that carries oxygen to the cells, is prevalent in African Americans. Sickle cell disease, the most severe variant of this condition, carries a significantly increased risk of disability and early death through a variety of infectious and thrombotic complications. Changes in lifestyle and compliance with regimens of preventive care, e.g. prophylactic antibiotic therapy, are easier for affected individuals to tolerate if they believe that the risks and benefits really apply to them.

Some might argue that diseases like these, though unquestionably worthy of public attention, represent a lesser national priority when compared to the other health care needs. In addition, other pressing domestic and international concerns—deficit reduction and national security—figure prominently, as they should, in the national debate. Wyoming has relatively few citizens at risk for some of the diseases I highlighted today, so most citizens of my state might, understandably, focus their thoughts elsewhere.

I think there are two reasons why they don't. The people of Wyoming take appropriate responsibility for one another's well-being. They lend a hand whenever help is necessary, not in the expectation that to do so will be of direct benefit to them, but because it is, simply, the right thing to do. There is a direct benefit, however, to be realized. Full implementation of the results of the human genome project will have a revolutionary impact on diseases that are of concern to all of us, in Wyoming and across the United States, regardless of our age, gender, or ethnicity. Already, experts recognize the practical and the potential applications of genetic research to the diagnosis and treatment of cancer—e.g., breast, colorectal and ovarian—heart disease, degenerative neurological disease—e.g., Alzheimer's and Parkinson's—diabetes, and asthma. No longer is it science fiction to anticipate that primary healthcare providers will, by combining environmental risk assessment and education with genetic evaluation, be able to develop, implement and monitor a comprehensive, life-long health plan that maximizes wellness.

Third, and, perhaps, most important of all, Americans must recognize that they have a civic responsibility not only to care for their own health, but to participate in the research yet to come that moves the science of healthcare forward for everyone. Those of us, including myself, who have contributed to this discussion over the last 9 years have all noted the remarkable ''explosion of knowledge'' and the ''great strides'' in healthcare that have resulted from research already performed. More importantly, though, we recognize that, while the science of human genomics has ushered in a new era of vast potential, that promise has not yet been fully realized. There is much that remains to be done to ''unleash the power'' of this science to change permanently the practice of healthcare for the better. Clinical trials are still necessary, to validate reasonable hypotheses and to determine where innovations should fit into practice. Once integrated, the actual effect of these innovations must be accurately and precisely assessed, recognizing that experience is the great teacher. We must work to foster a culture of enlightened self-interest in the American people, underscoring their altruistic motivation to do what's right. Finally, we have a responsibility to encourage our fellow citizens to participate fully in their own healthcare by working with their providers to incorporate advances in science into their personal health plans as quickly as possible.

Inherent in discharging this responsibility is the need to remove barriers to action. Thomas Jefferson said, ''Laws and institutions must go hand in hand with the progress of the human mind.'' No better example of this truism exists than the challenge we face in fulfilling, completely, the promise of the genomic revolution. Our objective is clear: to encourage people to seek genetic services, and to participate in essential genetic research, by reducing fears about misuse or unwarranted disclosure of genetic information.

I applaud my colleagues in voting for the Genetic Information Nondiscrimination Act of 2005.

The PRESIDING OFFICER (Mr. ISAKSON). The Senator from Oregon.

MORNING BUSINESS

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

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

PRESCRIPTION DRUG PRICES

Mr. WYDEN. Mr. President, getting a good deal for our senior citizens on prescription medicines is too important for word games. In the public debate over the prescription drug benefit, it is regrettable, because the administration seems to be confusing the matter of negotiation to get the seniors a good price with what constitutes price controls. This afternoon I would like to set the record straight.

First, I want to be clear: I am against price controls for this program. I am not in favor of mandating prices. I am against the whole concept. But what I have been talking about over the past 3 years, particularly with the bipartisan legislation I have with Senator SNOWE, is negotiating, which has Medicare sitting down and negotiating for the millions of older people who are going to be relying on this benefit in the years ahead.

