COMMITTEE ON AGING

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Special Committee on Aging be authorized to meet Tuesday, February 24, 2004 from 10:00 a.m.—12:00 p.m. in Dirksen 628 for the purpose of conducting a hearing.

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

COMMITTEE ON TERRORISM, TECHNOLOGY AND HOMELAND SECURITY

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on the Judiciary Subcommittee on Terrorism, Technology and Homeland Security be authorized to meet to conduct a hearing on ''Virtual Threat, Real Terror: Cyberterrorism in the 21st Century'' on Tuesday, February 24, 2004, at 10 a.m., in Dirksen 226.

Witness List

Panel I: Mr. John Malcolm, Deputy Assistant Attorney General, DOJ, Washington, DC; Mr. Keith Lourdeau, Deputy Assistant Director, FBI, Washington, DC; and Mr. Amit Yoran, director of the National Cybersecurity Division, DHS, Washington, DC.

Panel II: Mr. Dan Verton, Author, Burke, VA; Mr. Howard Schmidt, Chief Information Security Officer, EBay, San Jose, CA; and Mr. Michael Vatis, Executive Director, Task Force on National Security in the Information Age, New York, NY.

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

PRIVILEGES OF THE FLOOR

Mr. ENSIGN. Mr. President, I ask unanimous consent that Dr. Rita Redberg, a legislative fellow for Senator HATCH, be granted floor privileges during consideration of S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act.

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

Mr. DODD. Mr. President, I ask unanimous consent that privileges of the floor be granted to Lauren Doyle, a legislative fellow in my office.

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

Mr. HATCH. Mr. President, I ask unanimous consent that Patrick Shen and Brett Tolman, detailees on the Judiciary Committee staff, be granted the privileges of the floor for the duration of this session.

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

Mr. TALENT. Mr. President, I ask unanimous consent that one of my staffers, Telly Lovelace, be permitted the privilege of the floor for the rest of the afternoon.

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

COMMEMORATING 200TH ANNIVERSARY OF THE BIRTH OF CONSTANTINO BRUMIDI

AUTHORIZING PRINTING OF ''HISTORY OF THE UNITED STATES CAPITOL''

PERMITTING USE OF ROTUNDA OF THE CAPITOL FOR COMMEMORATION OF HOLOCAUST

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of the following resolutions which are at the desk en bloc: H. Con. Res. 264, H. Con. Res. 358, and H. Con. Res. 359.

The PRESIDING OFFICER. The clerk will report the concurrent resolutions by title.

The assistant legislative clerk read as follows:

A concurrent resolution (H. Con. Res. 264) authorizing and requesting the President to issue a proclamation to commemorate the 200th anniversary of the birth of Constantino Brumidi.

A concurrent resolution (H. Con. Res. 358) authorizing the printing of ''History of the United States Capitol'' as a House document.

A concurrent resolution (H. Con. Res. 359) permitting the use of the rotunda of the Capitol for a ceremony as part of the commemoration of the days of remembrance of victims of the Holocaust.

There being no objection, the Senate proceeded to consider the concurrent resolutions.

Mr. FRIST. Mr. President, I ask unanimous consent that the concurrent resolutions be agreed to, the preambles, where applicable, be agreed to, the motions to reconsider be laid upon the table en bloc, and any statements relating to the concurrent resolutions be printed in the RECORD.

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

The concurrent resolution (H. Con. Res. 264) was agreed to.

The preamble was agreed to.

The concurrent resolution (H. Con. Res. 358) was agreed to.

The concurrent resolution (H. Con. Res. 359) was agreed to.

MEASURE READ THE FIRST TIME—H.R. 3783

Mr. FRIST. Mr. President, I understand that H.R. 3783 which came over from the House is at the desk. I ask for its first reading.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 3783) to provide an extension of highway, highway safety, motor carrier safety, transit, and other programs funded out of the Highway Trust Fund pending enactment of a law reauthorizing the Transportation Equity Act for the 21st Century.

Mr. FRIST. I now ask for its second reading and object to further proceedings on this matter.

The PRESIDING OFFICER. Objection is heard.

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

Mr. FRIST. Yes.

Mr. REID. Mr. President, I know H.R. 3740 is an important piece of legislation. It extends the highway bill now in effect for 4 months. I have not spoken to Senator INHOFE today, but we have communicated through staff. He and I would rather have a 1-month extension. It is my understanding that the two leaders have met and think that 60 days would be an appropriate time. I want everybody to be on notice that if there is any effort to extend this beyond 60 days, I will do whatever I can to make sure that is not the case.

It is so important that we move this most important piece of legislation to 4 months, as there will be no bill this year. We have spent too much time over here. It now appears that the debate is over dollars. It is not about the content of the bill in any way.

I hope the two leaders understand the grief and difficulty that Senators INHOFE and I and KIT BOND and Senator JEFFORDS have gone through to get to the point where we are. I will agree with the decision of the two leaders, but when it comes back from the House, I hope there will be an agreement to split the difference after that.

Mr. FRIST. Mr. President, in all likelihood, we will be looking at 2 months. Again, for those listening now, a lot of people said 1 month. A lot of people said 4 months. A lot of people said a year. So this was negotiated again with both sides, and we understand the immediacy and the importance of this bill, which I do also strongly support.

ORDERS FOR WEDNESDAY, FEBRUARY 25, 2004

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m., Wednesday, February 25. I further ask that following the prayer and the pledge, the morning hour be deemed to have expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then resume consideration of the motion to proceed to S. 1805, the gun liability bill; provided that the time until 10:30 a.m. be equally divided between Senators CRAIG and REED of Rhode Island, or their designees, and the vote on the cloture motion occur at 10:30 a.m.

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

PROGRAM

Mr. FRIST. Mr. President, tomorrow the Senate will resume consideration of the motion to proceed to S. 1805, the gun liability bill. The cloture vote on the motion to proceed will occur at 10:30 a.m., and that will be the first vote of the day.

It is my hope that we will invoke cloture and begin consideration of the bill shortly thereafter. For the remainder of the day, we will work through amendments on the gun liability bill. Senators who wish to offer amendments should contact the managers to schedule time for floor consideration.

Senators should expect rollcall votes throughout the afternoon as we proceed in the amendment process.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. FRIST. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand adjourned under the previous order.

There being no objection, the Senate, at 6:45 p.m., adjourned until Wednesday, February 25, 2004, at 9:30 a.m.