S. 3519

At the request of Mr. HATCH, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. 3519, a bill to reform the State inspection of meat and poultry in the United States, and for other purposes.

S. 3609

At the request of Mrs. LINCOLN, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 3609, a bill to amend title XVIII of the Social Security Act to provide for the treatment of certain physician pathology services under the Medicare program.

S. 3628

At the request of Ms. SNOWE, the name of the Senator from Pennsylvania (Mr. SANTORUM) was added as a cosponsor of S. 3628, a bill to amend the Internal Revenue Code of 1986 to improve and extend certain energy-related tax provisions, and for other purposes.

S. 3705

At the request of Mr. KENNEDY, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 3705, a bill to amend title XIX of the Social Security Act to improve requirements under the Medicaid program for items and services furnished in or through an educational program or setting to children, including children with developmental, physical, or mental health needs, and for other purposes.

S. 3744

At the request of Mr. DURBIN, the name of the Senator from South Carolina (Mr. GRAHAM) was added as a cosponsor of S. 3744, a bill to establish the Abraham Lincoln Study Abroad Program.

S. 3771

At the request of Mr. HATCH, the names of the Senator from Indiana (Mr. LUGAR), the Senator from Virginia (Mr. WARNER), the Senator from Virginia (Mr. ALLEN), and the Senator from Idaho (Mr. CRAIG) were added as cosponsors of S. 3771, a bill to amend the Public Health Service Act to provide additional authorizations of appropriations for the health centers program under section 330 of such Act.

AMENDMENT NO. 4923

At the request of Mr. ISAKSON, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of amendment No. 4923 proposed to H.R. 4954, a bill to improve maritime and cargo security through enhanced layered defenses, and for other purposes.

AMENDMENT NO. 4945

At the request of Mr. NELSON of Nebraska, the names of the Senator from Louisiana (Ms. LANDRIEU) and the Senator from Iowa (Mr. HARKIN) were added as cosponsors of amendment No. 4945 proposed to H.R. 4954, a bill to improve maritime and cargo security through enhanced layered defenses, and for other purposes.

AMENDMENT NO. 5003

At the request of Mr. BAUCUS, the names of the Senator from Illinois (Mr. DURBIN), the Senator from Oregon (Mr. WYDEN), the Senator from Delaware (Mr. BIDEN), the Senator from New Jersey (Mr. LAUTENBERG), the Senator from Nebraska (Mr. NELSON), the Senator from North Dakota (Mr. CONRAD), the Senator from Maryland (Mr. SARBANES), the Senator from Vermont (Mr. LEAHY), and the Senator from West Virginia (Mr. BYRD) were added as cosponsors of amendment No. 5003 intended to be proposed to H.R. 4096, a bill to amend the Internal Revenue Code of 1986 to extend to 2006 the alternative minimum tax relief available in 2005 and to index such relief for inflation.

AMENDMENT NO. 5004

At the request of Mr. BAUCUS, the names of the Senator from Illinois (Mr. DURBIN), the Senator from Oregon (Mr. WYDEN), the Senator from Delaware (Mr. BIDEN), the Senator from New Jersey (Mr. LAUTENBERG), the Senator from Nebraska (Mr. NELSON), the Senator from North Dakota (Mr. CONRAD), the Senator from Maryland (Mr. SARBANES), the Senator from Vermont (Mr. LEAHY), and the Senator from West Virginia (Mr. BYRD) were added as cosponsors of amendment No. 5004 intended to be proposed to H.R. 4096, a bill to amend the Internal Revenue Code of 1986 to extend to 2006 the alternative minimum tax relief available in 2005 and to index such relief for inflation.

AMENDMENT NO. 5005

At the request of Mr. ROCKEFELLER, his name was added as a cosponsor of amendment No. 5005 intended to be proposed to H.R. 4954, a bill to improve maritime and cargo security through enhanced layered defenses, and for other purposes.

At the request of Mr. LEVIN, his name was added as a cosponsor of amendment No. 5005 intended to be proposed to H.R. 4954, supra.

At the request of Mr. MENENDEZ, his name was added as a cosponsor of amendment No. 5005 intended to be proposed to H.R. 4954, supra.

At the request of Ms. MIKULSKI, her name was added as a cosponsor of amendment No. 5005 intended to be proposed to H.R. 4954, supra.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. FRIST (for himself, Mr. MCCAIN, and Mrs. HUTCHISON):

S. 3892. A bill to reduce the number of deaths along the border between the United States and Mexico by improving the placement of rescue beacons, and for other purposes; to the Committee on the Judiciary.

Mr. FRIST. Mr. President, one cold May morning earlier this year, a Border Patrol agent found the body of a 3-year-old boy in a blue windbreaker, his arms crossed. He had died trying to cross our southern border, the youngest victim our borders have claimed this year.

The boy's mother's name is Edith Rodriguez. She is 25 years old. She attempted to cross the border illegally, in hopes that she might escape the desperate poverty of her home state of Veracruz, Mexico. Edith hired a human smuggler—a coyote.

The coyote gave his charges an illegal drug, ephedrine, to help them keep awake and moving. But Edith and her son still could not keep up with the group. So the coyote, in a cruel and heartless act, abandoned them in the desert. Alone. With no food and little water, with a dangerous drug coursing through his system, exposed to the elements—Edith Rodriguez's little boy died.

Edith Rodriguez violated the laws of the United States when she crossed the border illegally. She was wrong to violate our border. But all should agree that her son did not deserve to die.

Here are the facts: Every 18½ hours, someone dies trying to cross the border between the United States and Mexico. About a year ago, I asked the Government Accountability Office to study the deaths that take place along America's borders.

Today, my office released that study. The results are sobering, shocking, and, I strongly believe, a cause for action. Since 1995, deaths along our borders have doubled. Despite the heroic rescue efforts of the men and women of Customs and Border Protection, things have gotten worse. In 1995, 266 people died trying to cross our borders. Last year, 427 perished.

The increases, it appears, stem largely from an increase in deaths from exposure to the elements in the Sonoran Desert in Arizona. Illegal entries, however, have not increased. Quite frankly, it is getting more dangerous to cross our border.

Until recently, CBP did not even keep a systematic count of those who died crossing our borders. We still do not have a unified national strategy for reducing the deaths. We still do not know how well our safety efforts work—if they are saving lives or not. We need to do more.

The founding document of our Nation, the Declaration of Independence, lists ''life'' first on the list of Government's responsibilities. The overwhelming majority of the people who cross our border do so in search of a better life. They take enormous risks and make enormous investments in hopes of helping their families.

Illegal immigration needs to stop. We must defend our borders. We must construct physical barriers, add detention

beds, hire personnel, and equip them with better technology. But we have a higher moral obligation to protect the life of every person—every man, woman, and child—who sets foot on American soil. We must do everything in our power to preserve life.

That is why I propose the Border Death Reduction Act. I urge my colleagues to support it.

The law will implement the GAO's recommendations. It will require CBP to create a strategy for reducing border deaths. It will mandate a full count of deaths along the border. It will impose tough, new penalties on coyotes who abandon their charges, and it will expand the network of rescue beacons that people in trouble can use to call for help.

