

S. RES. 128

At the request of Mr. TORRICELLI, the name of the Senator from North Carolina (Mr. HELMS) was added as a cosponsor of S. Res. 128, a resolution calling on the Government of the People's Republic of China to immediately and unconditionally release Li Shaomin and all other American scholars of Chinese ancestry being held in detention, calling on the President of the United States to continue working on behalf of Li Shaomin and the other detained scholars for their release, and for other purposes.

At the request of Mr. BIDEN, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of S. Res. 128, *supra*.

S. CON. RES. 3

At the request of Mr. FEINGOLD, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. Con. Res. 3, a concurrent resolution expressing the sense of Congress that a commemorative postage stamp should be issued in honor of the U.S.S. *Wisconsin* and all those who served aboard her.

S. CON. RES. 28

At the request of Mr. BIDEN, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of S. Con. Res. 28, a concurrent resolution calling for a United States effort to end restrictions on the freedoms and human rights of the enslaved people in the occupied area of Cyprus.

S. CON. RES. 53

At the request of Mr. HAGEL, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. Con. Res. 53, concurrent resolution encouraging the development of strategies to reduce hunger and poverty, and to promote free market economies and democratic institutions, in sub-Saharan Africa.

AMENDMENT NO. 907

At the request of Ms. LANDRIEU, the names of the Senator from Ohio (Mr. VOINOVICH), the Senator from South Dakota (Mr. DASCHLE), the Senator from Arkansas (Mrs. LINCOLN), the Senator from South Carolina (Mr. HOLLINGS), and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of amendment No. 907, intendent to be proposed to H.R. 2217, a bill making appropriations for the Department of the Interior and related agencies for the fiscal year ending September 30, 2002, and for other purposes.

AMENDMENT NO. 921

At the request of Ms. COLLINS, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of amendment No. 921 intendent to be proposed to H.R. 2217, a bill making appropriations for the Department of the Interior and related agencies for the fiscal year ending September 30, 2002, and for other purposes.

AMENDMENT NO. 922

At the request of Ms. COLLINS, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of

amendment No. 922 intendent to be proposed to H.R. 2217, a bill making appropriations for the Department of the Interior and related agencies for the fiscal year ending September 30, 2002, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. FEINGOLD (for himself, Mr. MURKOWSKI, Ms. COLLINS, and Mr. KERRY):

S. 1169. A bill to streamline the regulatory processes applicable to home health agencies under the medicare program under title XVIII of the social Security Act and the medicaid program under title XIX of such Act, and for other purposes; to the Committee on Finance.

Mr. FEINGOLD. Mr. President, I rise today to introduce the Home Health Nurse and Patient Act of 2001. This legislation reduces administrative burdens, requires a focused analysis of crucial claims processing concerns, and provides the opportunity for constructive reforms of current inefficiencies.

I am especially pleased to be joined by a number of my colleagues, including Senator MURKOWSKI and Senator KERRY who have been leaders in the regulatory reform movement, and Senator COLLINS, who has truly been a champion for preserving access to home health care.

Without Senator COLLINS' leadership on this issue, including the 1999 hearing that she held on the issue of regulatory burdens facing the home health care industry, this legislation would not be where it is today.

Senator COLLINS' legislation to repeal the 15 percent reduction in payments to home health care providers is also of the utmost importance, and is the other piece to the puzzle in terms of preserving access to home health care. It is my hope that the Senate Finance Committee will report out her legislation this year.

Scope of the problem: As many of my colleagues know, home health care provides compassionate, at-home care to seniors and people with disabilities in cities and towns throughout America.

Without it, many patients have no choice but to go to a nursing home, or even an emergency room, to get the care they need. For too many home health patients in my home state of Wisconsin, that day has arrived.

Over the past few years, home health agencies around Wisconsin have closed their doors due to massive changes in Medicare, and seniors and the disabled have been forced to go elsewhere for care.

