copay for a prescription, and that has doubled, tripled or gone higher. This also makes no sense.

On top of that, those who were in Medicaid, our lowest income seniors, many in nursing homes, were automatically enrolled sometime in the last few months, into a plan, regardless of whether it covered the medicines. We have said to the lowest income seniors, many of them in nursing homes, you are signed up for a plan, and you have to go figure out whether it even helps you and how you are going to get out of it if it doesn't help you. And, by the way, you are going to pay more.

We can do better than this. I believe No. 1 is to stop the 6-day count. No. 1, we have to give folks more time to wade through all of this, to figure out what is going on, and we have to give some more time to the Government to get its act together. The administration is doing a disservice to people by the way this has been handled. Giving more time will allow that to happen.

I am also very hopeful we are going to come back and come together and give people the one choice they really want. People do not want 70 plans. They are not saying: Oh, please, give me a whole bunch of insurance papers to wade through. Give me increased premiums. Give me all kinds of deadlines to deal with. What they said was: I need help with my medicine.

We are blessed in this country to have more medicine available as a part of the way we allow ourselves to live healthier lives, longer lives, to be able to treat cancers, to be able to treat other chronic illnesses. Medicines are available now. But they are not available if they are not affordable. We can do better.

Mr. President, I am hopeful at some point we are going to come back to this floor and give people the choice they want: A real Medicare benefit through Medicare, with a reasonable copay and premium, where you sign up and you can go to your local pharmacy, and Medicare negotiates good prices. That is what we ought to be doing.

In the meantime, let's stop the countdown to May 15.

Thank you, Mr. President.

RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 p.m. having arrived, the Senate stands in recess until 2:15 p.m.

Thereupon, the Senate, at 12:32 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. VOINOVICH).

HEALTH INSURANCE MARKETPLACE MODERNIZATION AND AFFORDABILITY ACT OF 2006—MOTION TO PROCEED—Continued

The PRESIDING OFFICER. Under the previous order, the time until 2:30 shall be equally divided.

The Senator from North Carolina.

Mr. BURR. Mr. President, I am going to be here numerous times this week. This legislation is too important to have it shortcut. There is not enough time in the debate to say it all at one time.

Last night, this body had the opportunity to vote on proceeding to changes to the liability crisis that exists in health care today, but the minority denied us the ability to move forward. They denied the ability of the American people to hear an honest debate, to consider thoughtful amendments, and then to judge up or down on the content of the legislation.

They had two opportunities: liability that was reform for all medical professionals; and, then, liability that was only changed for those who are OB/GYNs—that next generation of medical professionals who are going to deliver our grandchildren and our great-grandchildren, that profession that is going to regenerate the population of this country and, in fact, is suffering today because of the high rate of liability costs for the premiums they have to have.

Now we are here. We are in debate—30 hours of debate—to see if we can proceed on a bill to bring small business group health insurance reforms into law, to enable small businesses in America to be able to price insurance for their employees in the same way large corporations are able to produce products for their employees.

Today, small businesses' choice is between nothing and nothing. It is not something and something. It is nothing and nothing. And what will we do? We will debate, for 30 hours, whether we should proceed. Some don't believe this is important enough or, if it is important enough, that there ought to be all sorts of changes to it that are unrelated to these millions of Americans for whom their employer cannot afford to provide health care. Why? Because they are not big. The marketplace discriminates because they are small.

Let me give you some statistics about North Carolina. In North Carolina, 98 percent of firms with employees are small businesses. Ninety-eight percent of my employers are shut out of the ability to negotiate a reasonable cost of health care for their employees. Because of that, their employees have a choice between nothing and nothing.

We will have 30 hours of debate to see if we are going to proceed in this body to provide something versus nothing—not something and something. How can anybody object to providing a choice of something for those who do not have an option today?

Additionally, in North Carolina, we have 1.3 million uninsured individuals. And 898,000—almost 900,000—North Carolinians are uninsured individuals in families or on their own with one full-time worker. Those are all individuals who potentially could be covered under an individual or a family plan.

Of the 1.3 million who are uninsured in North Carolina, 900,000 could be affected with this one piece of legislation in the Senate. But for the next 30 hours, we will debate whether we proceed or never get to the process of an up-or-down vote; in other words, it is a choice as to whether we keep them with nothing and nothing and the uninsured numbers stay at 1.3 million or, in fact, we are going to provide something for North Carolina—900,000 people who today have nothing provided for them.

Later today, I am going to come to this floor, and I am going to read for my colleagues real letters, handwritten letters—handwritten letters—from people who live in North Carolina, whose choice is nothing and nothing. These are individuals who have the same health needs, individuals who would like to have health insurance but whose employers cannot afford it today, who want the opportunity in employer-based health care, but because of the way the system is designed today, it is not achievable because it is not affordable for them.

We are here today and tomorrow, and we ought to be here as long as it takes to make sure Americans at all levels have choices between something and something. These 30 hours will determine, in fact, whether this historic institution will provide that for the American people or we will walk away; whereby, once again, the American people will be denied because some in this body do not believe there is a responsibility to move to a point where there is an up-or-down vote. Truly, people can look and say: You have my future in your hands. My health security is in the hands of the Senate, the Members of the Senate, and whether they are going to, in fact, respond to that.

Well, I think people in North Carolina desperately want choice. I think they desperately want this bill. They want their employers to have the opportunity to be able to look at health insurance and to find it affordable. Why? Because that is their security. That is their ability to have coverage.