These beacons, I believe, are an absolutely vital link in our border security system. Let me explain. Rescue beacons are devices at prominent locations that individuals can activate when they need help. They are tall polls with lights at the top and radio transmitters inside. People in trouble can activate a beacon to let CBP know that they need help. We know that beacons work: CBP has already saved dozens of people based entirely on beacon alerts.

But individuals who activate beacons do not get a free pass. They will, of course, receive necessary medical treatment. But rescued individuals will still be detained and deported like anyone else who violates our borders.

Deploying more beacons in the desert will save lives in the desert and simultaneously improve the security of our frontiers.

We cannot delay. We should not rest. We must protect the lives of all those who set foot upon our soil. I urge my colleagues to support the Border Death Reduction Act.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 3892

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 ''Border Death Reduction Act of 2006''.

SEC. 2. DEFINITION OF A RESCUE BEACON.

In this Act, the term ''rescue beacon'' means a clearly visible device with an internal power source that is placed in an area likely to experience extreme weather, that contains instructions for its use, and by means of lights, radio signals, and other means, allows individuals to alert the United States Customs and Border Protection of their presence.

SEC. 3. COLLECTION OF STATISTICS.

(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Commissioner of Customs shall begin collecting data relevant to deaths occurring at the border between the United States and Mexico, divided by sector, and including—

(1) the causes of the deaths;

(2) the total number of deaths;

(3) the location of deaths; and

(4) demographic characteristics, including the sex and approximate age of those deceased.

(b) DEVELOPMENT OF PROTOCOLS.—The Commissioner of Customs shall develop consistent, formal, written protocols for the collection of data described in subsection (a).

SEC. 4. ANNUAL REPORT ON BORDER DEATHS.

Not later than 1 year after the date of the enactment of this Act, and annually thereafter, the Commissioner of Customs shall submit to the Secretary of Homeland Security a report that contains—

(1) an analysis of trends with respect to the statistics collected under section (3)(a)(1) during the preceding year;

(2) an evaluation, using multivariate statistical approaches, of the Border Safety Initiative, including any rescue beacons deployed, and any successor program designed to reduce deaths along the border described in section 3(a); and

(3) recommendations of particular actions to reduce the deaths described in section 3(a).

SEC. 5. REPORT ON BEACON PLACEMENT.

(a) REPORT REQUIRED.—Not later than 6 months after the date of the enactment of this Act, the Commissioner of Customs shall submit to the Secretary of Homeland Security a report on enhancing the deployment of rescue beacons.

(b) FOCUS OF REPORT.—Such report shall contain particular emphasis on enhancing the deployment of rescue beacons in the Tucson Sector.

(c) CONTENTS OF REPORT.—The report required by subsection (a) shall include—

(1) an assessment of the efficacy of the deployment of rescue beacons in light of the statistics gathered under section 3, including analysis of the locations of deaths recorded and areas frequented by illegal migrants; and

(2) recommendations on where additional rescue beacons should be placed to reduce the number of deaths in the area described by section 3 and section 5(b).

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $500,000 to carry out the provisions of this section.

SEC. 6. DEPLOYMENT OF ENHANCED BEACON NETWORK.

(a) DEPLOYMENT OF RESCUE BEACONS.—Not later than 1 year after the date of the enactment of this Act, the Commissioner of Customs shall deploy additional rescue beacons in all areas recommended in the report required by section 5.

(b) GUIDELINES FOR PLACEMENT OF RESCUE BEACONS.—Not later than 1 year after the date of the enactment of this Act, the Commissioner of Customs shall issue to all sector chiefs formal, written guidelines for the ongoing placement and removal of rescue beacons and the appropriate response to the activation of such beacons.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,500,000 to carry out the provisions of this section.

SEC. 7. PROHIBITION ON ABANDONMENT OF ALIENS IN A BORDER ZONE.

(a) IN GENERAL.—Any person who commits an act described in section 274(a)(1)(A) of the Immigration and Nationality Act (8 U.S.C. 1324(a)(1)(A)) and abandons an alien with respect to that act in a place not within sight of a paved road or rescue beacon, shall be considered to have placed in jeopardy the life of a person as described in section 274(a)(1)(B)(iii) of such Act (8 U.S.C. 1324(a)(1)(B)(iii)).

(b) CONSTRUCTION.—Nothing in this section shall be construed to prohibit any person from being held in violation of section 274(a)(1)(B)(iii) of such Act (8 U.S.C. 1324 (B)(iii)).

By Ms. STABENOW (for herself and Mr. LEVIN):

S. 3896. A bill to provide for the return of the Fresnel Lens to the lantern room atop Presque Isle Light Station Lighthouse, Michigan, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Ms. STABENOW. Mr. President, I rise today to offer the Lester Nichols Presque Isle Light Station Act with my colleague, Senator LEVIN. Congressman STUPAK is introducing the companion legislation in the House of Representatives today. Our bill will restore the historic Fresnel lens to the Presque Isle lighthouse in Presque Isle Township, MI.

Michigan has the most lighthouses of any State in the Nation with a total of over 120. At one time we had over 100 manned lighthouses, more than any other State. This is not surprising considering that Michigan has 3,288 miles of shoreline along the Great Lakes. We are proud of our lighthouses and we are proud of the history and the maritime heritage that they represent. Our lighthouses are part of our identity as a State. In addition to performing as navigation aids, they remain a symbol of the importance that the Great Lakes played and continue to play in Michigan's history.

Most importantly, they are an important part of the economies of our coastal towns. Our lakeshore towns host visitors from across the country who travel to view the magnificence of our coastal areas and the lighthouses that illuminate them. These small communities are more dependent than ever on tourism dollars, and we must help them by coordinating our efforts to protect Michigan's lighthouses and promote Great Lakes' maritime culture.

In 2002 the U.S. Coast Guard, the Michigan State Historic Preservation Officer, and the township signed a memorandum of agreement stating that upon removal from the tower, the Fresnel lens would be restored by the township in a museum type setting with assistance from the Coast Guard. In 2005, the township completed their restoration work on the lens. Unfortunately, we soon learned that the Coast Guard has another policy that prevents a Fresnel lens from being replaced once it is removed from the tower.

The result is that this lighthouse has been historically compromised. Replacing the lens in its original home for the enjoyment of all who visit our historic lighthouse will not only ensure the integrity of the lighthouse, but it will enhance the function the lighthouse provides as an active navigational aid.

Very simply, our bill requires the Coast Guard to replace the restored Fresnel lens in the Presque Isle Lighthouse.

Our bill is named after Les Nichols, who through years of hard work and perseverance has led the successful effort in the restoration of the historic 3rd Order Fresnel Lens. The Fresnel lens is an integral part of the historic value of the New Presque Isle Lighthouse and will continue to attract tourists to this region of the State. Under Lester's leadership, this historic artifact will now be able to be viewed by future generations. I also want to acknowledge the work of Peter Pettalia, the Presque Isle Township Supervisor.

I hope that all of my colleagues will support this legislation and that we can move it quickly in the remaining time we have in the Senate.

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. 3896

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 ''Lester Nichols Presque Isle Light Station Act of 2006''.

SEC. 2. RETURN OF FRESNEL LENS TO PRESQUE ISLE LIGHT STATION LIGHTHOUSE, MICHIGAN.

(a) IN GENERAL.—Subject to subsection (b), the Commandant of the Coast Guard shall modify the 2004 Agreement for Outgoing Loans (AOL) with Presque Isle Township, Michigan, in order to provide for the return of the Historic Fresnel Lens to the lantern room atop the Presque Isle Light Station Lighthouse, Michigan.