In Wisconsin, over 40 Medicare home health providers have shut down since the implementation of the Interim Payment System. Still more have shrunken their service areas, stopped accepting Medicare patients, or refused assignment for high cost patients because the payments are simply too low.

Over the past 3 years, nearly 30 of Wisconsin's 72 counties have lost be-

tween one and fifteen home health care agencies.

Quite frankly, in many parts of Wisconsin, beneficiaries in certain areas or with certain diagnoses simply don't have access to home health care.

While we have thankfully moved beyond the interim payment system, many home health agencies are facing another cloud in the horizon—an impending nursing shortage and a regulatory system that causes nurses to fill out paperwork instead of caring for patients.

Burdensome and excessive paperwork often causes nurses to leave the home health care profession, and that can mean that patients stay in the hospital longer than necessary.

A 2000 national survey by the Hospital and Healthcare Compensation Service reported a 21-percent turnover rate for home health registered nurses, a 24-percent turnover rate for home health licensed practicing nurses, and a 28-percent turnover for home health aides.

The actual amount of time that a nurse provides medical care during an average "start of care" home health visit is approximately 45 minutes, only 30 percent of the average 2.5 hours of a nurse's time during the admission visit. According to Price Waterhouse Cooper, every hour of patient care time requires 48 minutes of paperwork time for hospital-owned home health agencies.

I would like to share with my colleagues this advertisement from Nursing Spectrum magazine.

Let me read this line here in bold print: "No OASIS."

As you can see the main selling point in the advertisement is the fact that the job will not force nurses to collect OASIS data. This is just one simple example of how the administrative burden we have imposed on our nurses.

Our legislation takes a common sense approach to developing Medicare home health regulatory policies that are pro-consumer, provider-friendly, and efficient for the Center for Medicare and Medicaid Services, CMS, to administer.

It would also help to ensure that the policies are successful, fair and effective because all parties would collaborate on recommendations to the Secretary of Health and Human Services, HHS, through joint task forces.

This legislation would significantly alleviate the burdens that the Outcomes Assessment and Information Set (OASIS), the claims process for patients who are enrolled in both Medicare and Medicaid, and certain audit and medical review processes have had on home health providers.

More importantly, the changes to the OASIS and the claims review process also would reduce the stress often experienced by home health patients due to the complexity of both regulations.

It would also create a task force to analyze the appropriateness and efficacy of the OASIS patient assessment

instrument on Medicare, Medicaid and non-government financed patients.

During the study, the OASIS process would be optional for the non-Medicare and non-Medicaid patients and inapplicable to those patients receiving personal care services only.

Many beneficiaries are also concerned about arbitrary coverage decisions, that leaves beneficiaries in the lurch. That is why this legislation requires the Secretary to form a task force to develop an efficient process for the handling of Medicare claims related to individuals also eligible for Medicaid coverage where the claim may not be covered under Medicare.

Finally, the Home Health Nurse and Patient Act would create a task force that would engage in a wholesale evaluation of the process used by Medicare to select and review home health services' claims.

The task force would consider such changes as establishing time limits for claim determinations, the use of alternative dispute resolution processes, the development of formal claims sampling protocols, allowing re-submission of corrected claims, and permitting physician assistants and nurse practitioners to establish care plans.

I hope to continue to work with both providers and beneficiaries to take a serious look at what refinements need to occur to ensure the home bound elderly and disabled can receive the services they need.

Without that fine-tuning, I am quite certain that more home health agencies in Wisconsin and across our country will close, leaving some of our frailest Medicare beneficiaries without the choice to receive care at home.

By Mr. MURKOWSKI:

S. 1170. A bill to make the United States' energy policy toward Iraq consistent with the national security policies of the United States; to the Committee on Finance.

Mr. MURKOWSKI. Mr. President, I take the opportunity at this time to introduce S. 1170. It is my intention to introduce the following bill to make the United States energy policy towards Iraq consistent with the national security policies of the United States.

I anticipate that several colleagues will be cosponsoring the bill with me. I will enter into that at a later time.