My hope today is that the outcome of this legislation will not be a quick death such as last night with medical liability reform. We all agree health care is too expensive. We disagree on what the solutions are. But to end up with nothing, to deny the ability to move forward, to deny the ability for the American people's voice to be heard through the amendment process on this floor is disgraceful.

My hope is after these 30 hours we will proceed, we will have a robust debate on the amendments, and, at the end of the day, the American people will have an opportunity for an up-or-down vote in the Senate.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. MENENDEZ. Mr. President, today we are here in the middle of what is being called Health Week in the Senate. But rather than debating important lifesaving, life-enhancing

legislation that has bipartisan support and could actually deliver hope and promise to millions of Americans, the Republican leadership in the Senate has, instead, decided to continue their political posturing, business-as-usual approach to governing.

It is no wonder the American people have become disillusioned with the leadership in Washington. Instead of debating and passing stem cell legislation that will end suffering and extend lives, we are again focusing on a partisan proposal to limit patient options, even when they are harmed, for example, through medical malpractice.

Instead of passing stem cell legislation that will provide new treatments and cures for debilitating diseases, such as Alzheimer's, juvenile diabetes, spinal cord injuries or cancer, we are debating a bill that would actually eliminate—eliminate—the health coverage that many States currently provide to cover some of these very diseases, that will cherry-pick, pitting the healthy versus older workers or those who have some chronic disease or illness. And where there is no insurance regulation, prices go up, insurance companies pick the healthy, and they discriminate against older workers and those who are less healthy.

And they can deny coverage that States have thought important to have to meet the challenges of their individual States, sometimes very uniquely so.

So instead of wasting an entire week debating legislation that I believe ultimately has no chance of passing, we owe it to the American people—to the millions of Americans and their families suffering from life-altering disabilities and diseases—to demonstrate our Nation's full commitment to finding a cure and doing all we can to help their hopes and dreams come true.

It has been almost 1 year since the House of Representatives passed the Stem Cell Enhancement Act, and yet the Senate still has not passed this vital legislation. I rise to urge the majority leader to do the same and bring this important legislation to a vote in the Senate.

I was fortunate to have had the opportunity to vote in favor of the bill as a Member of the House, where we had broad bipartisan support for the proposal. I believe that same bipartisan support exists in the Senate, which makes it even more difficult to understand why we cannot come together and do something meaningful for those who are suffering.

My support of stem cell research is partially a reflection of my home State's commitment to innovation and discovery. In 2004, New Jersey became the second State in the Nation to enact a law that specifically permits embryonic stem cell research. We know that embryonic stem cells have the unique ability to develop into virtually every cell and tissue in the body. And we know that numerous frozen embryos in fertility clinics remain unused by couples at the completion of their fertility treatments. Why shouldn't they be allowed to donate those embryos to Federal research to save lives? We allow people to donate organs to save lives. Why couldn't a couple, if they so chose, donate their frozen embryos instead of simply discarding them?

The great State of New Jersey offers more scientists, engineers, and technicians per capita than any other State, and I am proud to represent the innovation and research taking place in New Jersey. Our State is not only known as the Garden State but also as America's ''Medicine Chest.'' But for our State and our country to continue to compete globally with health care breakthroughs, it is going to take more than private and State support. It is going to take the support of our Nation. It is going to take leadership that looks beyond politics.

But, to me, similar to countless Americans and New Jerseyans, this issue is about more than our ability to compete as a nation. The promise of stem cell research is painfully personal. It means hope and promise—hope that people such as my mother who suffer from advanced Alzheimer's disease might one day be cured from the loneliness and confusion caused by this horrible disease and the promise that future generations of families will not have to see their loved ones enter into a world of dementia that robs them of the best years of their lives.

We hold the key to unlock that door. It is shameful that we have let partisan politics stand in the way of medical progress. We owe it to our parents, to our children, and our grandchildren to unlock that door.

Diabetes, Alzheimer's, cancer, Parkinson's—none of these diseases boast a party affiliation. And we cannot let ours keep us from doing what is right.

Today we have an opportunity to do what is right. But it is clear to me that the majority will again let that opportunity pass them by. I will continue to fight, along with many of my colleagues, to see that this bipartisan bill is debated on the Senate floor and becomes law. We can no longer afford to delay this bill when it holds the key to curing some of the most devastating and debilitating diseases of our day. As the bill waits in the wings of the Capitol, children and adults alike wait for the cure they have been praying for.

This is Health Week. What could better demonstrate our commitment to the health of this country than full Federal support for embryonic stem cell research? This bill has the potential to make a profound and positive impact on the health of millions of Americans. All we need is the leadership to bring the bill to the floor for a vote for the humanity of our Nation and for the mothers, fathers, brothers, sisters, sons, and daughters across this country who are suffering or watching a loved one suffer.

This bill means so much more than ending restrictions placed on stem cell research. This bill means hope and promise to countless Americans.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kansas.

Mr. ROBERTS. Mr. President, like many of my colleagues, I rise today in support of S. 1955, the Health Insurance Marketplace Modernization Act. As a member of the Health, Education, Labor, and Pensions Committee, I am proud to have worked on this legislation and to lend my support as a cosponsor.

First and foremost, I thank Chairman ENZI and Senator BEN NELSON, who have worked so hard on this legislation. The chairman and Senator NELSON did what many thought was impossible: they got the health insurers, State insurance commissioners, and the small business community to sit down together and work to find a compromise for small businesses. After over 10 years of deadlock, the Senate is finally considering a solution that will provide real relief to small businesses. This is truly a milestone. It has been said before, I am sure many times, that the House has passed this eight times, and we have yet to find a solution. Now is the time.