(b) CONDITIONS.—

(1) COMPLIANCE WITH APPLICABLE LAW.—Any modification under subsection (a) of the Agreement for Outgoing Loans described in that subsection shall comply with applicable provisions of section 5506 of the Omnibus Consolidated Appropriations Act, 1997 (Public Law 104–208; 110 Stat. 3009–518), relating to the conveyance of the Presque Isle Light Station.

(2) RETENTION OF OWNERSHIP OF LENS.—Notwithstanding the return of the Historic Fresnel Lens pursuant to subsection (a), the United States shall retain ownership of the lens.

(3) CONTINUING OPERATION OF AID TO NAVIGATION.—Notwithstanding the return of the Historic Fresnel Lens pursuant to subsection (a), the active aid to navigation, together with associated electronic and lighthouse equipment, at Presque Isle Light Station Lighthouse shall continue to be operated and maintained by the United States within the Historic Third Order Fresnel Lens at the Presque Isle Light Station Lighthouse.

By Mr. GRASSLEY (for himself and Mr. BAUCUS):

S. 3897. A bill to amend titles XI and XVIII of the Social Security Act to provide for the sharing of certain data collected by the Centers for Medicare & Medicaid Services with certain agencies, research centers and organizations, and congressional support agencies; from the Committee on Finance; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, I am pleased to join my colleague from Montana, Senator BAUCUS, in introducing the Medicare Data Access and Research Act. Senator BAUCUS and I have long enjoyed a good working relationship in our roles as chairman and ranking member of the Finance Committee. Our work on this bill once again demonstrates our commitment to working in a bipartisan manner.

The Medicare Data Access and Research Act establishes a process through which Federal agencies and other researchers can access Medicare data for the purpose of health services research. This might seem like a pretty mundane issue to some people, but I can assure you that it is far from it. Medicare processes 500 million claims for benefits each year; millions of prescriptions have been filled under the new Medicare prescription drug benefit.

Linking data on hospital and physician services provided to Medicare beneficiaries to prescription drug data will offer a tremendous resource for researchers in our Federal agencies, as well as those based at universities and other research centers. What of research can these data support? They can support studies and analyses related to postmarketing surveillance of prescription drugs and research on drug safety. More concretely, analyzing the Medicare claims data can help agencies, such as the Food and Drug Administration FDA, identify situations like the one involving Vioxx more quickly, and provide a new valuable tool to enable the FDA to take swifter action to protect the public's health and well-being.

The Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, and the National Institutes of Health all have missions that require the conduct of meticulous health services research. The Medicare database and access to it established under the bill we are introducing today will help these agencies fulfill their missions to study immunization rates; to develop and monitor the use of preventive screenings; conduct research on the clinical comparative effectiveness of prescription drugs; and to help prevent, diagnose, and treat disease.

To ensure access to the data, the bill requires the Secretary of Health and Human Services to enter data release agreements on an annual basis with these agencies. In entering the data release agreements, the Secretary must take appropriate steps to protect the confidentiality of the information, while maintaining the ability of researchers at Federal agencies to conduct meaningful analyses.

The bill also permits the Secretary to enter into data use agreements to permit researchers at universities and other organizations to have access to the data. As will be the case for the Federal agencies, these researchers may only use the data for purposes of advancing the public's health. They can conduct studies on the safety, effectiveness, and quality of health services.

Some people might be concerned that these data will be given to just anyone. That is not the case. In applying for data access, researchers at universities and other organizations will have to meet strict criteria. They must have well-documented experience in analyzing the type and volume of data to be provided under the agreement. They must agree to publish and publicly disseminate their research methodology and results. They must obtain approval for their study from a review board. They must comply with all safeguards established by the Secretary to ensure the confidentiality of information. These safeguards cannot permit the disclosure of information to an extent greater than permitted by the Health Insurance Portability and Accountability Act of 1996 and the Privacy Act of 1974.

The final section of the bill ensures that congressional support agencies, including the Congressional Budget Office, the Congressional Research Service, the Government Accountability Office, and the Medicare Payment Advisory Commission, also have access to data they need to carry out their functions and responsibilities. This body depends on the research and analyses conducted by those agencies to inform our deliberations and decisions on the Medicare Program.

Last year, Senator BAUCUS and I introduced the Medicare Value-Based Purchasing Act to establish a pay for performance system under Medicare. That bill was aimed at promoting quality and ensuring value under the Medicare Program. The bill that we are introducing today complements that objective. How can we promote quality and ensure value in Medicare? By having a better understanding of what services are effective, by knowing how we can help beneficiaries avoid illness and disease, by having insight about potential over-use and under-use of health care services, and by identifying troubling trends and patterns. How can we learn about those topics? By supporting rigorous health services research.

Mr. President, the Medicare Data Access and Research Act creates a sound framework for accomplishing that objective.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 3897

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 ''Medicare Data Access and Research Act''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The new Medicare drug benefit under part D of title XVIII of the Social Security Act is delivered through private prescription drug plans. Private plans submit administrative and beneficiary level data to the Centers for Medicare & Medicaid Services as a condition of participation and payment in the new Medicare drug program.

(2) Data from the new Medicare drug benefit can be linked with hospital, ambulatory care, and other data to create a new comprehensive resource for the study of drug safety and effectiveness of medical care in older adults and low-income, disabled, and vulnerable populations. With appropriate protections for privacy, this data should be available to the Food and Drug Administration, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, and the National Institutes of Health, and university-based research centers and other research organizations interested in furthering the public health through research on the safety, effectiveness, and quality of health care services provided under the Medicare program under title XVIII of the Social Security Act.

(3) Timely and ready access to certain data from the new Medicare drug benefit will allow congressional support agencies to inform and advise Congress on the cost, scope, and impact of the new benefit and assess its quality.

SEC. 3. DRUG AND HEALTH CARE DATA RELEASE.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1121 the following new sections:

''DRUG AND HEALTH CARE CLAIMS DATA RELEASE

''SEC. 1121A. (a) IN GENERAL.—Notwithstanding any provision under part D of title XVIII that limits the use of prescription drug data collected under such part, for the purpose of improving the public's health, the Secretary, acting through the Centers for Medicare & Medicaid Services, shall—

''(1) enter into data release agreements on an annual basis with the agencies described in subsection (b) to provide access to relevant data submitted by prescription drug plans and MA–PD plans under part D of title XVIII, excluding negotiated price concessions under such part (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations), and linked to hospital, physician, and other relevant medical claims, utilization, and diagnostic data collected under titles XVIII and XIX, including data from the uniform reporting systems established under section 1121(a); and

''(2) permit agencies described in such subsection to link data provided under this section with other relevant health data, including survey data, vital statistics, and disease registries, as needed by the agency in order to accomplish its research objectives.

''(b) AGENCIES DESCRIBED.—The agencies described in this subsection are as follows:

''(1) The Food and Drug Administration.

''(2) The Centers for Disease Control and Prevention.

''(3) The Agency for Healthcare Research and Quality.

''(4) The National Institutes of Health.