Mr. MURKOWSKI. Mr. President, for some time I have been coming to the floor to speak of a major inconsistency in our foreign and energy policies. I am referring, of course, to our growing dependence on imported petroleum from Iraq.

We import somewhere between 500,000 to 750,000 barrels of oil from Iraq every day. About six billion dollars worth last year. Since the end of the gulf war, we have also flown some 250,000 sorties to prevent Saddam Hussein from threatening our allies in the region. We spend billions every year to keep him in check.

We fill up our planes with Iraqi oil, send our pilots to fly over and get shot

at by Iraqi artillery, and return to fill up on Iraqi oil again.

Saddam heats our homes in winter, gets our kids to school each day, gets our food from farm to dinner table, and we pay him well to do that.

What does he do with the money he gets from oil?

He pays his Republican Guards to keep him safe.

He supports international terrorist activities; he funds his military campaign against American servicemen and women and those of our allies; and he builds an arsenal of weapons of mass destruction to threaten Israel and our allies in the Persian Gulf.

Am I missing something? Is this good policy? For a number of years the United States has worked closely with the United Nations on the "Oil-for-Food" Program.

This program allows Iraq to export petroleum in exchange for funds which can be used for food, medicine and other humanitarian products.

Despite more than \$15 billion available for those purposes, Iraq has spent only a fraction of that amount on its people's needs.

Instead, the Iraqi government spends that money on items of questionable, and often highly suspicious purposes. Why, when billions are available to care for the Iraqi people, who are malnourished, sick, and have inadequate medical care, would Saddam Hussein withhold the money available, and choose instead to blame the United States for the plight of his people?

Why is Iraq reducing the amount it spends on nutrition and pre-natal care, when millions of dollars are available?

Why does \$200 million of medicine from the UN sit undistributed in Iraqi warehouses?

Why, given the urgent state of humanitarian conditions in Iraq, does Saddam Hussein insist that the country's highest priority is the development of sophisticated telecommunications and transportation infrastructure?

Why, if there are billions available, and his people are starving, is Iraq only buying \$8 million of food from American farmers each year?

I have no quarrel with the Oil-for-Food program. It is a well-intentioned effort.

I do, however, have a problem with the means in which Saddam Hussein has manipulated our growing dependency on Iraqi oil.

Three times since the beginning of the Oil-for-Food program, Saddam Hussein has threatened or actually halted oil production, disrupting energy markets and sending oil prices skyrocketing.

Why do this? Simply to send a message to the United States: "I have leverage over you."

Every time he has done this, he has had his way. We have proven ourselves addicted to Iraqi oil. Saddam has been proven right: he does have leverage over us.

We have placed our energy security in the hands of a madman.

The Administration has attempted valiantly to reconstruct a sensible multilateral policy toward Iraq. Those attempts have unfortunately not been successful.

I think that before we can construct a sensible US policy toward Iraq, we need to end the blatant inconsistency between our energy policy and our foreign policy.

We need to end our addiction to Iraqi oil. We need to go "cold turkey."

To that end I have introduced legislation today which would prohibit imports from Iraq, whether or not under the Oil for Food Program, until it is no longer inconsistent with our national security to resume those imports.

I hope that this will be an initial step towards a more rational and coherent policy toward Iraq.

By Mr. LEAHY (for himself, Mr. HATCH, and Mr. KENNEDY):

S. 1174. A bill to provide for safe incarceration of juvenile offenders; to the Committee on the Judiciary.

Mr. LEAHY. Mr. President, I rise today to introduce with Senator HATCH legislation that addresses the problems caused by housing juveniles who are prosecuted in the criminal justice system in adult correctional facilities. In addition, this legislation reauthorizes the Juvenile Justice and Delinquency Prevention Act, to maintain the core protections afforded to juveniles who are adjudicated delinquent and detained in the juvenile court system. This two-pronged approach will help ensure that we treat juvenile offenders with appropriate severity, but also in a way that assists States in providing safe conditions for their confinement and appropriate access to educational, vocational, and health programs that address the needs of juveniles. Improving conditions for juveniles today will improve the public safety in the future, as juveniles who are not exposed to adult inmates have a lower likelihood of committing future crimes.