Like many rural States, the Kansas economy is built on thousands of small businesses. Whether it is the farm implement store or the local pharmacy, the beauty salon or the downtown coffee shop, these small businesses and their employees are the backbone of our communities. They are what we are all about. But one nagging problem for virtually every small business owner is the high cost of providing health insurance. Most small businesses can't even afford to offer health insurance to their employees, forcing many to go without health coverage.

In Kansas, only about 41 percent—not even 50 percent, not even half—of our small businesses offer any health insurance coverage. This is in stark contrast to the 97 percent of our larger businesses that offer health insurance to their employees. Without such health insurance coverage, employees are vulnerable to huge health care debts of their own, and it is harder for small employers to attract a good worker. I have literally heard from hundreds of Kansas small business owners and entrepreneurs, local Chamber of Commerce members over the years who say they are forced to choose between staying in business or providing the health care they deserve to their hard-working employees.

Take for example Kimberly Smith of Andover, KS. Kimberly has three children, including a 3-year-old with a mild heart condition. She is self-employed. She is a realtor. She is a good realtor. Like many, she does not have access to affordable health insurance. Because of this, Kimberly and her family have been forced to go without health insurance coverage, and now she must pay all of her medical costs out of her pocket.

Denise Breason from Lawrence, KS, is also facing the same crunch to find affordable health care. Even though Denise is a hard-working small business employee, she has been without health insurance for over a year and a half and had to stop taking all of her medications because she could no longer afford them without health insurance.

Denise Hulse and her husband went without health insurance for their family for years. They prayed their children would remain healthy so they would not have to make a visit to the doctor or the emergency room. In the end, her husband was forced to let his small business go and take a low-paying job, just because it came with health insurance. To quote Denise:

It is sometimes very hard just making it in the small business community, and very few small business owners are rich enough to be able to afford the high costs of health insurance for their families.

Another small business owner in Kansas told me he is paying over $2,000 a month each month in premiums alone for health insurance for his family. This is more than his house payment, more than his utility bills and grocery expenses, all combined.

These stories go on and on, not limited to my home State of Kansas. I heard these stories when I had the privilege of serving in the House of Representatives. Eight times we approached this issue. Eight times we passed a bill. Now it is our turn in the Senate, and it is long overdue. I hear these stories from small business owners and employees across the country. Small businesses all share one main concern: finding affordable health care insurance.

This is why I am asking my colleagues today to support and pass the Health Insurance Marketplace Modernization Act. The real question is, Do we take it up? Do we vote for cloture? Or do we let the House pass the bill the ninth time while we sit in the Senate and do nothing for those who cannot afford health insurance? I cannot imagine us doing that at this particular time.

This legislation allows small businesses to pool together through an association and offer health insurance. Everything has to have an acronym in Washington. This one does, too. It is SBHP. I won't venture into what that acronym will be called, but it stands for small business health care plan. It is going to give small businesses an affordable choice for health care.

The legislation is built on the fact that small businesses, unlike large companies such as Microsoft or others, or unions, do not have the power to negotiate affordable prices for health care.

The concept of small business pooling together is not new. I supported legislation when I served in the House. In fact, the association health plan legislation has passed the House numerous times over the years without any action in the Senate. Now we finally have a solution that will provide meaningful relief to small businesses across Kansas and the country. We all know small businesses face many pressures in running the businesses. I believe we must enact commonsense policies to overcome these hurdles. We should allow the local farm implement dealer to pool together with other dealers in Kansas and across the Nation to purchase affordable care.

Kimberly Smith should no longer have to worry about finding affordable health insurance for her children. Denise Breason should not have to stop taking her medications just because she works for a small business and cannot afford her care. Denise Hulse and her husband should not have been forced to let go of their small business, their dream they loved, just to find affordable health coverage. Instead, we need to find these hard-working folks affordable options that allow them to continue to contribute to our small communities, rural and smalltown America. This is why I support the legislation.

As I stand before my colleagues today, I know there have been strong concerns expressed about this and previous association plan proposals. However, the small business health plans that are created under this bill have the necessary protections in place to address these concerns. I would like my colleagues who have concerns to please pay attention.

The small business health plans will be regulated by the States, not the Federal Government. The small business plans will have to play by the same set of rules as other small group health plans. They must purchase their insurance through the regular insurance market. They cannot self-insure. Finally, the SBHPs may offer coverage that varies from State benefit mandates, but they must also offer an alternative plan that provides comprehensive coverage. This gives the consumer a choice in choosing a health plan that best fits their needs, and that is the key.

I have heard concerns from organizations and individuals who fear this bill will take away their coverage for cancer screenings, mental health benefits, or any other mandates required by State law. However, I stress that this is simply not true. Small business, under this bill, will have access to a more comprehensive plan which will cover screenings, mental health services, or numerous other benefits. However, it is up to the small businesses to decide whether such a comprehensive plan is right for them.

The purpose of this language is to give small businesses the option of choosing comprehensive benefits but not requiring them to buy such a rich package or a package they cannot afford. Simply put, this legislation trusts small businesses to choose a health care plan that best fits their needs and puts these small businesses, not health insurers or the Government, in the driver's seat when choosing their health care coverage. If a small employer wants to choose a more affordable plan for himself, his family, and his employees, he should have that option. Under this legislation, he has that option. However, he should not be forced by law to buy benefits that may be beyond what he can afford or beyond what he and his employees really need.