If anybody is not sure what negotiating is, if anybody can't tell the difference between negotiation and price controls, I want to be specific about what constitutes negotiation. First, with negotiation, you simply sit down at the table. You say to the people you are negotiating with: I am one of your best customers. And third, you say: So, buddy, what are you going to do for me. And this, of course, is what goes on in the private sector in Minnesota, in Oregon, in Florida, every part of the country.

To tell the truth, I guess I have more faith in the folks over at Medicare than they do in themselves, because I noted that the Medicare chief actuary said yesterday this kind of negotiating power isn't going to do anything, isn't going to produce any savings, and talked about how this was going to lead to price controls and that sort of thing.

I happen to think that Medicare, through their talented folks, does have the ability to negotiate better prices, as does the private sector. But if they don't think they do, they can bring in some negotiators who make sure that the older people do get a good deal.

The story that has been trotted out in the last 24 hours is about previous and fruitless negotiations for other drugs. Cancer drugs have been cited, for example. I think that is comparing apples to oranges. There wasn't any negotiation in the past. Medicare paid up. Medicare paid up, and that was the end of it.

What I hope the Senate will see is that there is a real distinction between the kind of bargaining power Senator SNOWE and I want to see this program have at a critical juncture and the notion of price controls, which we do not support and oppose strongly.

It comes down to whether the Senate wants Medicare to be a smart shopper. I have said that Medicare purchasing of prescription drugs is like the fellow in Price Club buying toilet paper one roll at a time. Nobody would go out and do their shopping that way. Yet that is essentially what the country faces, if there are no changes at all.

One other point on this issue is also worth noting. Yesterday Secretary Leavitt came to the Finance Committee and was asked by me and Senator SNOWE and others about this question of how to contain costs for prescription drugs. The Secretary said he was hopeful that in July and August Senators and Members of Congress and others would go home and make the case to constituents this was a good program and that older people and their families would sign up for the benefit. I said to the Secretary during the course of questioning, as somebody who voted for the benefit, I hoped that was the case, that folks would sign up,

but that the big barrier to older people signing up is they were skeptical that the costs would be restrained. Older people were concerned about the costs of medicine in Georgia and Oregon and everywhere else.

The Secretary's comment was: Well, there are going to be plenty of private plans, and the private plans are going to hold the costs down.

My response was, I certainly hope that is the case. That was one of the reasons I felt it was important to get started with the program and why I voted for it. But I pointed out to the Secretary that may be the ideal, but what would be done in areas where there weren't a number of private plans and the opportunity to hold the costs down. That will certainly be the case in areas where there are what are called fallback plans. My guess is in rural Georgia and rural Oregon, we are going to see a number of those fallback plans because those are communities where you are not going to see multiple choices for the seniors. You will be lucky to have one plan, if there is to be any coverage for the older people.

What Senator SNOWE and I have said is that at a minimum, let's make sure in those areas where the older people don't have any bargaining power, it is possible for the Government to step in and make sure seniors and taxpayers can get the best possible deal on medicine.

In effect, what Senator SNOWE and I have been talking about is the position of Mr. Leavitt's predecessor, Secretary Thompson. At Secretary Thompson's last press conference he said, almost verbatim, that he wished the Congress had given him the power Senator SNOWE and I believe is important for this program.

In saying so, the Secretary made it clear, also, he was not for price controls; he wasn't interested in a one-size-fits-all approach to containing costs. He simply made clear that if it is apparent in a community that the older people won't have any bargaining power at all because choices are limited, the Secretary wanted essentially a kind of fallback authority, which would mean the Government at that point could make sure the older people and taxpayers were in a position to have some leverage in the marketplace.

I asked the Secretary why he disagreed with his predecessor. I asked specifically: Why do you see it differently than Secretary Thompson? Essentially, he said he simply believes in the marketplace, and there are going to be lots of choices. I hope he is right. I know he is certainly sincere in his views.

