expressing the sense of Congress to fully use the powers of the Federal Government to enhance the science base required to more fully develop the field of health promotion and disease prevention, and to explore how strategies can be developed to integrate lifestyle improvement programs into national policy, our health care system, schools, workplaces, families and communities.

S. CON. RES. 94

At the request of Mr. WYDEN, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. Con. Res. 94, a concurrent resolution expressing the sense of Congress that public awareness and education about the importance of health care coverage is of the utmost priority and that a National Importance of Health Care Coverage Month should be established to promote that awareness and education.

AMENDMENT NO. 4508

At the request of Mr. FEINGOLD, the names of the Senator from Nevada (Mr. REID) and the Senator from Maryland (Mr. SARBANES) were added as cosponsors of amendment No. 4508 intended to be proposed to H.R. 5005, a bill to establish the Department of Homeland Security, and for other purposes.

AMENDMENT NO. 4509

At the request of Mr. FEINGOLD, the names of the Senator from Nevada (Mr. REID) and the Senator from Maryland (Mr. SARBANES) were added as cosponsors of amendment No. 4509 intended to be proposed to H.R. 5005, a bill to establish the Department of Homeland Security, and for other purposes.

AMENDMENT NO. 4510

At the request of Mr. BAYH, the name of the Senator from Arkansas (Mr. HUTCHINSON) was added as a cosponsor of amendment No. 4510 intended to be proposed to H.R. 5005, a bill to establish the Department of Homeland Security, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. DEWINE (for himself and Mr. DURBIN):

S. 2913. A bill to amend the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code of 1986 to provide health insurance protections for individuals who are living organ donors; to the Committee on Health, Education, Labor, and Pensions.

Mr. DEWINE. Madam President, I rise today to raise the awareness of an issue that affects over 22,000 people a year, and that issue is organ donation. The sad fact about organ donations is this: We have the medical know-how to save lives, but we lack the organs. We lack organs because most Americans simply are unaware of the life-giving difference they can make by choosing to become organ donors.

Sadly, each day the waiting list for those needing organs continues to grow. Today, nearly 79,000 people remain on the national transplant waiting list. Right now, more than 50,000 people, alone, are waiting for kidney transplants. That number is expected to double within the next decade. Additionally, between 12 and 16 people die each day just waiting for an available organ.

To remedy the organ shortage, we must increase public awareness. By educating the public and raising awareness, more people will choose to become organ donors. At the very least, through these efforts, we can encourage more families to discuss what their wishes are and whether they would want to be organ donors.

But our efforts must not stop there. We must do more than just implement public awareness campaigns, because the face of organ donation is changing. For the first time ever, the number of living organ donors outnumbered cadaver donors. Last year, there were 6,081 donor cadavers while 6,485 people opted to become living donors, usually giving up a healthy kidney to help a family member or friend.

Recognizing this, my colleague, Senator DURBIN, and I introduce a bill today that would help protect living organ donors in the group insurance market. Our bill would ensure that those individuals who choose to be living organ donors are not discriminated against in the insurance marketplace. Our bill builds on the protections provided by the Health Insurance Portability and Accountability Act, so that living organ donors are not denied insurance nor are they applied discriminatory insurance premiums because of their living organ donor status.

Quite simply, a brother who donates a part of his kidney to his sister should not be denied health insurance. But tragically, that is what oftentimes happens. Frequently, individuals who are living organ donors are denied health insurance or restricted from the insurance market. Instead, we should celebrate living organ donors and remove obstacles and barriers for the successful donation of organs. Insurance shouldn't undermine someone's decision to be a living organ donor.

Some States are evaluating how living organ donors affect the market. States are amending their Family Medical Leave eligibility so that living organ donors can participate and benefit from the program. The Federal Government, with the Organ Donor Leave Act of 1999, offered 30 days paid leave to Federal employees who chose to be an organ donor. But, paid leave and job protection doesn't mean much if people are denied health insurance or are required to pay higher premiums because they donated an organ to save another person's life.