I want to put the problem of mandating coverage in perspective. While small employers want to provide affordable health insurance for their employees, expensive and burdensome benefit mandates make doing so very difficult. Small firms and self-employed people have almost no leverage with insurance companies. In addition, they have to deal with an enormous array of State-level health insurance regulations. I don't think you read them; I think you weigh them. All of the benefit mandates, all of these regulations add to the cost and the complexity of the coverage.

In contrast, however, big businesses generally don't have to deal with burdensome regulations. Federal law lets large companies, such as Microsoft and GM, and unions bypass expensive State benefit mandates to provide affordable comprehensive coverage for their workers. I ask my colleagues, why shouldn't small businesses be able to enjoy these same opportunities?

Today, there are more than 1,800 State mandates, making it nearly impossible for associations to offer uniform and affordable benefit packages on a regional or national basis. Taken together, these benefit mandates create a confusing web, an unfunded mandate that prices many Americans out of the health insurance market. The Congressional Budget Office and the Government Accountability Office and others have found that State-imposed benefit mandates raise the cost of health insurance anywhere from 5 to 22 percent. In addition, CBO estimates that every 1-percent increase in insurance costs results in 200,000 to 300,000 more uninsured Americans. In reality, benefit mandates represent an unfunded mandate on employers because insurance companies simply pass the cost of each mandate along. When the cost goes up, the coverage goes down. You have more uninsured.

The legislation we are debating today simply provides an opportunity for a small business health plan to relax these burdensome mandates to offer affordable health insurance to small businesses on a regional or national basis, just like the big businesses and unions currently do. We should not be forcing small businesses to choose between staying in business or offering health insurance to their employees. Boy, that is a Hobson's choice. Instead, we need to give them more affordable health insurance choices and be willing to trust them to choose the option that makes the most sense for themselves, their families, their employees, and the future of their businesses.

I know this bill is not perfect. Seldom do we or the other body pass a bill that is perfect. I have long said that we usually achieve the best possible bill, but sometimes must settle for the best bill possible.

I appreciate the concerns that have been expressed with this legislation. However, I express to my colleagues that I think this bill is the best opportunity we have for easing the burden on our small businesses and allowing them to finally offer affordable health care insurance to their employees. I am proud to support this legislation. I urge my colleagues to do the same and vote for cloture. Eight times in the House, zero in the Senate. That should not be a moment of pride for this body. Let us vote for cloture and let us support this bill.

I yield back my time.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized.

Mr. GREGG. Mr. President, I rise to associate myself with the remarks of the Senator from Kansas, and especially with the efforts of the Senator from Wyoming who brought this bill to the floor of the Senate. This is a very significant piece of legislation in our efforts to try to make sure more Americans have the opportunity to get fair, affordable, and good health care insurance. It is a piece of legislation about people. It is directed at people who work in what is termed ''small business.'' That is the person who works as a cook in a local family restaurant or a person who works as a mechanic in a garage or a person who runs a mom-and-pop real estate agency.

Literally, there are tens of thousands, millions of these small entrepreneurial centers throughout this country. Most of these folks don't make a great deal of money. They work very hard. They are taking care of their families. One of their biggest concerns is whether they can get health insurance so if somebody should get sick who works with them or should somebody in their family get sick, they will be able to have adequate care. But too many of them are not able to afford health insurance. Approximately 22 million people who are in these small businesses, these small retail businesses, small manufacturing businesses, small entrepreneurial shops, don't have insurance. Another 5 million people, who are sole proprietors and work by themselves, do not have a number of employees working with them, also don't have insurance. That is 27 million people who fall into this category. So Senator ENZI has brought forward a bill to try to address that problem. It is going to try to make it possible for these people who work so hard and who would like to have insurance policies that are affordable to get them. By allowing them to band together in trade groups, so realtors can come together, as well as automobile dealers, garage owners, restaurant associations, and hotel associations can come together and form a large enough group so that they can create enough of a mass of interest and buying power so that they can go out and purchase insurance. That is something they cannot do today as individuals. This bill allows them to do that.

It is hard to understand how anybody could oppose this concept. But people do oppose it, and I think most of the opposition comes from folks who either misunderstand the bill or who are using the bill as a way to energize their constituencies with information that is at the margin of believable, to be kind. The biggest opposition today to this bill, other than insurance companies who might see this as a competitor, comes from these groups that represent various different diseases and have compelling stories to tell about their diseases. They have gone to the State legislatures and they have gotten them to put in place what is known as mandates so any policy sold in that State has to cover that disease.

As was pointed out by the Senator from Kansas, every time that happens that increases the cost of the insurance in that State. For every 1 percent increase in the cost of insurance—and some of these specific mandates are expensive enough so they by themselves represent a 1-percent increase in insurance premiums. But there are 200,000 to 300,000 people who cannot afford insurance because the insurance bills go up and 200,000 or 300,000 people fall off the rolls.

What this bill tries to do is address the issue of the person who has fallen off the rolls, the person who hasn't been able to get the insurance, by giving them an option that they can buy, which they feel is adequate to their needs—it may not have a specific mandate in it because maybe they don't need those mandates to be covered, but at least it gives them the basic coverage they need in order to get through their health insurance risks.

The flip side of this coin, which isn't talked about much but which is fairly obvious, is that these people have no insurance at all. When these mandate groups argue, if you pass this bill, you are going to undermine the capacity of people to get insurance for this disease group, that is a totally misleading presentation because the people this is focused on don't have insurance to begin with. You cannot take something away from somebody who doesn't have it. If a person doesn't have an insurance policy, he doesn't have the mandates that the insurance policy requires.

