grantee. Under the auspices of a NIDA funded treatment research project I have utilized buprenorphine as a maintenance therapy and have been very impressed not only with its effectiveness in curtailing heroin use, but as well with its acceptance by patients who would not have considered treatment with methadone. Thus this medication may reach opiate addicts who currently are resistant to enrollment in opiate maintenance programs that use ORLAAM and methadone. I have letters on my desk from patients whose lives have been turned around by the buprenorphine maintenance treatment we have provided them. I have even more letters from opiate addicted people who are asking where they can find such treatment. Because of the approval by the FDA of two buprenorphine preparations and the passage of the Drug Abuse Treatment Act of 2000, it is now possible to give the answer. Find a qualified physician in your area of the country and be seen as a regular patient in their office receiving a prescription for buprenorphine. Tragically, I see young people every day who are in need of medications to ease their need for heroin so that they can become invested in rehabilitation activities that can return their life trajectory to a normal, productive and fulfilling course. Currently the available medications, methadone and ORLAAM, are extremely useful but ensnared in regulations that grossly limit their potential effectiveness. Having a safe, effective narcotic preparation like buprenorphine that can be used by qualified physicians for the treatment of opiate addition that is unfettered by the methadone regulations is a major advance in our ability to provide badly needed services in a cost effective manner.

I am very proud as a resident of the state of Michigan to have Senator Levin as my representative in the United States Senate. He and his staff have worked tirelessly to secure the passage of the Drug Abuse Treatment Act of 2000. This landmark legislation represents a major shift in policy in how we view and treat the problem of opiate addition. This advance in our policies regarding the treatment of opiate addition has been a long time in coming. But thanks to the efforts of Senator Levin, it has finally arrived. I join in celebrating this achievement which has the potential for providing significant help to those attempting to overcome the ravages of opiate addition. Individuals seeking help for their opiate addition do not have much political power and are rarely heard in drug abuse policy debates. Fortunately for them they have a compassionate and steadfast advocate in Senator Levin.

REMARKS OF DR. HERBERT KLEBER AT PRESS CONFERENCE ON FDA APPROVAL OF BUPRENORPHINE/NX

Today marks an important milestone in the treatment of substance dependence disorders. Buprenorphine, both in the combined form with antagonist naloxone and in the mono-form, have just been approved by the Food and Drug Administration, the first therapies approved for in-office prescribing under the Federal Drug Addiction Treatment Act of 2000. The path has been a long and at times torturous one but a careful one. It can hardly be described as a rush to market: my first research paper on buprenorphine was published in 1988 and colleagues had published earlier. During this decade and a half we have learned much about this agent and it's potential for the treatment of narcotic addition. I am very grateful for the help from certain key senators, both in passing the Drug Addition Treatment Act and for their continued encouragement during this long and difficult process. Senator Carl Levin of Michigan has been a special stalwart in this process but the effort has truly been a bipartisan one with Senators Orrin Hatch of Utah and Joseph Biden of Delaware both playing active roles along with Senator Levin.

The importance of this day, however, is much more than the particular medications involved. Buprenorphine to be sure should help in combating opioid dependence in formerly underserved communities. It is estimated that there are up to 1 million opioid dependent individuals in the United States of whom less than 200,000 are in treatment. The annual cost to society of opioid addiction is more than 20 billion dollars. Buprenorphine may increase the likelihood of people who have not currently sought out treatment to do so, thus reducing the enormous toll, both in health and in crime, that addiction takes on society. Injecting drug users and their sexual partners, for example, have become the largest new group of individuals becoming HIV positive. While buprenorphine is neither a panacea nor a magic bullet, it has major advantages in terms of safety, duration of action, and ease of withdrawal in comparison to existing medications on the market. That plus the ability to be treated in the privacy of the doctor's office are all important advances.

The major importance of the FDA approval and the Drug Abuse Treatment Act, however, go well beyond the particular medications and instead to how we think about addiction. Papers by myself and my colleagues have emphasized that opioid dependence as with other addictions is a chronic relapsing disorder, not a character flaw, failure of will, or lack of self-control. These drugs change our brains, changes that can persist long after the individual has stopped taking the drug and lead frequently to relapse. When a patient who cannot stop smoking on his own seeks help from his physician, he is seen as a patient who needs help and the physician will respond with a variety of medications and behavioral interventions. Likewise, it is my hope that with the advent of these medications the treatment of opioid dependence will be able to be mainstreamed. Individuals who are dependent either on street opioids like heroin or on prescription opioids will be able to receive help in doctors' offices and medical clinics. They will hopefully one day be treated with the same dignity with which we treat the patient trying to give up smoking or the diabetic or the hypertensive, all individuals that have chronic relapsing disorders involving both physical and behavioral components.