The impact of living organ donation is profound. A living organ donor not only can save the life of one patient, but can also take that person off the waiting list for a cadaver donation. That means the next person on the waiting list is ''bumped up'' a spot—giving additional hope to the 79,000 persons on the national transplant waiting list.

Living organ donors give family members and friends a second chance at life and the opportunity to reduce the number of people on the waiting list to receive an organ. It is time for Congress to make a sensible decision in support of a person's decision to be a living organ donor. I encourage my colleagues to join me in co-sponsoring this bill.

By Mr. ROCKEFELLER:

S. 2914. A bill to amend title XVIII of the Social Security Act to provide for appropriate incentive payments under the medicare program for physicians' services furnished in underserved areas; to the Committee on Finance.

Mr. ROCKEFELLER. Mr. President, today I introduce the Medicare Incentive Payment Program Refinement Act of 2002. This bill makes needed and long-overdue changes to the Medicare Inventive Payment Program, an initiative conceived to address the growing primary care physician shortage in some of our country's most medically underserved communities. The number of physicians needed to care for all individuals, especially our aging seniors, continues to grow in remote rural areas and in underserved urban areas. However, rising health costs and the difficulties of operating a practice in underserved communities has exacerbated the physician shortage. Although the Medicare Incentive Payment Program aims to address the financial hurdles facing physicians in needy areas, the program has failed to achieve real results. This bill will make fundamental changes to improve the program's effectiveness.

Rural areas, in particular, are in need of efforts to retain primary care physicians, since the difficulties of operating a practice often drive doctors to larger areas with more resources and professional support. According to the Federal Office of Rural Health Policy, over 20 million Americans live in areas that have a shortage of physicians, and between 1975 and 1995 the smallest counties in the U.S., population under 2,500, experienced a drop in their physician-to-population ratio. More than 2,200 primary care physicians would be needed to remove all nonmetropolitan HPSA designations, and more than twice that number is needed to achieve adequate physician staffing levels nationwide.

According to the National Rural Health Association, nonmetropolitan physicians treat a larger number of Medicare and Medicaid beneficiaries than their urban counterparts do, generating less income for physicians per patient. Furthermore, nonmetropolitan physicians are less likely to perform high cost medical services due to their limited number of resources. Understandably, MIPP monies can affect the quality of life for rural physicians and help prevent the mass migration of

needed health care professionals from underserved areas.

The Medicare Incentive Payment Program, as it exists today, has not fulfilled its original mandate, to recruit and retain primary care physicians in health professional shortage areas. Passed as part of OBRA 87, the program pays all physicians a 10 percent bonus for each Medicare recipient they treat. This enhanced reimbursement is meant to offset the financial advantage of providing service in more populous areas, as well as help physicians with the costs associated with operating a practice in an underserved community. Most importantly, the program aims to increase health care access for Medicare beneficiaries and improve the health of communities overall.

However, analyses from the Office of the Inspector General of HHS, the GAO, and independent health experts confirm that the program is unfocused and largely ineffective. All physicians are eligible for bonus payments, even when they may not be in short supply. Bonus payments are 10 percent, not enough to lure physicians to underserved areas, especially if the payment is based on a basic, primary care visit. Finally, many physicians do not even know this program exists, and those that do are often unsure whether they are delivering care in a HPSA and how to bill for the payment appropriately.

To improve the program, this bill increases the bonus payment from 10 percent to 20 percent and allows only those physicians providing primary care services, including family and general medicine, general internal medicine, pediatrics, obstetrics and gynecology, emergency medicine, and general surgery, to receive the incentive payment. Finally, my bill automates payments, so physicians no longer have to guess whether they are eligible for the program. These improvements will strengthen the original intent of the legislation, to recruit and retain primary care physicians in underserved areas, and strengthen the primary health care infrastructure of our country's most needy communities.

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:

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 Incentive Payment Program Refinement Act of 2002''.

SEC. 2. REVISION OF INCENTIVE PAYMENTS FOR PHYSICIANS' SERVICES FURNISHED IN UNDERSERVED AREAS.