''(c) USE OF THE DATA PROVIDED.—Data provided under a data release agreement under subsection (a)(1) shall only be used for the following purposes:

''(1) FDA.—In the case of the Food and Drug Administration, to enhance post marketing surveillance by—

''(A) studying patterns of drug and vaccine utilization over time after a drug has been placed on the market;

''(B) studying health risks associated with such utilization, particularly with respect to improving the speed of risk identification in order to mitigate or resolve such risks;

''(C) studying drug utilization in order to promote consumer education that would allow consumers and health care providers to make informed product choices and informed drug compliance choices; and

''(D) performing such other functions, consistent with the purposes of this section and the Agency's mission, as are determined appropriate by the Secretary.

''(2) CDC.—In the case of the Centers for Disease Control and Prevention, to—

''(A) improve surveillance of clinical outbreaks and emerging threats;

''(B) study immunization rates;

''(C) study outcomes of specific diseases;

''(D) develop and monitor the use of preventive screening protocols using claims data;

''(E) study drug and medical utilization in order to promote consumer education and treatment for specific public health risks; and

''(F) perform such other functions, consistent with the purposes of this section and the Agency's mission, as are determined appropriate by the Secretary.

''(3) AHRQ.—In the case of the Agency for Healthcare Research and Quality, to—

''(A) carry out the Agency's research obligations under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003;

''(B) conduct research consistent with the Agency's mission to improve the quality, safety, efficiency, and effectiveness of health care; and

''(C) perform such other functions, consistent with the purposes of this section and such mission, as are determined appropriate by the Secretary.

''(4) NIH.—In the case of the National Institutes of Health, to—

''(A) help prevent, detect, diagnose, and treat disease and disabilities; and

''(B) perform such other functions, consistent with the purposes of this section and the Agency's mission, as are determined appropriate by the Secretary.

''(d) TIMEFRAME FOR DATA RELEASE.—A data release agreement entered into under this section shall provide for the release of information as needed by the Agency for the uses described in subsection (c).

''(e) DATA RELEASE PROCEDURES.—

''(1) DETERMINING APPROPRIATE LEVEL AND ELEMENTS OF DATA FOR RELEASE.—

''(A) IN GENERAL.—The Secretary shall establish a process to determine the appropriate level and elements of data to be released to an Agency under this section in order to ensure that the Agency, and researchers within the Agency, are able to conduct meaningful analyses while maintaining the confidentiality of the data provided under the data release agreement.

''(B) RELATIONSHIP TO PROCEDURES FOR RELEASE TO PRIVATE RESEARCHERS.—The process established under subparagraph (A) may be analogous to the process used by the Centers for Medicare & Medicaid Services for the release of data to private researchers.

''(2) AGENCY FEEDBACK ON ANALYSES CONDUCTED.—The Secretary shall establish a process for Agencies that are provided data under a data release agreement under this section to provide the results of the analyses conducted using such data to the Centers for Medicare & Medicaid Services for use in the administration and assessment of programs administered by the Centers for Medicare & Medicaid Services, including the program under part D of title XVIII.

''(3) REVIEW OF DATA PROCEDURES.—The Secretary shall establish a process to review and update the following:

''(A) The processes established under paragraphs (1)(A) and (2).

''(B) Procedures for transmission and retention of data released under this section.

''(f) NOTIFICATION OF INACCURACIES DISCOVERED IN DATA PROVIDED.—The Secretary shall establish procedures to ensure that an Agency that is provided data under this section notifies the Secretary of any inaccuracies discovered in the data by the Agency within a reasonable time of such discovery.

''(g) REPORT.—The Secretary shall include (beginning with 2007), as part of the annual report submitted to Congress under section 1875(b), an evaluation of the data release agreements entered into under subsection (a)(1), including a description of the reports and analyses conducted by agencies using data provided under such an agreement.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the purposes of this section.

''RESEARCH CENTER AND ORGANIZATION DRUG AND HEALTH CARE DATA USE

''SEC. 1121B. (a) IN GENERAL.—Notwithstanding any provision under part D of title XVIII that limits the use of prescription drug data collected under such part, for the purpose of improving the public's health, the Secretary shall—

''(1) enter into data use agreements with the research centers and organizations described in subsection (b) to provide access to relevant data submitted by prescription drug plans and MA–PD plans under part D of title XVIII, excluding negotiated price concessions under such part (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations), and linked to hospital, physician, and other relevant medical claims, utilization, and diagnostic data collected under titles XVIII and XIX, including data from the uniform reporting systems established under section 1121(a);

''(2) permit research centers and organizations described in such subsection to link data provided under this section with other relevant health data, including survey data, vital statistics, and disease registries, as needed by the research center or organization in order to accomplish its research objectives; and

''(3) prepare the linked sets of data described in paragraph (1) for release not later than July 1, 2007.

''(b) RESEARCH CENTERS AND ORGANIZATIONS DESCRIBED.—The research centers and organizations described in this subsection are as follows:

''(1) A University-based research center.

''(2) Any other research center or organization—

''(A) whose primary mission is to conduct public health research; and

''(B) which the Secretary determines can appropriately conduct analyses consistent with the purposes of this section.

''(c) USE OF DATA AND PENALTIES.—

''(1) USE OF DATA.—

''(A) IN GENERAL.—Data provided to a research center or organization under a data use agreement under this section shall be used solely for purposes of research on the safety, effectiveness, and quality of, disparities in, and related aspects of health care use by individuals entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of such title, conducted for the purpose of developing and providing generalizable knowledge to inform the public health through scientific publication and other forms of public dissemination.

''(B) APPROVAL BY REVIEW BOARD FOR THE PROTECTION OF HUMAN SUBJECTS.—Such use shall be approved by a review board for the protection of human subjects.

''(C) REVIEW PROCESS.—The Secretary shall establish a review process to ensure that—

''(i) data use agreements under this section include a detailed description of how the data is to be used under the agreement; and

''(ii) such use is consistent with the purposes described in subparagraph (A).

''(2) PENALTIES.—

''(A) IN GENERAL.—A research center or organization who knowingly or intentionally uses data provided under a data use agreement under this section for any purpose other than the purposes described in paragraph (1)(A) shall be subject, in addition to any other penalties that may be prescribed by law, to—

''(i) a civil money penalty of not less than $25,000 for each infraction; and

''(ii) disqualification from receipt of any data under this section for not less than 2 years.

''(B) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(d) RELEASE OF DATA.—

''(1) IN GENERAL.—A data use agreement entered into under subsection (a)(1) shall provide for the release of information according to a schedule approved by the Secretary under the criteria developed in accordance with paragraph (2).

''(2) CRITERIA FOR APPROVING RESEARCH APPLICATIONS.—

''(A) DEVELOPMENT.—The Secretary, in consultation with health services researchers and academicians, shall develop criteria for the approval of a data use agreement under this section.

''(B) CRITERIA.—The criteria developed under subparagraph (A) shall include the following requirements:

''(i) The research center or organization has well-documented scientific expertise, a record of scholarship on the topic of the proposed study, and a likelihood of successful publication, as demonstrated by a prior record of relevant publication by key staff and other evidence of appropriate scientific qualifications of the proposed research team.

''(ii) The research center or organization demonstrates a credible capability to conduct and complete the proposed study, including experience with scientific investigations using similar types of data.

''(iii) The research center or organization demonstrates the public health importance of the proposed study, and the potential of such study to provide public knowledge needed to improve the safety, use, and outcomes of treatments, the administration of the program under title XVIII, and the care provided to individuals entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of such title.