If a cook working in a restaurant or a garage attendant working at a gas station or a realtor working in a small mom-and-pop real estate agency doesn't have any health insurance, you cannot take away from them mandated coverage for health insurance because they don't have it to begin with.

What this bill tries to do is allow that individual to participate in a group where they will have health insurance as an option. And if they have that option of health insurance, without mandates, they also have to have—that group, that restaurant, that real estate agency, that garage the option to purchase a fully mandated policy. In other words, it is a policy that is, for lack of better terms, a higher option policy, where you have everything covered. It has to track the five States in this country which have the most mandates on their insured. So the bill is balanced in that area of mandates.

A second opposition to this bill has been the fact that it moves from community rating to a banding system. What does that mean? It essentially means that on a community rating you basically force everybody to be rated the same, no matter their health risk or age group or occupation. With a rating system, you adjust marginally for what health experience it may be or what age it is. Adjustments can be made, but they are limited by the State. If you have a community-rated system, you inevitably have a much higher cost going in for a lot of those people who are banding together in groups, who maybe don't have as much risk as others. But if you have a rating system, some people are going to be lower in insurance costs and some people will be higher. They are going to be within a relatively narrow band.

So this bill allows these policies to be offered with a rating system, with a band. In New Hampshire—and this has been referred to on the floor by the Senator from Massachusetts—they had a very bad experience because, regrettably, New Hampshire did it the wrong way. We had a community rating system and then we went to a band rating system because we recognized that was better policy. I congratulate the State for that, but they didn't go to it correctly. They went sort of cold turkey. The practical effect was that one day people got one type of bill, and the next day they got a different type of bill. For some people it went up, for some people it went down, and it was a rather startling event for them. We looked at that experience in committee and said we don't want to emulate what happened in New Hampshire. We want to make this a much more responsible approach. We put into place a glidepath, 5-year phasing, so there will be plenty of time to adjust and to be able to handle this.

That type of opposition to this bill, clearly, in my opinion, has been addressed. It has been addressed specifically because of the New Hampshire experience. So it is a misrepresentation to say that continues to be a major issue with this bill. As a practical matter, there are about 85 million people in this country who work in small businesses. That is a huge number. They deserve the opportunity to have this type of insurance made available to them. They should have the same opportunity as big businesses—the IBMs,

the Microsofts, the major manufacturers—in our country, if for no other reason than they happen to be the engine of economic activity in this country. Most of the new jobs are created by small businesses, the moms and pops who are willing to build that restaurant, take on that exciting opportunity, start small and grow. When they do that, they ought to have the opportunity to also have an insurance option available. But many of them don't because it is not affordable, because of the way the States work the system, and because of that these small groups, as individuals, have no buying power. So this bill has addressed that need.

It is not the answer. This isn't a magic wand, but it is another opportunity put on, let's say, the cafeteria line of insurance that gives a small businessperson the chance to go down that cafeteria line and say: Yes, this plan works for the five people who work for me, and I am going to buy into the plan because I can afford it. Today, most people who walk down that cafeteria line, if they are small businesspeople, don't choose anything because they cannot afford the price of anything, or many of them are in that capacity, that 22 million. This will take a fairly significant number of those folks and give them the opportunity to purchase health insurance.

So it will take people from a noninsurance status to an insured status, from a situation where if they get sick, they don't know how they are going to pay for it, to a situation where if they get sick, they will have coverage. It is very important financially to most people and, obviously, it is important psychologically to everybody. So it is a good bill, something we should support.

I do think much of the opposition to it is misguided because it doesn't recognize that the basic goal is to take people who don't have insurance today and get them insurance. Therefore, the arguments around mandates are irrelevant to that group of people and the argument of community rating as I think we will address.

I congratulate the Senator from Wyoming for bringing this bill forward. I look forward to working with him on this bill.

I want to speak on another matter briefly because there is a lot going on that is very good in this country relative to the economy, and it is not being highlighted.

Today, there was an editorial in the New York Times that said we should not extend the tax cuts put into place in 2003. They say those tax cuts should not be extended in the areas of capital gains and dividends. That argument is good in 1930s economics. It is the old left theory of tax policy, which is that you increase revenues by constantly increasing taxes on people. It has been proven wrong this year, last year, and the year before. It was proven wrong by John Kennedy when he put in place the first tax cut. It was proven wrong by Ronald Reagan when he put in place the tax cut of 1980. And it has been proven wrong again.

In fact, in the first 6 months of this year, tax revenues jumped 11 percent, $134 billion, and a large percentage of that is the increase in tax revenues from capital gains and the fact that we have reduced the rate on capital gains which causes people to free up assets. Over the last 3 years, revenues have jumped dramatically—in fact, last year by 14 percent, and the year before by 7 percent, and next year they are projected to jump again. Why is that? It is because we are seeing an economic boom which has created 5.3 million new jobs since those tax cuts were put into place. There have been more jobs added in the United States in that period than Europe and Japan combined have created. And those jobs have led to economic activity and, in turn, have led to revenues to the Federal Government.

Revenues to the Federal Government are dramatically increasing because the economy is growing, and the economy is growing because the burden on those people who go out and are willing to take risks through capital investment, dividend activity, through income tax activity—those people are taking risks and creating economic activity and, as a result, creating jobs which, in turn, create taxpayers, which, in turn, increases the Federal revenues.