(a) IN GENERAL.—Section 1833(m) of the Social Security Act (42 U.S.C. 1395*l*(m)) is amended to read as follows:

''(m) INCENTIVE PAYMENTS FOR PHYSICIANS' SERVICES FURNISHED IN UNDERSERVED AREAS.—

''(1) IN GENERAL.—In the case of physicians' services furnished by a physician with an applicable physician specialty to an individual who is enrolled under this part and who incurs expenses for such services in an area that is designated under section 332(a)(1)(A) of the Public Health Service Act as a health professional shortage area, in addition to the amount otherwise paid under this part, there also shall be paid to the physician (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund, an amount equal to 20 percent of the payment amount for the service under this part.

''(2) APPLICABLE PHYSICIAN SPECIALTY DEFINED.—In this subsection, the term 'applicable physician specialty' means, with respect to a physician, the primary specialty of that physician if the specialty is one of the following:

''(A) General practice.
''(B) Family practice.
''(C) Pediatric medicine.
''(D) General internal medicine.
''(E) Obstetrics and gynecology.
''(F) General surgery.
''(G) Emergency medicine.

''(3) AUTOMATION OF INCENTIVE PAYMENTS.—The Secretary shall establish procedures under which the Secretary shall automatically make the payments required to be made under paragraph (1) to each physician who is entitled to receive such a payment. Such procedures shall not require the physician furnishing the service to be responsible for determining when a payment is required to be made under that paragraph.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to services furnished on or after January 1, 2003, in an area designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area.

By Mr. BIDEN:

S. 2916. A bill to put a college education within reach, and for other purposes; to the Committee on Finance.

Mr. BIDEN. Mr. President, as another school year starts, many college students are worrying not only about their class loads and their coursework, but about where the money to pay for their educations will come from. Today, the average cost of attending a public 4-year college has jumped to $9,000, up 7.7 percent from last year. This represents the highest rate of increase since 1993. For those families that choose to send their children to a private institution, that number rises. Up 4.7 percent from the year before, the average cost of a private 4-year institution is now close to $24,000 a year.

What do these rising tuition costs mean? Hard working American families are spending a larger percentage of their incomes than ever before to send their children to college. To attend the University of Delaware, where I went to school, it costs nearly 20 percent of a Delaware family's average annual income to cover costs. To attend a private college or university, that number, in some instances can jump to over 40 percent of annual income.

To help remedy this situation I come to the floor today to reintroduce legislation to help American families afford their children's tuition. This comprehensive package, ''The Tuition Assistance for Families Act,'' builds upon previous steps that others and I have taken to make it possible for more families to provide their children with a college education. I introduce this bill so that the decision to send one's child to college will not be overshadowed by the decision of how to pay for it.

The ''Tuition Assistance for Families Act'' will provide middle class American families with a $12,000 tuition tax deduction each year. Based on legislation that I introduced with Senator SCHUMER last year, at $12,000 this deduction provides real, meaningful tax relief. Tax relief that American families have been waiting for. Tax relief that can go a long way in helping them afford room, board and tuition.

The bill that I am introducing today also expands the two tuition tax credits enacted in 1997—the Hope Scholarship and the Lifetime Learning Tax Credit. Under current law, the Lifetime Learning Credit allows a 20 percent tax credit on the first $10,000 in higher education expenses in year 2003. Under my bill, the Lifetime Learning Tax Credit percentage would jump from 20 to 25 percent and raise the amount of education expenses subject to the credit to $12,000. In terms of real dollars, this would mean that a student who files in tax year 2003 under my plan could get up to $3,000 back in taxes. Under current law, the maximum allowable credit is only $2,000. That is a $1,000 difference. $1,000 that can go directly into a student's pocket to pay for books, a computer or tuition. The also raises the income limits for each credit to $130,000 per family, per year, so that more families are afforded the help that they need.

This bill reintroduces the idea of a $1,000 merit scholarship to be awarded to the top 5 percent of each high school's graduating class. These types of scholarships not only reward student achievement, they help to ensure that the best and brightest students have the ability to go on to college—thereby increasing the pool of well-qualified American workers for the information technology age.