''(iv) The research center or organization develops a data management plan that describes in detail the measures that will be implemented to safeguard the data and protect the privacy of individuals entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of such title, including any proposed data linkages.

''(v) The research center or organization enters into an agreement under which the research center or organization agrees to—

''(I) place detailed results of the proposed study in the public domain through publication in a reasonable timeframe, not to exceed 1 year after completion of such study, including a thorough description of the methodology used to conduct the study;

''(II) make available to the public, without charge, any product or tool developed using the data provided under this section; and

''(III) not sell such data to other entities or create commercial data products (such as data extracts or analytical files) using such data.

''(vi) The research center or organization and the proposed research team provide assurances that such team is independent from the sources of funding or any other party and has the right to independently and freely publish the scientific findings of the study.

''(vii) Such other requirements, consistent with the purposes of this section, as the Secretary determines appropriate.

''(3) TIMELY REVIEW AND ACTION ON REQUESTS.—The Secretary shall provide for timely review of, and action on, requests for a data use agreement under this section, taking into consideration the reasonable needs of the research center or organization.

''(4) PUBLIC DISCLOSURE.—The Secretary shall make available to the public the criteria used to grant or deny data use agreements under the criteria developed under paragraph (2)(A).

''(e) FEEDBACK BY RESEARCH CENTER OR ORGANIZATION.—

''(1) NOTIFICATION OF INACCURACIES DISCOVERED IN DATA PROVIDED.—The Secretary shall establish procedures to ensure that a research center or organization that is provided data under this section notifies the Secretary of any inaccuracies discovered in the data by the center or organization within a reasonable time of such discovery.

''(2) FEEDBACK ON DATA COLLECTION.—The Secretary shall permit researchers to provide feedback on the collection of data with respect to the programs administered by the Centers for Medicare & Medicaid Services and make recommendations with respect to the collection of additional data elements with respect to such programs.

''(f) CONFIDENTIALITY.—

''(1) DETERMINING APPROPRIATE LEVEL OF DATA TO BE PROVIDED.—The Secretary shall establish a process to determine the appropriate level of data to be provided to a research center or organization under this section in order to ensure that the center or organization, and researchers within the center or organization, are able to conduct meaningful analyses while maintaining the confidentiality of the data provided under the data use agreement.

''(2) SAFEGUARDS TO PROTECT CONFIDENTIALITY OF DATA PROVIDED.—

''(A) IN GENERAL.—The Secretary shall establish safeguards to protect the confidentiality of data after it is provided to a research center or organization under this section. Such safeguards shall not provide for greater disclosure by the research center or organization than is permitted under any of the following:

''(i) The Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(ii) Sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable beneficiary health information.

''(B) CONFIDENTIALITY OF PHYSICIANS AND MEDICAL PRACTICES.—The safeguards established under subparagraph (A) shall ensure that the data provided to a research center or organization under this section that identifies individual physicians or medical practices is not released by the research center or organization, or otherwise made public.

''(g) REPORT.—The Secretary shall include (beginning with 2007), as part of the annual report submitted to Congress under section 1875(b), an evaluation of the agreements entered into under subsection (a).

''(h) REASONABLE FEE.—The Secretary may charge a research center or organization a reasonable fee based on the cost of preparing and providing data to such center or organization under this section.''.

(b) CRITERIA DEVELOPMENT AND PUBLICATION.—The Secretary shall develop and publish the criteria required under section 1121B(d)(2)(A) of the Social Security Act, as added by subsection (a), not later than 180 days after the date of enactment of this Act.

SEC. 4. ACCESS TO DATA ON PRESCRIPTION DRUG PLANS AND MEDICARE ADVANTAGE PLANS.

(a) IN GENERAL.—Section 1875 of the Social Security Act (42 U.S.C. 1395ll) is amended—

(1) in the heading, by inserting ''TO CONGRESS; PROVIDING INFORMATION TO CONGRESSIONAL SUPPORT AGENCIES'' after ''AND RECOMMENDATIONS''; and

(2) by adding at the end the following new subsection:

''(c) PROVIDING INFORMATION TO CONGRESSIONAL SUPPORT AGENCIES.—

''(1) IN GENERAL.—Notwithstanding any provision under part D that limits the use of prescription drug data collected under such part, upon the request of a congressional support agency, the Secretary shall provide such agency with information submitted to, or compiled by, the Secretary under part D (subject to the restriction on disclosure under paragraph (2)), including—

''(A) only with respect to congressional support agencies that make official baseline spending projections, conduct oversight studies mandated by Congress, or make official recommendations on the program under this title to Congress—

''(i) aggregate negotiated prices for drugs covered under prescription drug plans and MA–PD plans; and

''(ii) bid information (described in section 1860D–11(b)(2)(C)) submitted by such plans; and

''(B) access to drug event data submitted by such plans under section 1860D–15(d)(2)(A), except, with respect to data that reveals prices negotiated with drug manufacturers, such data shall only be available to congressional support agencies that make official baseline spending projections, conduct oversight studies mandated by Congress, or make official recommendations on the program under this title to Congress.

''(2) RESTRICTION ON DATA DISCLOSURE.—

''(A) IN GENERAL.—Data provided to a congressional support agency under this subsection shall not be disclosed, reported, or released in identifiable form.

''(B) IDENTIFIABLE FORM.—For purposes of subparagraph (A), the term 'identifiable form' means any representation of information that permits identification of a specific prescription drug plan, MA–PD plan, pharmacy benefit manager, drug manufacturer, drug wholesaler, or individual enrolled in a prescription drug plan or an MA–PD plan under part D.

''(3) TIMING.—The Secretary shall release data under this subsection in a timeframe that enables congressional support agencies to complete congressional requests.

''(4) USE OF THE DATA PROVIDED.—Data provided to a congressional support agency under this subsection shall only be used by such agency for carrying out the functions and activities of the agency mandated by Congress.

''(5) CONFIDENTIALITY.—The Secretary shall establish safeguards to protect the confidentiality of data released under this subsection. Such safeguards shall not provide for greater disclosure than is permitted under any of the following:

''(A) The Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(B) Sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable beneficiary health information.

''(6) DEFINITIONS.—In this subsection:

''(A) CONGRESSIONAL SUPPORT AGENCY.—The term 'Congressional support agency' means—

''(i) the Medicare Payment Advisory Commission;

''(ii) the Congressional Research Service;

''(iii) the Congressional Budget Office; and

''(iv) the Government Accountability Office.

''(B) MA–PD PLAN.—The term 'MA–PD plan' has the meaning given such term in section 1860D–1(a)(3)(C).

''(C) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' has the meaning given such term in section 1860D–41(a)(14).''.

(b) CONFORMING AMENDMENT.—Section 1805(b)(2) of the Social Security Act (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

''(D) PART D.—Specifically, the Commission shall review payment policies with respect to the Voluntary Prescription Drug Benefit Program under part D, including—

''(i) the factors affecting expenditures;

''(ii) payment methodologies; and

''(iii) their relationship to access and quality of care for Medicare beneficiaries.''.

Mr. BAUCUS. Mr. President, today, I am pleased to join Chairman GRASSLEY in introducing the Medicare Data Access and Research Act. This bill will take an important step to advance the safety, efficacy, and quality of health care services delivered to people under the Medicare Program and it will help improve the care delivered to all Americans.

