

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 Non-discrimination 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,