The numbers don't lie. They are huge, significant, and they confirm, once again, that John Kennedy was right, Ronald Reagan was right, and George Bush was right. By making tax rates fair, especially on capital formation, you energize economic activity and, in turn, you create massive increases in Federal revenues. Regrettably, I must say the New York Times is wrong.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Arkansas is recognized.

Mrs. LINCOLN. Mr. President, I am so happy to come to the floor today because the Senate is finally debating how we can help small businesses across our country afford health care for their employees. Just as Senator GREGG has mentioned how important it is to provide benefits to groups who want to invest, and to individuals and companies who want to invest and grow the economy, so too it is critically important that we provide small businesses the ability to invest in themselves. That is what I want to talk about today.

Small businesses are critical to this country. They are critical to rural States such as mine in Arkansas, but they are the engine of our economy in this great Nation. They are the No. 1 employers. That is why it is so important that we get this right, that we provide them with a tool that will allow them to reinvest in themselves and their employees and their communities, so that we can keep that engine going.

I applaud my colleague from Wyoming, Senator ENZI, for all he has done in bringing about this debate. He has worked hard and genuinely on this issue, and I appreciate very much what he has put into this. He has helped us make sure this is not a debate about whether this is a critical issue.

This reminds me of something I was taught by my father who said: If it is worth doing, it is worth doing right. It is worth doing correctly. That is what we are here to talk about today.

I believe very strongly that our small businesses are so important to us—our self-employed individuals in this country have the greatest spirit in the world—and it is so important that we should not offer them a second-rate opportunity. We should offer them the same opportunity we have as Federal employees and Members of Congress: The opportunity to build a pool that will offer them greater access, greater choice at a lower cost, by pooling all of themselves together across this great country, while maintaining the quality, which is what we do for ourselves. We maintain the quality of the product of the health insurance we receive or have access to as Federal employees and Members of Congress, and we should do no less for the small businesses and the self-employed individuals in this great country.

So I hope, as we continue this debate, we will remember those hard-working American families who are depending on us not just to do something, but to do what is right and fair, and offering what we see as fair tax policy and offering what we see as fair access to the same quality product of health care and health insurance that we as Members of Congress get.

The small business health care crisis is undoubtedly one of the issues I hear the most about when I return home to Arkansas. In fact, in every community in our Nation, as well as millions of working families across this country, we are seeing the difficulty of having access to quality health care and health insurance and the ability to pay for that.

There are approximately 46 million Americans currently without health insurance, including 456,000 Arkansans whom I am responsible for in terms of producing a product that is worthy of those individuals. Small businesses are the No. 1 source of our jobs in Arkansas. Yet only 26 percent of the businesses with fewer than 50 employees offer health insurance coverage. Workers at these businesses, which again are the engine of our economy, are most likely to be uninsured. In fact, 20 percent of working-age adults are uninsured in Arkansas. This number is alarming, and addressing this problem should be a national priority, and we should approach it as if we are going to do the best job that we are capable of doing. That is why we are here today, to talk about that.

Mr. President, 224 major organizations are opposed to the proposal that

Senator ENZI has brought before us. Two hundred-and-twenty-four is a huge number: everywhere from diabetes to mental illness to hospital federations. These individuals understand how important the years have been in allowing State insurance commissioners to be able to set mandates in order to cover what is important to individuals in their States, and what is important to small businesses and everyone in those States. Those States have the right and the ability to figure out what is important to them, and the majority of them have agreed on many of these major issues.

Those who lack health insurance do not get access to timely and appropriate health care. We know that, and we see it. We see it in the cost of Medicare when people don't get health care for 20 or 25 years when they are in the working marketplace as a small business owner or employee, and then they become more costly to us when they hit Medicare age because they haven't received the screenings, the timely visits to the doctor, and they haven't been getting the kind of health care they truly need. They have less access to these important screenings. They don't have access to the state-of-the-art technology that exists or prescription drugs, which is another piece of what can help keep down the cost of health care.

Working families need help with this problem. The Institute of Medicine has reported that 18,000 people die each year because they are uninsured. The fact is, being insured does matter. It makes a big difference. It makes a difference in our health care costs. It makes a difference in whether you are going to survive—longevity, the ability to care for your family. It makes a big difference. We have reached a juncture where we are going to debate how we deal with those who are uninsured, whether we are going to give them substandard coverage or whether we are going to give them the coverage that we have.

Again, I commend my colleagues, Senator ENZI from Wyoming and Senator NELSON from Nebraska, for their leadership. I appreciate their hard work on this issue. But I do disagree, because I believe that the devil is in the details on this issue, and I am deeply concerned about the very harsh and unintended consequences that will occur if S. 1955 were to become law.

Senator DURBIN and myself have been working together for several years to come up with what we believe is a better health care plan for America's small businesses. What we have done is looked to a 40-year-old tested delivery system, and it is the one that we ourselves use. It is a Federal plan that takes the best of what Government can do and combines it with the best of what private industry can do. The private marketplace and the competition that it can create allows the Government to pool all of its Federal employees and use that pool as a negotiating tool to bring us greater choice at a lower cost.

About 3 years ago, I suppose it was, my staff and I were discussing the way we could help small businesses, and I thought about the way my Senate office operates. It operates much like a small business in my home State and here. As I looked at my employees, I saw that I had two employees, one with 26 years with the Federal Government, another with 30 years with the Federal Government. I had two women who had delivered babies and were on maternity leave. I had some, such as myself, with small children and a husband that is on my plan, and then I had a host of young, healthy staffers who were single. But I had a whole array of different individuals who needed a tailor-made insurance plan for their needs. While there are similarities in our Senate office and small businesses, there are also some obvious differences. One of the most glaring contrasts is access to affordable and quality health care. I saw what my office went through and realized that is what small businesses are going through. I knew we could do better. I knew we could take the plan of what we have and apply it to small businesses.