Addiction is initiated by a voluntary act but this initial voluntary behavior is in many cases shaped by pre-existing genetic factors and there are early brain changes, which may evolve into compulsive drug taking less subject to voluntary control. It is important to recognize, however, that drug dependence erodes but does not erase a dependent individual's responsibility for control of their behavior. Many patients with other chronic illnesses fail to see the importance of their symptoms and thus may ignore physician's advice, fail to comply with medication, and engage in behaviors that exacerbate their illnesses. While such patients may not be as disruptive, demanding, or manipulative as alcohol or drug dependent patients, the patterns of denial of symptoms, failure to comply with medical care and subsequent relapse are not particular to addiction. One thing, however, that does separate addiction from other illnesses is the waiting list for treatment throughout the United States which contradicts assertions that addicted persons do not want help.

Compassion or sympathy is not the basis for the argument that physicians should treat addicted individuals. Medically oriented treatments can be quite effective. In addition, addiction treatments have been effectively combined with legal sanctions such as drug courts and court-mandated treatments. Medical interventions should be taught in medical schools and primary care residencies. If physicians develop and apply the skills available to diagnose, treat, monitor, and refer patients in the early stages of substance dependence, there will be fewer late-stage cases.

I have been involved in treatment and research with substance dependent individuals for over 35 years, initially at Yale University and the last decade at Columbia University. In between I spent approximately 2½ years as the Deputy Director of the Office of National Drug Control Policy under Bill Bennett and the first President Bush. The new era in office-based treatment of opioid dependence is a worthy successor to efforts made by our Office back in the early 1990's to expand the number of individuals in treatment with substance dependence. My appreciation—and that of many future patients—to the legislators and federal agencies that made this possible.

Thank you.

PRESS CONFERENCE PARTICIPANTS, FDA APPROVAL OF BUPRENORPHINE/NALOXONE, OCTOBER 9, 2002, SR 236

Senator Carl Levin.

Senator Orrin Hatch.

Dr. Frank Vocci, Director of the Division of Treatment Research and Development, National Institute on Drug Abuse.

Dr. Steven K. Galson, Deputy Director, Food and Drug Administration's Center for Drug Evaluation and Research.

Dr. Wesley Clark, Director, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Dr. Herbert D. Kleber, Professor of Psychiatry and Director, Division of Substance Abuse, Columbia University.

Dr. James H. Wood, Professor, Department of Psychology and Pharmacology and Director of Drug Addiction Research Projects, University of Michigan.

Dr. Chris-Ellyn Johanson, Professor of Psychiatry and Associate Director of Substance Abuse Research, Wayne State University.

Dr. Charles Schuster, Professor of Psychiatry and Behavioral Neuroscience, Wayne State University.

THE IMPORTANCE OF ENERGY LITERACY TO A NATIONAL ENERGY POLICY

Mr. ALLARD. Mr. President, I wish to bring the Senate's attention to the importance of energy literacy to a national energy policy.

The National Energy Policy Development Group recommended an energy literacy project in the May 2001, National Energy Policy. You can find it on the first page of Chapter Two, entitled ''Striking Home.'' The recommendation states, ''The NEPD

Group recommends that the President direct the Secretary of Energy to explore potential opportunities to develop educational programs related to energy development and use. This should include possible legislation to create public awareness programs about energy. Such programs should be long term in nature, should be funded and managed by the respective energy industries, and should include information on energy's compatibility with a clean environment.''

The legislation currently under consideration in the House/Senate conference addresses a lot of important issues but these are tactical issues relating to energy. In order to better solve the Nation's long-term energy security or energy needs we must address public education.

One of the best ways to go about this would be with a broad based education program as recommended in chapter two. Today's public is far better informed about their energy choices than the public of even a decade ago, but there is always more room to learn. A highly informed public will be able to make better energy choices and will demand a long-term, far-reaching energy policy.

This will require broad based national, and international, public education and information programs on energy issues, including conservation and efficiency, the role energy plays in the economy and the impact energy use has on the environment. There must also be a focus on the interlocking relationship of what are referred to as the 3 Es: energy, economy, and environment.

It is important that all 3 Es be considered simultaneously in order to have credibility and to recognize this interlocking relationship. It is also important that any effort that tries to achieve a cultural change in how society views energy recognize its importance in the public's economic well-being and its role in the public's quality of life.

An excellent example of this is being conducted by the Energy Literacy Project, ELP. The ELP is currently supporting an ongoing research effort at the Colorado School of Mines to identify programs that offer educational material about the interlocking nature of Energy, the Economy and the Environment, the 3 Es. The ELP is a non-profit 501(c)(3) corporation whose goal is to see a cultural change in how society views the role energy plays in its economic well-being and in its quality of life. They have an excellent web site that explains much of their work located at www.energyliteracy.org.