This act also increases the maximum Pell Grant award from $4,000 to $4,500. During the 2001–2002 school year, the maximum Pell Grant award covered about 42 percent of the average tuition, room and board at a public 4-year university. During the 1975–76 it covered 84 percent of these same costs. Clearly, the purchasing power of these grants has dramatically declined. As such, the debt load of American families and American students has increased considerably over the years as students have looked to federal and private loans to finance their educations. A report released just this March by the State PIRG's Higher Education Project found that at the end of the 1999–2000 school year, 64 percent of college students graduated with student loan debt at an average of $16,928, nearly double the average debt load just eight years ago. Double the debt load in 1994.

It is the dream of every American to provide for their child a better life than they had themselves. Helping families afford the increasing cost of a college education will move us closer to making that dream a reality. For this reason, I have spent a great deal of time in the Senate fighting to provide tax relief for middle class American families struggling with the cost of college. And while I was pleased when some of the ideas I advocated were adopted in the 1997 tax cut bill, it is clear that as tuition costs rise dramatically, working Americans need additional assistance. The ''Tuition Assistance for Families Act'' will provide extra help so that more families can afford to give their children a brighter and better future. Let's not allow a college education to become a luxury when, in the information technology age, it is an absolute necessity.

STATEMENTS ON SUBMITTED RESOLUTIONS

SENATE RESOLUTION 324—CONGRATULATING THE NATIONAL FARMERS UNION FOR 100 YEARS OF SERVICE TO FAMILY FARMERS, RANCHERS, AND RURAL COMMUNITIES

Mr. JOHNSON (for himself, Mr. WELLSTONE, Mr. HARKIN, Mr. LUGAR, Mr. DASCHLE, Mr. CONRAD, Mr. DORGAN, Mr. GRASSLEY, Mr. DAYTON, Mr. NELSON of Nebraska, Mr. DURBIN, Mr. BAUCUS, Mr. ALLARD, Mr. FEINGOLD, Mr. BAYH, Mr. CRAPO, Mrs. CARNAHAN, Mr. BINGAMAN, Mrs. MURRAY, Mr. JERFFORDS, Mr. LEVIN, Mr. LIEBERMAN, Mr. DEWINE, Ms. STABENOW, and Mr. BREAUX) submitted the following resolution; which was referred to the Committee on Agriculture, Nutrition, and Forestry:

S. RES. 324

Whereas the National Farmers Union celebrates its centennial anniversary in 2002;

Whereas during its 100 years of service to rural America, the National Farmers Union has faithfully promoted the organization's mission of education, legislation, and cooperation as identified by its founders and proclaimed in its triangular symbol;

Whereas the National Farmers Union represents nearly 300,000 family farmer and rancher members across the United States;

Whereas the National Farmers Union epitomizes the spirit and energy of hundreds of thousands of family farmers, ranchers, rural advocates, and communities;

Whereas the National Farmers Union remains dedicated to protecting and enhancing the quality of life for rural America;

Whereas the National Farmers Union has been instrumental in the establishment and progress of the farmer-owned cooperative movement; and

Whereas the National Farmers Union strives to improve rural America through proactive support and proposals to enhance rural economic development, educational opportunities, resource conservation, market competition, domestic farm income, and international cooperation: Now, therefore, be it

Resolved, That the Senate commends and congratulates the National Farmers Union for a century of dedicated service to the farmers, ranchers, and rural communities of the United States.

SENATE CONCURRENT RESOLUTION 138—EXPRESSING THE SENSE OF CONGRESS THAT THE SECRETARY OF HEALTH AND HUMAN SERVICES SHOULD CONDUCT OR SUPPORT RESEARCH ON CERTAIN TESTS TO SCREEN FOR OVARIAN CANCER, AND FEDERAL HEALTH CARE PROGRAMS AND GROUP AND INDIVIDUAL HEALTH PLANS SHOULD COVER THE TESTS IF DEMONSTRATED TO BE EFFECTIVE, AND FOR OTHER PURPOSES

Mr. REID (for himself and Ms. CANTWELL) submitted the following concurrent resolution; which was referred to the Committee on Health, Education, Labor, and Pensions:

S. CON. RES. 138

Whereas ovarian cancer is a serious and under recognized threat to women's health;

Whereas ovarian cancer, the deadliest of the gynecologic cancers, is the fourth leading cause of cancer death among women in the United States

Whereas ovarian cancer occurs in 1 out of 57 women in the United States;

Whereas approximately 50 percent of the women in the United States diagnosed with ovarian cancer die as a result of the cancer within 5 years;

Whereas ovarian cancer is readily treatable when it is detected in the beginning stages before it has spread beyond the ovaries, but the vast majority of cases are not diagnosed until the advanced stages when the cancer has spread beyond the ovaries;

Whereas in cases where ovarian cancer is detected in the beginning stages, more than 90 percent of women survive longer than 5 years;

Whereas only 25 percent of ovarian cancer cases in the United States are diagnosed in the beginning stages;

Whereas in cases where ovarian cancer is diagnosed in the advanced stages, the chance of 5-year survival is only about 25 percent; and

Whereas ovarian cancer may be difficult to detect because symptoms are easily confused with other diseases and because there is no reliable, easy-to-administer screening tool: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That it is the sense of Congress that—

(1) the Secretary of Health and Human Services, acting through the Director of the National Institutes of Health—

(A) should conduct or support research on the effectiveness of the medical screening technique of using proteomic patterns in blood serum to identify ovarian cancer, including the effectiveness of using the technique in combination with other screening methods for ovarian cancer; and

(B) should continue to conduct or support other promising ovarian cancer research that may lead to breakthroughs in screening techniques;

(2) the Secretary of Health and Human Services should submit to Congress a report on the research described in paragraph (1)(A), including an analysis of the effectiveness of the medical screening technique for identifying ovarian cancer; and

(3) if the research demonstrates that the medical screening technique is effective for identifying ovarian cancer, Federal health care programs and group and individual health plans should cover the technique.

Mr. REID. Madam President, I rise today for myself and Senator CANTWELL to submit a concurrent resolution expressing the sense of the Congress that the Secretary of Health and Human Services should conduct or support research to improve early detection of ovarian cancer. Specifically, our resolution encourages continuing and accelerating the development of an ovarian cancer screening test currently underway through a public-private partnership including the National Cancer Institute and the Food and Drug Administration.

Ovarian cancer is the deadliest of the gynecologic cancers and the fourth leading cause of cancer death among women in the United States. Ovarian cancer occurs in 1 out of 57 women, and an estimated 13,900 American women died from ovarian cancer in 2001 alone.

Currently, approximately three-quarters of women with ovarian cancer are diagnosed when they are already in advanced stages of the disease, and only one in five will survive five years. However, if the disease is caught early, the five-year survival rate jumps to 95 percent. Thus providing a way to routinely identify the disease in its ''Stage 1'' phase could have a dramatic impact in what is now a very deadly cancer. No screening test exists that can accurately detect ovarian cancer in the early states when it is highly curable.

In the February 2002 issue of The Lancet, scientists from the Food and Drug Administration and the National Cancer Institute reported that patterns of protein found in patients' blood serum may reflect the presence of ovarian cancer. Using an innovative testing approach, analyzing patterns of blood protein rather than identifying single blood biomarkers, researchers were able to differentiate between serum samples taken from patients with ovarian cancer and those from unaffected individuals.

However, this research finding was only a first step. Before the scientific community will agree that protein screening is an accurate and beneficial tool, additional multi-institutional trials must be completed.

Patients would certainly be more willing to be tested if all that it involved were a simple, finger-stick blood test, thus eliminating the need for surgery, biopsy, or other painful, invasive, or risky procedures. The critical advantage of such as screening test is early detection, finding the disease when it is most treatable. Of course, early detection of ovarian cancer will save health care costs, but, more importantly, it will save lives.

This is why I am submitting this resolution. Our resolution encourages the Department of Health and Human Services to rapidly evaluate the efficacy of this cutting-edge work in the area of testing for ovarian cancer. If the screening tests are proven effective, the public must have the widest