This bill requires the Secretary of Health and Human Services, HHS, to make Medicare data accessible to Federal health agencies and the health services research community for the purpose of conducting studies that will serve the public health. As the largest single payer of health care services in the United States—covering over 40 million lives, 70 million hospital days, and processing nearly a billion physician claims per year—Medicare collects and maintains a wealth of information on the health services delivered to a significant portion of the population. This information has been a national resource for research and analysis of health care. And with the addition of the Medicare prescription drug benefit, it will be the most comprehensive resource our Nation has to study the effects of diseases and the treatments we have for them.

The Centers for Medicare and Medicaid Service, CMS, currently releases certain Medicare data to the public and more comprehensive data to the research community. This bill would build on current activities by requiring CMS to link hospital claims, physician claims, and other relevant information to data collected under the new Medicare drug benefit.

In addition, the Secretary will provide yearly access to the linked Medicare dataset to all Federal health agencies within the department, such as the Food and Drug Administration, the Centers for Disease Control, the National Institutes of Health, and the Agency for Healthcare Quality and Research. These agencies will enter into data use agreements with CMS to ensure that the type and level of Medicare data shared is appropriate, that the agencies conduct research in accordance with their missions and the purpose of furthering the public health, and that the privacy of the data is protected. The goal is to give Federal health agencies another tool to evaluate the safety, efficacy, and quality of care delivered to Medicare beneficiaries—a large segment of the health system.

This bill also provides public health researchers access to the linked Medicare dataset. Expanding access to Medicare data will open up a new era in our health system. It will enable scientists to more quickly identify both short- and long-term safety concerns with drug regimens and health treatments. It will enable more treatments to be compared. And it will promote more development of guidelines, so providers and patients know more about what works best.

Some may argue that access to linked Medicare data should not be limited to researchers and should be available for commercial purposes. But the full Medicare database should be used exclusively for the public good and not for private or commercial gain. This is the crux of this bill. Hence, the bill limits the use of data to the purpose of providing ''generalizable knowledge to inform the public health through scientific publication and other forms of public dissemination.'' Strict penalties will be imposed on any unauthorized use of the data including civil money penalties and disqualification from receiving Medicare data for at least 2 years.

CMS will publish criteria used to approve research applications to ensure that those selected are qualified and experienced to conduct analyses and maintain the confidentiality of Medicare information. Researchers will also make public their detailed results and methods within 1 year from completing their studies. They will make available to the public at no charge any tool developed through this program. They must agree not to sell data or create commercial data products using such data and abide by safeguards protecting the confidentiality of the data established by the Secretary.

The final section of the bill ensures that congressional support agencies, including the Congressional Budget Office, the Congressional Research Service, the Government Accountability Office, and the Medicare Payment Advisory Commission, also have access to the full range of data they need to carry out their functions and responsibilities. Congress depends on the research and analyses conducted by these agencies to inform our deliberations and decisions on the Medicare Program.

Last year, I worked with Senator GRASSLEY to introduce the Medicare Value-Based Purchasing Act, which establishes a pay for performance system under Medicare. An important element of that system is the collection and reporting of quality measures to CMS and to the public. The bill we are introducing today complements those activities. We can improve health care by allowing Medicare to become a value-based purchaser of services and by reporting quality measures through the Medicare Program. And we can improve health care for all by allowing rigorous health services research to be conducted using the resource of Medicare data.

Mr. President, the Medicare Data Access and Research Act will allow us to expand our knowledge of health care and improve the quality of care for all Americans.

By Mr. GREGG (for himself, Mr. FRIST, Mr. BURR, Mr. CORNYN, and Mr. BENNETT):

S. 3900. A bill to amend title XVIII of the Social Security Act to improve the quality and efficiency of health care, to provide the public with information on provider and supplier performance, and to enhance the education and awareness of consumers for evaluating health care services through the development and release of reports based on Medicare enrollment, claims, survey, and assessment data; to the Committee on Finance.

Mr. GREGG. Mr. President, I rise today to introduce the Medicare Quality Enhancement Act of 2006 to improve quality and reduce the cost of health care.

The Medicare Quality Enhancement Act addresses three important problems in our Nation's health care delivery system: rising costs, broad variations in the quality of care, and a lack of information on health care quality and cost.

Among the most pressing issues that need to be addressed in the area of health care is the issue of rapidly rising health care costs. The United States spends more on health care as a percentage of GDP than any other industrialized country. According to the Centers for Medicare and Medicaid Services (CMS), total health expenditures are estimated to be $2.16 trillion in 2006 and are projected to rise to over $4 trillion in 2015.

The pressures of rising health care costs are being felt by consumers, providers, employers, State and local governments, and the Federal budget alike—with no end in sight. Premiums for employer-based health insurance rose by 9.2 percent in 2005—the fifth consecutive year of increases over 9 percent. Health insurance expenses are the fastest growing expense to employers, consuming more and more of each company's bottom line.

From a Federal budget perspective, over the next 10 years, Medicare will grow on average 8.5 percent to $885 billion and Medicaid will grow similarly at 8 percent to $413 billion. These programs along with Social Security will take up 56 percent of the total budget in 2016. Such rate of growth is unsustainable.

Despite this enormous level of spending, there is wide variation in the quality of the care Americans receive. In addition to the existing crisis of ever increasing costs, we are now learning that there are vast variations in the ratio of spending to outcomes, meaning that more care is not necessarily better care. A recent report by the Dartmouth Atlas Project demonstrated this point and showed no correlation between high utilization of services and high quality of care. This information provides an opportunity to improve care and reduce costs. We simply cannot afford business as usual in health care, especially when we have no way of determining the value of what we are purchasing.

The Agency on Healthcare Research and Quality (AHRQ) also reports wide variation in health care practice. AHRQ claims that millions of Americans fail to receive necessary care resulting in complications and increased costs. Others, they say, receive health care services that are completely unnecessary, which also increases costs.

These problems are compounded by a third issue the lack of information available to consumers and purchasers on quality and cost. Currently, health care consumers do not have the tools necessary to make sound quality and cost decisions about their care. The few tools that are available to them are based on limited amounts of privately held data and their analysis is often not broad enough to provide the most accurate results.

The Medicare Quality Enhancement Act gives consumers, employers, providers and others the tools they need to begin controlling unnecessary spending; improves quality of care in our nation's health care delivery system; and provides the public with reports to make informed health care decisions.

The bill works by sharing taxpayer funded Medicare data with private sector Medicare Quality Reporting Organizations (MQROs), allowing them to develop reports to measure health care quality for the public. Consumer groups, employers, insurance companies, labor unions and others have repeatedly requested access to Medicare claims data to improve the quality of the health care provided to their members, employees, and beneficiaries and to help control the ever-rising costs of health care. The Medicare Quality Enhancement Act ensures that the data collected by Medicare and paid for by the taxpayer can be utilized by qualified organizations to measure quality and control costs while protecting beneficiary privacy.

The measure also empowers consumer groups, providers, employers, insurance plans, labor unions and others by allowing them to request health care quality and efficiency reports from the newly-formed MQROs—information that will assist in better-informed purchasing decisions. Further, the bill provides for the public release of all reports, including detailed information on the methodology, standards and measures of quality used in developing the reports ensuring the information is available for the general public. In addition, MQROs that contract with the Department of Health and Human Services will be authorized to aggregate both private and public data, providing a significantly more robust assessment of both quality and efficiency.