The Justice Department reported last fall that of the 50 States and the District of Columbia, 44 house juveniles in adult jails and prisons, and 26 of those do not maintain designated youthful offender housing units. As a nation, we are relying increasingly on adult facilities to house juveniles; for example, according to the Bureau of Justice Statistics' survey of jails, there was a 35 percent increase in the number of juveniles held in adult jails between 1994 and 1997. I believe that there is a will in the States to improve conditions for these juveniles, but resources are often lacking. The Federal Government can play a useful role by providing funding to States that want to take account of the differences between juveniles and adults.

Although many juvenile offenders serving time in adult prisons have committed extraordinarily serious offenses, others are there because of relatively minor crimes and will be released at a young age. According to the

1999 report of the Office of Juvenile Justice and Delinquency Prevention, 22 percent of juveniles committed to State prisons were there because they had committed property crimes, 11 percent because they committed drug-related crimes, and only 25 percent because they had committed murder, kidnaping, sexual assault or assault. Certainly, many of those juveniles can be convinced not to commit further crimes. The social and moral cost of not making that attempt is simply incalculable.

There is stunning statistical evidence that something is deeply wrong with our current approach to incarcerating juveniles. According to the Justice Department, the suicide rate for juveniles held in adult jails is five times the rate in the general youth population and eight times the rate for adolescents in juvenile detention facilities. Juveniles in adult facilities are also more likely to be violently victimized. Sexual assault was five times more likely than in juvenile facilities, beatings by staff nearly twice as likely, and attacks with weapons almost 50 percent more common.

Moreover, many scholars have questioned whether housing juvenile offenders with adult inmates serves our long-term interest in public safety. Multiple studies have shown that youth transferred to the adult system recidivate at higher rates and with more serious offenses than youth who have committed similar offenses but are retained in the juvenile justice system. Some would suggest that we should not be transferring youth to the adult system at all, and I am sympathetic to that view. But that is a decision our States must make, and for now most of our States have taken the contrary position. At the very least, then, we must ensure that juveniles are treated humanely in the criminal justice system to reduce the risks that upon release they will commit additional and more serious crimes. One of the ways we can do that is by helping States improve confinement conditions.

The problem this bill is intended to address cannot be described simply through statistics or academic studies. The compelling stories of young people who have been part of the corrections system should command our attention. For example, United Press International and numerous newspapers have reported the story of 15-year-old Robert, who was held in a Kentucky adult jail for the minor infraction of truancy and petty theft. One night during his time there, Robert wrapped one end of his shirt around his neck, and one around the cell bars, and hanged himself. The county has now agreed not to house juveniles and adults together.

The New York Times magazine last year told the story of Jessica, who at 14 was the youngest female in the Florida correctional system and, within her first few weeks in prison, tried to com-

mit suicide. Jessica was then transferred to a rougher Miami prison where she does not receive psychological counseling or attend class to get her GED. Jessica has found an extensive surrogate prison family whom she turns to for advice. The woman she refers to as "Mommy" is serving a life sentence for murder. Jessica will be released at age 22 with no education beyond the sixth grade, no job skills, and no life experience outside of prison after age 13. Now some will point out that Jessica committed a serious criminal offense she and two older teenagers robbed her grandparents and she deserves harsh punishment. And I agree that we must deal severely with such crimes. But the fact remains that when Jessica is released from prison she will be 22, with an entire adult life ahead of her. I believe it is critical for the public safety for her and others like her to have options besides a life of crime.