What I am concerned about is, I think it is going to be very hard for the Senator from Georgia and other colleagues to go home in July and August and get the older people to sign up for this program if they don't see this body is taking additional bipartisan steps to control costs. The older people are reading the newspaper and walking into their pharmacies, and they are seeing what is going on.

Regrettably, the cost of the program has continued to go up. We can debate how much it has gone up. I am not interested in some kind of partisan wrangle on it. But the cost of the benefit has gone up. And the number of seniors who have signed up for the first part of the benefit was really very low. So what this has created is a situation for the prescription drug benefit, where there is a real likelihood that a huge amount of Government money will be spent on a very small number of people. That is not a prescription for the survival of the program. Certainly, as somebody who voted for the program, I want to see it survive. So I will keep up my end of the bargain. I will keep working on a bipartisan basis.

I want to express my continued interest in working with the Bush administration to save this prescription drug benefit that we worked so hard to get off the ground. We need to have an honest conversation about how to do it. I don't think that conversation is helped by this confusion about what is the difference between negotiating—which I and Senator SMITH and Senator SNOWE have advocated—what goes on in the private sector and what constitutes price controls. Senator SNOWE and I want to be for what goes on in the private sector. We are against price controls.

This will certainly not be the last time this topic is discussed on the floor of the Senate. It certainly won't be the last time that I discuss it. I am glad to have the chance to take a few minutes to set the record straight because I think there was needless confusion on this point in the last 24 hours. I think the remarks of the Medicare chief actuary were unfortunate. I guess I have more faith in the folks at Medicare to be able to negotiate good deals than they apparently do in themselves. I simply urge that there be a continued focus on this program during this crucial month, where it is going to be important to get older people to sign up. The key to getting them to sign up will be to hold down the cost.

I yield the floor and 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. FRIST. I ask unanimous consent that the order for the quorum call be rescinded.

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

FIRST RESPONDERS

Mr. FRIST. Mr. President, my first statement refers to first responders and the tremendous progress made over the last several years in addressing responses to emergencies of all types. On Tuesday, the director of the Tennessee Emergency Management Agency came to Washington to brief me and the entire Tennessee delegation on our State's homeland security needs. It was fitting, I was thinking at the time, for him to be here on the day that we voted on the nomination of Judge Michael Chertoff.

It has been 3½ years since we were attacked on September 11. Since then we have taken significant steps to strengthen and improve in so many ways our homeland security, from information and technology to training and to overall preparedness. The Department of Homeland Security was established in March of 2003 and has been central in overseeing and coordinating all of these efforts. It is a huge job. I applaud Secretary Tom Ridge for his skillful leadership during those very uncertain times.

Since the September 11 tragedy, we have taken a number of steps. We hardened cockpit doors on 100 percent of large passenger aircraft; 100 percent of all baggage is screened. We have deployed thousands of Federal air marshals and professionally trained screeners at our ports. We now screen 100 percent of high-risk cargo. We have also launched the US VISIT system which creates a database of pictures and finger scans of everyone entering the United States with a nonimmigrant visa. All of these preventive measures, along with many others, are indeed making America safer and more secure.

September 11 taught us that the front lines of a catastrophic terror attack are not here or in policy but are local, in communities all across this country. It is the folks in our fire departments, in our police stations, in our emergency rooms, and in the volunteer corps. It is the brave men and women who rush to an attack site with almost superhuman stamina and compassion, working to save their fellow citizens.

I am reminded of the Memphis and Shelby County Urban Search and Rescue Task Force that traveled to Washington to help at the Pentagon after September 11. All airplanes were shut down. The team loaded two tractor trailers, three buses, and a few cars, and drove all through the night from Tennessee until they arrived early in the morning of September 12th. It was a team of firefighters, doctors, nurses, computer technicians, and rescue dog handlers who worked 12-hour back-breaking shifts every day for days—believe it was a total of 8 days—to help secure the Pentagon's structure and save lives.

Two or three days after September 11, I had the opportunity to go and visit with this rescue task force and to