In the development of this bill, my first goal was to protect beneficiary privacy. Specifically, the bill limits the number of MQRO participants and explicitly holds them to the strict standards of both the Health Insurance Portability and Accountability Act (HIPAA) and the Privacy Act. It also requires MQROs to have operational standards and procedures in place to provide for the security of the database. Lastly, the bill requires a privacy review by the Department of Health and Human Services of each analytical report prior to release.

The Medicare Quality Enhancement Act promotes the development of model quality standards through a newly established Quality Advisory Board within the Department of Health and Human Services and encourages the Administration to continue its extraordinary work with providers, consumers, insurers and others in the health care community toward sound quality measurement for all patients. Collaborative groups such as the Ambulatory Care Quality Alliance (AQA) and the Hospital Quality Alliance (HQA) are working hard to establish standards and the Medicare Quality Enhancement Act encourages their work to continue.

Under the bill, researchers are granted additional access to Medicare data and are allowed to report in a provider- and supplier-identifiable format as long as they meet existing strict criteria for the use of Medicare data within CMS. Some of our best information on quality and efficiency has been borne of fine academic institutions and private study and they, too, should have the opportunities to use this data to improve our health care system.

In closing, the Medicare Quality Enhancement Act is needed in order for America's health care system to improve. The public needs to understand the quality of the care they are purchasing and the time has come for the health care community to compete on quality, value, and cost payment should not simply be for the volume of care provided, but instead for the quality of the care provided.

The Medicare Quality Enhancement Act takes important steps to provide health care consumers with the information they need to make educated decisions about health care; information they already have to make decisions on nearly every other product they purchase in the marketplace. It requires that information paid for by the taxpayer and held by Medicare is fully available to improve our health care system. The public will then finally have the tools necessary to make informed health care decisions for themselves and their families.

This bill has the support of groups that represent consumers, providers, employers and insurers. I hope my colleagues will see the merit of this legislation and that it will be considered before we adjourn this year.

Mr. FRIST. Mr. President, for decades, healthcare analysts and industry experts have wondered whether healthcare should consume 16 percent of our Nation's economic output, as it currently does.

By virtually any measure, we spend more on healthcare than any other country in the world.

Consider the facts. According to the World Health Organization; we spend twice as much per person on healthcare as Britain and Japan; and we spend

nearly 30 percent more than second-ranking Monaco.

In the past 5 years alone, the cost of health insurance to companies has nearly doubled—from $4,200 to $8,100 per family.

But experts also concur that rising healthcare costs does not mean the quality of healthcare is improving. Just this summer, the Institute of Medicine released the most extensive report ever on medication errors.

The results? At least 1.5 million Americans are sickened, injured, or killed each year by errors in prescribing, dispensing, and taking medications.

Errors are widespread—on average, a hospital patient is subjected to 1 error each day he or she occupies a hospital bed—and they are costly, at an estimated expense of $3.5 billion per year.

We have good reason to question the cost and quality of our healthcare services. That is why, in August, President Bush issued an executive order requiring all Federal agencies with a health insurance program to increase price transparency and provide options promoting quality and efficiency of care.

The Executive Order builds on the Federal Govermment's efforts to release Medicare payment information for individual healthcare providers.

While this is an important step toward transparency, more can be done. We need a way to analyze that data and make the results of the analysis consumer friendly, so that patients have real information they can use to make better informed healthcare decisions.

The bill before us today—of which I am a proud cosponsor—picks up where current Federal efforts leave off. The Medicare Quality Enhancement Act establishes quality transparency in the Medicare Program.

It doesn't require anything extra of providers. In fact, CMS is already collecting the data we need—because any provider that accepts Medicare patients must report quality data to CMS.

Instead, the bill requires CMS to establish public-private partnerships with Medicare quality reporting organizations, or MQROs. CMS will provide MQROs with data CMS already collects—Medicare enrollment, claims, and survey and assessment data. The MQROs will then perform the analysis.

Any entity or provider will be able to make report requests of MQROs, the results of which will be made public. The methodology an MQRO uses to analyze the data will also be made public. And providers can additionally instruct MQROs to use a certain methodology when making a report request.

I know many providers are concerned about CMS's capacity and capability to analyze healthcare quality data.

In part, that is why this bill requires CMS to contract with MQROs. The Secretary must determine that each MQRO has the research capability to conduct and complete reports as a condition for entering into the contract. MQROs must also demonstrate that they have the experience and expertise to analyze quality data.

As an additional contract requirement, each MQRO must comply with Federal privacy regulations to ensure beneficiary confidentiality. Additionally, MQROs must disclose financial interests as a condition to contract.

As a transplant surgeon, I understand the concerns and fears providers have. Many providers are worried that we aren't far enough along in terms of quality data collection to be able to analyze it.

But we must push the envelope in this area. It is my hope that provider groups will take the lead and request reports using a methodology and standards of quality that represent the best care in each of their fields.

Quality transparency is absolutely essential to improving healthcare. Without it, beneficiaries cannot make informed decisions about their healthcare.

Consumers already enjoy transparency in other industries. When we buy a new car, we can open an Internet browser and in a matter of moments can make objective side-by-side comparisons of different models—and then we can take them for a test drive.

When we need groceries, we pull out the Sunday supermarket ads to see what is on sale and where.

And when we furnish our homes, we shop around—comparing style, price, color, quality, warranty, and service.

But right now, we can't do that in healthcare. Whether it is a routine checkup or a heart transplant, we have no way of assessing how much bang we are getting for a buck.

Only when we institute quality transparency do we empower beneficiaries to make informed decisions about their healthcare.

This bill is a great step toward the goal of complete quality transparency. It is a formidable goal; that is why we are starting with something we know—Medicare.

Senator GREGG has worked long hours to bring this bill to fruition, and I thank him for his efforts. I hope our colleagues will join us in supporting this important measure.

By Mr. BAUCUS:

S. 3902. A bill to provide for education competitiveness; to the Committee on Finance.

Mr. BAUCUS. Mr. President, in August of 1802, from his desk in Monticello, President Thomas Jefferson glimpsed the future of the young American economy. He was shaken by what he saw.

Jefferson had just finished reading a book published a year earlier in London. The slim volume was the travel account of Alexander MacKenzie, a young Scotsman working in Great Britain's Canadian colonies.

In June of 1793, MacKenzie had crossed the Continental Divide at a place where it was just 3,000 feet high and easily portaged. Two weeks later, he reached the Pacific Ocean. Using a makeshift paint of vermilion and grease, Mackenzie inscribed his name on a rock to memorialize his discovery, and to claim it for Great Britain.

The economic implications of MacKenzie's discovery were enormous. In his book, MacKenzie urged the British to build on his discovery and develop a passage to the Pacific. Such a passage would give Great Britain control over much of North America's lucrative fur trade and access to the world's markets. Worse, MacKenzie's discovery threatened to stunt America's economic growth in its infancy.

MacKenzie's book lit a fire under Jefferson. That summer, he talked of little else. He enlisted the most qualified man he knew. And with him, Jefferson devised a plan for action. It was a plan to counter the economic threat from the north. It was a plan to safeguard America's economic future.