The Miami Herald reported the stories of Joseph Tejera and Rebekah Homerston. Tejera was sentenced as an adult for a burglary offense, and was placed in an adult prison instead of an intensive juvenile program where he would have received 24-hour supervision, had access to educational and other programs, and been surrounded by other juveniles. Instead, at the age of 16 and weighing 135 pounds, he was surrounded by adult inmates who constantly tried to beat him up. Despite a sterling disciplinary record, he was involved in five fights because of the aggressiveness of adult inmates. Homerston was the daughter of a father serving life in prison for sex crimes against minors and a mother arrested for theft and drunk driving. At the age of 13, she ran away from home, and lived on the streets of Fort Lauderdale. At 15, she too was prosecuted and sentenced to a two-year term as an adult after vandalizing the city's recreation center. Upon her release from that prison term, she was arrested at age 16 for shoplifting a shirt, and is now serving three and a half years in an adult facility for that offense. While in prison, she has witnessed numerous suicide attempts.

Housing juveniles with adult inmates creates problems not just for the juveniles involved. Such policies also create difficulties for corrections administrators, whose prisons and jails often lack the physical structure, programs, and trained personnel to manage a mixed juvenile-adult population. John Gorsik, the head of the Department of Corrections in my State of Vermont, has advised that corrections officials from around the nation dislike having juveniles in their facilities. These officials often become responsible for delivering those services to which juveniles are entitled, including special education services. As one report on Youth in the Criminal Justice System recently recommended: "Administrative staff and people in policy making positions dealing with youth in the

adult system should have education, training, and experience regarding the distinctive characteristics of children and adolescents." This bill would provide for such education and training to make the jobs of corrections officials around the nation easier. In addition, the presence of juveniles among adult inmates can lead to increased disciplinary problems and the inculcation of a criminal mentality in young, highly impressionable offenders like Jessica. Our prisons and jails are too often becoming schools for young lawbreakers.

I would like to explain how this bill addresses confinement conditions for juveniles.

Title I: The first title of this bill creates a new incentive grant program for State and local governments and Indian tribes. These grants can be used for the following purposes related to juveniles under the jurisdiction of an adult criminal court: (a) alter existing correctional facilities, or develop separate facilities, to provide segregated facilities for them, (b) provide orientation and ongoing training for correctional staff supervising them, (c) provide monitors who will report on their treatment, and (d) provide them with access to educational programs, vocational training, mental and physical health assessment and treatment, and drug treatment. Grants can also be used to seek alternatives to housing juveniles with adult inmates, including the expansion of juvenile facilities.

It is important to note that States that choose not to house juveniles who are convicted as adults with adult inmates are still eligible for grants under this bill. For example, they could use the money to train staff, or to provide educational or other programs for juveniles, or to improve juvenile facilities.

Applicants for these grants must provide a detailed plan explaining how they will improve conditions for juveniles in their adult corrections system. Let me be clear: the purpose of this grant program is not to fuel a prison-building boom, or to make it easier for States to prosecute juveniles as adults, but to improve conditions for juveniles. States will need to take this purpose into account in making their grant proposals. Moreover, to be eligible for a grant, States must have developed guidelines on the appropriate use of force against incarcerated juveniles, and must also have prohibited the use of electroshock devices, chemical restraints and punishment, and 4-point restraints. The use of such punishment is inconsistent with our commitments to treating juveniles humanely, and is at variance with the very purpose of this grant program. Every State that can meet the requirements of the grant program will receive funding under this title, and rural representation is guaranteed.

Title II: The second title of the bill authorizes States to use their Violent Offender Incarceration/Truth in Sentencing (VOI/TIS) grant money to improve the treatment of juveniles under

the jurisdiction of the adult criminal justice system. It also offers States an incentive to use a substantial percentage of their VOITIS money for that purpose. States that use 10 percent of their grant money to improve juvenile conditions will receive a bonus of 5 percent above the amount to which they are otherwise entitled under that program. The money can be used to alter existing facilities to provide separate space for juveniles under the jurisdiction of an adult criminal court, or to provide training and supervision of corrections officials and reporting on juvenile conditions. This title, in conjunction with Title I, allows us to make improving conditions for juveniles a national priority by working through the States. No State will be forced to use their money for this purpose or see their funding reduced if they choose not to. But those States that do make a serious effort in this regard will be rewarded.