Last year, more than 8 million people were banded together in the Federal employees purchasing pool, and that gave us choices among 10 national health insurance plans and a variety of local insurance plans, and a total of 278 private insurance plans from the private marketplace. Not government-run—not government-run health care at all—but health care from the private industry, health insurance from the private industry that was created by competition of the multiple Federal employees across the country. It offered us greater access, greater choices at a lower cost.

So I am here to ask this question: Why don't we try to give small businesses access to that same type of private health insurance option that Members of Congress and Federal employees enjoy today? Rather than reinvent the wheel, why don't we create a program for small businesses that is based on our Federal Employees Health Benefit Plan, through the FEHBP, by pooling them, the small businesses, together in one nationwide pool. That is exactly what Senator DURBIN and I have proposed in our Small Employers Health Benefit Program. By pooling small businesses across America into one risk and purchasing pool similar to the FEHBP, our program will allow employers to reap the benefit of group purchasing power and streamline administrative costs as well as access to more plan choices. The SEHBP, as we have introduced, lowers costs for small businesses in two key ways: It pools them into one national pool across the country, therefore spreading the risk between the healthy and the sick, the young, the old, those who live and work in the remotest parts of this great land and those who work in the most urban areas. Second, our plan significantly lowers administrative costs for small businesses.

Two economists have estimated that SEHBP would save small businesses between 27 and 37 percent annually, even if they don't take advantage of the tax cut that we offset costs with by insuring lower income workers. We provide a tax cut to small businesses, and for the life of me, I can't figure out why those on the other side of the aisle, for the first time I have ever noticed, will fight a tax cut for small businesses. Providing small business a tax cut to be able to engage in what is such an important tool in getting themselves and their employees insured makes good sense. What a great investment.

Senator GREGG was talking about balancing all of that and the economy. What a great way to balance what corporate America gets and their ability to deduct health insurance costs that they have and small business getting a tax cut for investing in their employees and health benefits for them. Under our bill, employers will receive an annual tax credit for contributions made on behalf of their workers who make $25,000 per year or less. And if the employer contributes 60 percent or more to the health insurance premium of an employee making $25,000 or less, the employer will receive a 25-percent tax credit. And the tax credits increase with the number of people covered and the proportion of premium the employer chooses to cover. Also, the employer receives a bonus tax credit for signing up in the first year of the program, because we know from the example of the Federal employees that the more employees who are in the pool, the greater advantage to everyone concerned. Small businesses will save thousands of dollars—even more—under our plan.

Segmenting the market into different association pools, as S. 1955 does under Senator ENZI's bill, will not achieve these savings that would be created by instituting one large pool with all of those small businesses and self-employed individuals. Each association will be administering to a separate group with a different administrative structure and different costs, obviously. More funds would be going to administrative costs as opposed to serving the people with a quality health plan. Our SEHBP would have one administrative structure and could pool approximately 53 million workers together, therefore balancing the risk of sick and healthy, young and old, rural and urban, for affordable rates for everybody. Why wouldn't we want to make our pool as big as it possibly could be, as we do with the Federal workers?

I believe our plan takes a real moderate and balanced approach that combines the best of what Government can do with the best of what the private sector can do, and preserving important coverage for preventive health

care treatment such as diabetes supplies, mammograms, prostate screening, maternity and well-baby care, immunization, things that States themselves have decided are important enough to mandate coverage for and ensure that the people of their State are going to get the safe and important coverage of illnesses that are critical to them in their State.

Like the FEHB Plan, our program does not promote Government-run health care, but it harnesses the power of market competition to bring down health insurance costs using a proven Government negotiator in the Office of Personnel Management, OPM, which is the negotiator for our plan. We, once a year, as Federal employees, can choose among 270-plus plans. We are able to actually benefit from that proven Government negotiator and the harnessing of that power.

Our legislation, S. 2510, has been endorsed by many organizations—the National Association of Women Business Owners, Small Business Majority, the American Medical Society, the American Diabetes Association, the National Mental Health Association, the Cancer Society, and many more that have realized how important it is to use a proven example, a proven structure that maintains quality but helps by pooling and bringing down those costs.

The Mental Health Liaison Group, representing over 35 national mental health organizations, wrote to us and said about our bill:

S. 2510 does not sacrifice quality of coverage for affordability or allow the offering of second class health insurance to small businesses. Within the FEHBP program, small business owners, employees and their family members would be covered by all the consumer protections in their home states—including hard-won state mental health parity laws and mandated benefit laws.

The American Academy of Pediatrics, writing to us on behalf of over 60,000 primary care pediatricians and pediatric specialists, wrote:

Through the benefits of pooling small businesses and providing tax cuts to small employers, small pediatric practices will be assisted in the health insurance market without sacrificing health care services for children.

The American Diabetes Association wrote to us and said:

While other proposals seeking to provide health benefits for small businesses . . . have exempted or eliminated coverage for important diabetes care protections, [our bill,] S. 2510, will allow individuals with diabetes to receive the important health care coverage they require to remain healthy and productive members of the workforce.