The public wants and deserves sound, reliable information. A sustainable energy policy will be much more easily attained with a knowledgeable public that can make informed, well-reasoned decisions about its choices and a sustainable energy policy.

SKILLED NURSING FACILITIES

Mr. SMITH of Oregon. Mr. President, I would like to raise another issue today which has a major impact on older and disabled Americans and their families, nursing homes. Under current law, Medicare rates for seniors in nursing homes were reduced by ten percent as of October 1, because a series of previously-enacted add-on provisions expired. Let me be clear. On October 1, the average per diem payment to a nursing home to care for a Medicare patient was cut to a level ten percent lower than it was on September 30. The average rate fell from $337/day to slightly more than $300/day. This is a real cut.

This negative quirk results from the fact the Clinton Administration poorly implemented the Balanced Budget Act, BBA, of 1997, and in the process, set Medicare rates for seniors in nursing homes far below the levels Congress set out in the BBA of 1997. Recognizing that the new system was paying much less for nursing home care for Medicare patients than it had intended, Congress passed the Balanced Budget Refinement Act of 1999 and then the Beneficiary Improvement Protection Act of 2000, which provided limited fixes to the payment structure for skilled nursing care through add-on payments. But, because it was expected HCFA, now CMS, would ''refine'' the rates and fix the problem, these add-ons were temporary. However, CMS has not yet acted, and the ''add-on'' provisions have now expired.

Recognizing the pending cuts needed to be prevented, in June, I, along with several of my Senate colleagues, introduced the Medicare Skilled Nursing Beneficiary Protection Act of 2002. Because I felt Congress must ensure beneficiary access to quality care, my bill would protect funding levels for Medicare skilled nursing patients by maintaining payments at 2002 levels going forward.

During the last few years, five of the nation's largest providers of long-term care have filed for Chapter 11 bankruptcy protection. Some of those companies are just now emerging from that wrenching process. Moreover, 353 skilled nursing homes have closed. In my home State of Oregon alone, 23 skilled nursing facilities, SNFs, have closed—a loss of almost 1,500 beds. For a small state like Oregon, this is a significant loss. With the cuts in Medicare funding, a vital segment of our country's health care system is beginning to be thrown, once again, into crisis. More facilities will close. Patients, especially those in rural areas, will find it more difficult to obtain the long-term care services they need.

The instability of skilled nursing facilities is expected to worsen as states reduce Medicaid expenditures in the face of significant budget shortfalls and as private market capital continues to withdraw from the sector. If Congress goes home before re-instating the Medicare payment add-ons, it will result in failures in the sector that will translate to unparalleled access problems for Medicare patients needing care in our nation's skilled nursing facilities. I will do everything I can to ensure quality care for our nation's seniors is not threatened.

CONGRESSIONAL-EXECUTIVE CONSULTATION ON TRADE

Mr. BAUCUS. Mr. President, in the coming weeks, the Finance Committee will be working closely with the Office of the U.S. Trade Representative to develop written Guidelines on consultations between the Administration and Congress in trade negotiations. These Guidelines will be our roadmap for collaboration between the Executive and Legislative Branches on trade negotiations for the next five years. They will be the basis for the partnership of equals called for by the Trade Act of 2002.

The trade negotiation agenda promises to be busy. Even before passage of the Trade Act, work was under way in the Doha Round of WTO negotiations and in the Free Trade Area of the Americas negotiations. USTR also was busy concluding free trade agreements with Chile and Singapore. Since passage of the Trade Act, USTR has expressed the Administration's interest in beginning FTA negotiations with Morocco, Central America, the Southern African Customs Union, and Australia.

This busy agenda requires maximum clarity in the rules governing interaction between the Administration and Congress. Clear rules will form a foundation for a common understanding of how we bring trade agreements from the concept phase to the implementation phase. This common understanding will help ensure a smooth process, with few if any surprises or bumps in the road.

The Trade Act defines the scope of coverage of the contemplated Guidelines on trade negotiations. Specifically, the Guidelines are required to address: the frequency and nature of briefings on the status of negotiations; Member and staff access to pertinent negotiating documents; coordination between the Trade Representative and the Congressional Oversight Group at all critical periods during negotiating sessions, including at negotiation sites; and consultations regarding compliance with and enforcement of trade agreement obligations.

The Guidelines also must identify a time frame for the President's transmittal of labor rights reports concerning the countries with which the United States concludes trade agreements.

The Trade Act contemplates collaboration among USTR, the House Ways and Means Committee and the Senate Finance Committee in developing the Guidelines. I would like to use this opportunity to propose specific provisions that should be included in the Guidelines to maximize the potential for a