Title III: The third title of this bill reauthorizes the Juvenile Justice and Delinquency Prevention Act. Under the JJDPA, States receiving federal funds must maintain core protections for detained juveniles. These protections include “sight” and “sound” separation between those in the juvenile detention system and adult offenders. Children cannot be put in adjoining cells with adults, or placed in circumstances that allow them to be subject to threats and verbal abuse from adults in dining halls, recreation areas, and other common spaces. In addition to establishing sight and sound separation, the JJDPA provides three additional core protections: (1) removal of juveniles from adult jails or lockups, with a 24-hour exception for rural areas and other exceptions for travel and weather-related conditions; (2) deinstitutionalization of status offenders; and (3) efforts toward reducing the disproportionate confinement of minority youth in the juvenile justice system.

I am very pleased that Senator HATCH has agreed with me that we need a straightforward reauthorization of the JJDPA. He and I both worked very hard in the last Congress to reauthorize that law, and our efforts were sidetracked by numerous factors.

Title IV: Finally, the fourth title of this bill contains a number of provisions that I would like to highlight today. First, it authorizes funding for rural States and economically distressed communities that lack the resources to provide secure custody for juvenile offenders. Second, this title calls for a study on the effect of sentencing juvenile drug offenders as adults. Many have raised concerns about the toll taken on some of our communities, especially those in poorer areas, by lengthy drug sentences. There is no question that the proliferation of illegal drugs over the last 20 years has presented a social crisis with particularly serious effects on poor and urban communities. But we need to take a systematic look at whether our

approach to that crisis has been effective and fair, and the study in this bill should be part of that effort. Third, this bill instructs the General Accounting Office to prepare a report on the prevalence and effects of the use of electroshock weapons, 4-point restraints, chemical restraints, restraint chairs, and solitary confinement against juvenile offenders in both the Federal and State corrections systems. I am deeply concerned about the disciplinary methods being used against juvenile offenders in the U.S., and I believe it is important for Congress to receive an accounting of the problem so we can consider whether further legislation in this area is appropriate. Fourth, this title reauthorizes the Family Unity Demonstration Project, which provides funding for projects allowing eligible prisoners who are parents to live in structured, community-based centers with their young children. A study by the Bureau of Justice Statistics found that about two-thirds of incarcerated women were parents of children under 18 years old. According to the White House, on any given day, America is home to 1.5 million children of prisoners. And according to Prison Fellowship Industries, more than half of the juveniles in custody in the United States had an immediate family member behind bars. This is a serious problem, and reauthorizing the Family Unity Demonstration Project will help us address it.

I would like to thank numerous people who have worked with me and my staff on this proposal: Ken Schatz of the Vermont Children and Family Council, Marc Schindler and Mark Soler of the Youth Law Center, David Doi of the Coalition for Juvenile Justice, Jill Ward from the Children's Defense Fund, and John Gorsik and John Perry at the Vermont Department of Corrections. Without their help, I would not be able to introduce this bill today.

In conclusion, let me say that Congress must act to ensure that minimum standards are created in as many States as possible to ameliorate the problems resulting from sentencing juveniles as adults. I think this bipartisan bill accomplishes that goal, and I urge the Senate to give its full consideration, and its approval, to this proposal.

By Ms. SNOWE (for herself, Ms. COLLINS, Mr. JEFFORDS, and Mr. LEAHY):

S. 1177. A bill to amend title XI of the Social Security Act to clarify that the Secretary of Health and Human Services has the authority to treat certain State payments made in an approved demonstration project as medical assistance under the Medicaid program for purposes of a rebate agreement under section 1927 of the Social Security Act, and for other purposes; to the Committee on Finance.

Ms. SNOWE. Mr. President, I rise today to introduce a bill along with

Senator COLLINS, JEFFORDS and LEAHY to provide the states of Maine and Vermont continued authority to expand access to discounted prescription drugs under Medicaid.