That December, President Jefferson presented his plan to Congress. It was America's first economic competitiveness plan. It called for one officer, a dozen soldiers, and $2,500.

Thomas Jefferson's economic competitiveness plan of 1802 has become better known as the Lewis and Clark Expedition. Today, we see that expedition as one of our Nation's great displays of ambition and courage. And today, we see that it laid the foundation of the United States as we know it.

Today, America faces a new competitive challenge. Our challenge is not over control of the fur trade. It comes not from an imperial power or its colony. It is not a race for territory in unexplored lands. Our challenge is far more complex. And the need to act is even more urgent.

America today faces a world more integrated, more interdependent, and more intensely competitive than ever in our history. In this world, it is our challenge to succeed. It is our challenge to leave our children and grandchildren an economy that is better than the one that we inherited.

We seek an economy that is not laden with debt, but bursting with opportunity. We seek an economy that plants the seeds of innovation and education today, knowing that generations far in the future will harvest their bounty. We seek an economy whose workers are increasingly productive, and whose skills are continuously sharpened.

Our challenge is to create an economy in which investment in our workers is our greatest asset, not our heaviest burden. Our challenge is to create

an economy known for what it will be, rather than for what it was.

To realize this competitive economy, we must—like Jefferson—rise to the challenge. We must—like Jefferson—look to unknown horizons and march out to meet them. We must call upon our greatest minds and set them to creating a plan. And we must dedicate the resources necessary to implement that plan.

I have spent much of the past year planning a comprehensive competitiveness agenda. In February, I introduced the Trade Competitiveness Act, a bill to open markets and keep a level playing field for America's ranchers, farmers, and businesses.

In March, I introduced the Energy Competitiveness Act, to fund cutting edge research in energy while making alternative energies more affordable.

In April, I introduced the Savings Competitiveness Act, to create savings today, so that we may invest and innovate tomorrow.

In May, I introduced the Research Competitiveness Act, to give start-ups and universities better access to capital for research and development, and to improve and make permanent the R&D tax credit.

Today, I am introducing the fifth in this series of bills: the Education Competitiveness Act of 2006. Just as education is the foundation of a competitive economy, this legislation is the foundation of my competitiveness agenda.

Thomas Jefferson knew that it was not enough to send Lewis and Clark to the Pacific Ocean without the means to return. Lewis and Clark knew that the discoveries and contacts that they made had to be lasting to make a difference for our economy.

The Education Competitiveness Act is also designed to have a lasting effect. This legislation embraces education in its earliest stages, following through to continuing education and worker training. Each provision is designed with maximum flexibility to meet our States' unique needs. It is a bill that recognizes excellence, welcomes innovation, and rewards ambition.

The Education Competitiveness Act has seven important components.

First, it recognizes that our Nation needs to continue to bring quality teachers into the classroom. The bill funds 100,000 scholarships for future teachers of languages, early education, and science. It creates incentives for teachers to serve in rural and underserved areas. And it rapidly expands funding to advanced placement and international baccalaureate programs.

Second, the bill recognizes that early education is widely considered to be one of the best education investments that money can buy. The bill creates a flexible program of matching grants to build a national system of universal, voluntary prekindergarten. The bill sets out benchmarks for quality and provides help for States to make sure that their teachers are the best that they can be.

Third, the bill helps students to go the extra mile in their studies, by offering States the means to expand afterschool programs in everything from college test preparation to drug prevention. Summer programs get students out of the classroom for hands-on experience in science, technology, mathematics, and engineering.

Fourth, the bill looks to the needs of tomorrow's workforce. That workforce will increasingly demand technical skills based in math, science, and engineering. The bill provides a free college education to any student wishing to study science, technology, math, or engineering. In return, the student must work 4 years in that field of study. The bill offers States matching grants to establish and expand specialty math, science, and technology schools. And the bill makes young promising scientists eligible for cash grants to continue their research.

Fifth, the bill addresses the chronic neglect of our Nation's Indian education. The bill fully funds Indian colleges and makes a real commitment to the Johnson O'Malley program. The bill also increases the Pell grant to $6,000. Eighty percent of Montana's students rely on financial aid, including Pell grants.

Sixth, the Education Competitiveness Act allows American workers to continue learning. The bill funds programs to link businesses and schools, to give workers the skills that they need. Where universities and community colleges are too far away, distance learning grants will help bridge that gap.

Finally, the bill's tax provisions grant greater access to education. The bill starts by simplifying confusing tax credits and combining them into a single refundable higher education credit of up to $2,000 per student. The bill eases the burden of loan repayment by permitting graduates to deduct more of the interest paid on their student loans. And the bill increases the deductions for charitable contributions to schools as well as teachers' expenses in classrooms.

Taken together, these seven components form a bill that is both comprehensive and responsible. It is a bill that would help to secure a more competitive American economy.

I look forward to returning to the floor to describe each title in greater detail. I also look forward to discussing these proposals with my colleagues.

The Education Competitiveness Act sets out a bold agenda, to be sure. Some of its rewards may only be reaped decades from now. Some of its benefits may only be realized by our grandchildren. But I firmly believe that this is an agenda that we must begin to implement today.

Like the journey of Lewis and Clark 200 years ago, this is an agenda that portends discovery and rewards for America. It is an agenda that promises a passage to a new nation. I urge my colleagues to join me as we advance to this future, and join me in sponsoring the Education Competitiveness Act.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 570—DESIGNATING THE MONTH OF SEPTEMBER AS ''NATIONAL AMERICAN HISTORY AND HERITAGE MONTH''

Mr. DEWINE (for himself and Mr. VOINOVICH) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 570

Whereas the United States has a remarkable history and a cherished legacy abounding with stories and biographies of heroes and patriots;

Whereas time has proven that, by teaching the principles of the foundation of the United States, the children of the Nation grow up to become good citizens;

Whereas George Washington stated, ''A primary object . . . should be the education of our youth in the science of government'';

Whereas the children of the United States have the right and the responsibility to know the history and heritage of the Nation;

Whereas, in 1952, Olga Weber, a mother and homemaker from the State of Ohio, out of concern that citizens of the United States were taking their freedoms for granted, petitioned the municipal officers of her town to establish a Constitution day in honor of the ratification of the Constitution of the United States, and further requested that the State of Ohio designate September 17, 1952, as ''Constitution Day'';

Whereas, in 1953, Governor Frank J. Lausche of the State of Ohio signed a law designating September 17, 1953, as ''Constitution Day'';

Whereas, in August 1953, Mrs. Weber urged the Senate to pass a resolution designating the period beginning September 17, 1953, and ending September 23, 1953, as ''Constitution Week'';

Whereas, in 1955, President Dwight D. Eisenhower signed into law the request of Mrs. Weber, and designated the period beginning September 17, 1955, and ending September 23, 1955, as ''Constitution Week'';

Whereas many parents have become increasingly concerned by the lack of knowledge and interest that the people of the United States have for their history and heritage;

Whereas the period beginning September 17, 2006, and ending September 23, 2006, is nationally designated as ''Constitution Week'';

Whereas September 17, 2006, is nationally designated as ''Citizenship Day'';

Whereas September 11, 2006, is nationally designated as ''Patriot Day'';

Whereas the Constitution of the United States was signed on September 17, 1787;

Whereas the greatest honor that the citizens of the United States can give to all of those citizens who have dedicated their lives