Maine has instituted an innovative demonstration program called the “Healthy Maine Prescriptions” program that is leading the way in providing affordable prescription drugs for qualifying Maine residents. This was made possible because Maine is one of two States, along with Vermont, to have received approval from the Secretary of the Department of Health and Human Services for demonstration projects to expand access to prescription drugs under Medicaid. Thousands of individuals with no other prescription drug insurance benefits are enrolled in those programs.

The sad truth is, many low-income individuals cannot afford to purchase the drugs prescribed by their doctors. The result is that these individuals either split the doses to make them last longer—in violation of doctors' orders; they cut back on other necessities like food or clothing; or they simply decide not to fill the prescription at all—surely a prescription for medical disaster.

Not only does the inability to pay for medications have an adverse and potentially dangerous effect on individuals, it is also a detriment to the health care system in general when you consider the number and expense of ailments that could have been prevented with the proper prescription drug.

The reason why we are introducing this legislation is that, unfortunately, last month, a three-judge panel of the U.S. Court of Appeals for the District of Columbia ruled against the Vermont program, finding that Vermont “lacked the authority to offer the same prescription rebates offered under federal Medicaid insurance” because Congress “imposed rebate requirements to reduce the cost of Medicaid.” More recently, because of that ruling, a complaint has been brought by PHARMA against the Secretary of Health and Human Services to provide injunctive relief in the case of Maine’s program.

This bill sets forth findings that support the need and legitimacy of the Maine and Vermont programs and provides, in statute, specific authority for these prescription drug discounts for states whose waivers were approved before January 31, 2001.

Specifically, the bill amends Section 1115 of the Social Security Act—the portion of the act granting the Secretary of Health and Human Services the authority to approve demonstration projections. It makes clear that any expenditures the state may make under the demonstration project will be treated as payments made under the state plan under Medicaid for covered outpatient drugs for purposes of a rebate agreement, regardless of whether these expenditures by the state are offset or reimbursed, in whole or in part, by rebates received under such an agreement.

It also makes clear that these projects are entirely consistent with the objectives of the Medicaid program. Finally, it states that the regular cost-sharing requirements under Medicaid do not have to apply in the instance of these programs.

One of the objectives of the Medicaid program is “to enable each State, as far as practicable under the conditions in such State, to provide medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services.” As part of carrying out this objective, every state has elected the option of providing prescription drugs as a benefit under the Medicaid program, thereby providing an important means of increasing the access of low-income individuals to drugs prescribed by their doctors.

Furthermore, Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to approve demonstration projects that are likely to assist in promoting the objectives of the Medicaid program, and waive compliance with any of the state plan requirements of the Medicaid program. The fact of the matter is, Medicaid demonstration projects help promote the objectives of the Medicaid program, including obtaining information about options for increasing access to prescription drugs for low-income individuals.

If indeed the States are truly laboratories of democracy—and I believe they are—these demonstration projects deserve the chance to work, to be examined, and to assist those that they are designed to assist. And there is no question of the need—in Maine, 50,000 people signed up within the first three weeks of the program.

Under the “Healthy Maine Prescriptions Program,” Maine provides prescription drug discounts of up to 25 percent for all adults with incomes of up to 300 percent of the Federal Poverty Level. A second benefit offering discounts of 80 percent of the cost of prescription drugs is available for disabled citizens, and low-income adults over the age of 62 who have an income of up to 185 percent of the Federal Poverty Level.

During this time when virtually everyone agrees that something must be done to increase access to affordable prescription drugs, we ought to be encouraging innovative programs like those in Maine and Vermont. Terminating Medicaid demonstration projects prior to their planned expiration dates may result in significant waste of public funds and may be detrimental to those who have come to rely on such projects.

We ought to be doing all we can to provide relief to low-income Americans, and at the same time give our-

selves the opportunity to evaluate what works and what doesn’t. Maine and Vermont are to be commended for their efforts, not punished—they are entirely in keeping with the spirit and intent of Medicaid and I hope my colleagues will recognize the value of these demonstration projects.

Ms. COLLINS. Mr. President, I am pleased to join with my colleague from Maine, Senator SNOWE, and my colleagues from Vermont, Senators JEFFORDS and LEAHY, in introducing legislation to ensure that States like Maine and Vermont, which have taken the initiative in developing innovative programs to make prescription drugs more affordable for their citizens, can proceed with these efforts.

The last 20 years have witnessed dramatic pharmaceutical breakthroughs that have helped reduce deaths and disability from heart disease, cancer, diabetes, and many other diseases. As a consequence, millions of people around the world are leading longer, healthier, and more productive lives. These new medical miracles, however, often come with hefty price tags, and many people—particularly lower Americans without prescription drug coverage—are simply priced out of the market.

As so often happens, the States have been the laboratories for reform in this area and have come up with some creative ways to address this problem. In January of this year, the Department of Health and Human Services granted Maine a waiver under the Medicaid program through which States can offer drug discounts of up to 25 percent for individuals with incomes up to three times the Federal poverty level. Our new Healthy Maine Prescriptions Program includes both this new discount prescription drug benefit and a separate benefit, financed entirely with State funds, that offers discounts of up to 80 percent for low-income elderly and the disabled. Maine began providing benefits under the Healthy Maine Prescription Program on June 1st of this year, and by June 26th the Department of Human Services had enrolled 50,460 individuals into the program. Ultimately, it is estimated that 225,000 Mainers qualify for the program.

Unfortunately, however, this important new program has run into a stumbling block. Last month, in a case brought by the Pharmaceutical Research and Manufacturers of America (PhRMA), a three-judge appeals panel ruled that a similar program developed by Vermont “lacked the authority to offer the same prescription rebates offered under federal Medicaid insurance” because Congress “imposed rebate requirements to reduce the cost of Medicaid.” The pharmaceutical trade group has subsequently sued the Department of Health and Human Services to block the Maine waiver, and the State of Maine has become a party to that case.

The Maine program is different enough from Vermont’s to provide a different result in court. However, we believe that innovative programs like these, which meet such a clear human need, should be able to proceed without having to fight endless legal battles. That is why we are introducing legislation today to give the Department of Health and Human Services clear authority to grant States these kinds of waivers, which will allow them to pursue innovative uses of Medicaid, such as the Health Maine Prescription program. Secretary of Health and Human Services Tommy Thompson made creative use of these kinds of Medicaid waivers when he was Governor of Wisconsin. We believe that he should be able to continue to do so in his new role as Secretary without the chilling effect brought by lawsuits like PhRMA’s.

The legislation we are introducing today will allow States like Maine to proceed with the innovative programs they have developed to meet the prescription drug needs of their citizens, and I urge all of my colleagues to join us in cosponsoring the legislation.

SENATE RESOLUTION 129—ELECTING JERI THOMSON AS SECRETARY OF THE SENATE

Mr. DASCHLE (for himself and Mr. LOTT) submitted the following resolution; which was considered and agreed to:

S. RES. 129

Resolved, That Jeri Thomson be, and she is hereby, elected Secretary of the Senate, effective July 12, 2001.

SENATE RESOLUTION 130—NOTIFYING THE HOUSE OF REPRESENTATIVES OF THE ELECTION OF A SECRETARY OF THE SENATE

Mr. DASCHLE (for himself and Mr. LOTT) submitted the following resolution; which was considered and agreed to:

S. RES. 130

Resolved, That the House of Representatives be notified of the election of the Honorable Jeri Thomson as Secretary of the Senate.

SENATE RESOLUTION 131—NOTIFYING THE PRESIDENT OF THE UNITED STATES OF THE ELECTION OF A SECRETARY OF THE SENATE

Mr. DASCHLE (for himself and Mr. LOTT) submitted the following resolution; which was considered and agreed to:

S. RES. 131

Resolved, That the President of the United States be notified of the election of the Honorable Jeri Thomson as Secretary of the Senate.