This is not just about quality of life, although many of us believe that is very important. We as Members of Congress enjoy a quality of life because of the very healthy health insurance program we are offered. We want our small businesses that are vital to our economy to enjoy that same opportunity. But it is also about economics. It is about making sure we keep our workforce, particularly our small businesses and their workforce, healthy and thriving and productive and in the workplace. It is about making sure America's working individuals and working families get the health care they need before they reach 65. When they hit 65 in the Medicare Program, then they are going to be more costly to Government because they are not going to have gotten the health care they needed and deserved in their working years.

I believe our plan is better in so many ways. I am proud we are having this debate, and I hope so many people will realize we can do better. We can do better and make sure we truly elevate small businesses and self-employed people to the same level we hold ourselves, in providing them the access to the same quality type of health care.

Our SEHBP bill offers tax cuts for small employers. Senator ENZI's bill does not. SEHBP relies on a proven program. It is based on the successful Federal Employees Health Benefit Program which has efficiently and effectively provided extensive benefit choices at affordable prices to Members of Congress and Federal employees for decades. For decades, we have had a proven program out there that proves you can harness the competitive nature of the marketplace, and with the oversight of Government and the State mandates, you can actually provide that quality of health insurance at a lower cost. By pooling small businesses together and allowing OPM to negotiate with private health insurance companies on their behalf, they, too, could have access to this wide variety.

On the other hand, Senator ENZI and Senator NELSON's bill establishes a new set of responsibilities at the U.S. Department of Labor, to administer an untried and an untested program. We don't reinvent the wheel. What we do is use what already exists. To invent a new section of the Department of Labor to administer Senator ENZI's bill is going to take time and money. We are not going to know how it needs to be administered through the Department of Labor. They have never done it before. Even the Department of Labor employees currently enjoy benefits from the health insurance program that is negotiated by the Office of Personnel Management. So it is hard to believe they are going to want to go to another system.

SEHBP offers individual self-employed workers the same access to health insurance that is offered to group businesses. SEHBP defines small businesses as groups of 1 to 100, so an individual self-employed person will be treated exactly as a business with 2 or more people. Any business with 1 to 100 employees is eligible to participate in what we are trying to do.

Under Senator ENZI's bill, the self-employed people are not pooled with the small businesses, unless they are mandated by State law. And there are not that many State laws that actually mandate that. But the self-employed people in 36 States, including Arkansas, will not have access to the same negotiated rates of businesses with 2 or more people. They will be pulled out of that pool and rated on their own. That means, if they are younger women of childbearing years or perhaps they are older workers at 50 or 55 and are diabetic, they will be rated completely separate from the pool, which means they will be segregated and treated differently. They don't get to enjoy the benefit of a larger risk pool which could bring down their costs and offer them greater choice.

Our bill also ensures access to health care specialists. Many States have passed laws requiring insurers to cover certain health care providers, including dentists or psychologists or chiropractors. All three of these and many more are required by our State of Arkansas law. I know the people of my State enjoy the assurance they have of knowing that their State regulator, their State insurance commissioner, is looking out for their needs. They can do that better on a State level. That is why we have always left those types of regulatory issues up to our State—because they know and can work.

Can you imagine being a small business, or better yet an employee of a small business, having to call some big, huge, Federal bureaucratic office to request or to complain or to have your concerns heard about what is not covered under your insurance plan? No, they call the State insurance commissioner today, and that is the way it should be. The State insurance commissioner can then respond to the concerns of their constituency and has done so very well over many years.

The coverage for diabetes supplies, mammography, and other important screenings are mandated by State law which would be preempted by what Senator ENZI is trying to do. Many States have passed laws requiring health insurance companies to cover these benefits because insurers simply were not doing it. It did not happen because the insurance commissioners just decided on a whim to do it; it is because the insurers were not covering it. Why do we have to go back and relearn that lesson?

For 40 years, the Federal Government has used the effectiveness of the pool of the 8 million Federal employees and been able to enjoy the protections that are there, guided by State insurance commissioners.

Our bill also prevents unfair rating on gender and health status. Under our bill, health insurers will be prohibited from ratings based on health status—whether you happen to be diabetic, whether you happen to have eating disorders—your gender, or the type of industry in which the employees are working. Under Senator ENZI's rules, that will be all preempted, even for the 15 States that don't allow ratings on these factors.

Our bill also frees employers to focus on running their businesses. They don't

have to go and negotiate these plans through their association or with their association. They are going to get sent a booklet just as we do, once a year, to review all that is available to them, and choices, and then figure out what is best for them. My employees—each of them picks something different. I pick coverage for a family with children. Some of them pick a PPO or an HMO. Some of them pick all different kinds of State plans and others that are offered to them in that process.

Mr. CARPER. Will the Senator yield?

Mrs. LINCOLN. Absolutely.

Mr. CARPER. Mr. President, how much time is left on our side during this period of debate?

The PRESIDING OFFICER. There is 5 minutes remaining.

Mr. CARPER. How much longer does the Senator expect to speak?

Mrs. LINCOLN. How about if I just go ahead and yield to the Senator from Delaware because as a former Governor, he has some incredible stories to tell, and I think they really add to this debate. I will simply say to my colleagues that I hope they follow this debate very closely and certainly appreciate how important this is to the working families of all of our States.

Mr. CARPER. I thank my colleague for yielding. I ask if she would stay on the floor.

I commend Senator LINCOLN for actually coming up with this idea. It is an idea for which she and Senator DURBIN share credit. When you think of some of our options, the options basically are do nothing, maintain the status quo, continue to make the cost of insurance very steep and rising for small businesses or to adopt the proposal of our colleagues, Senator ENZI and Senator NELSON, whom I believe are two of the most thoughtful Members of the Senate. They have worked hard to try to make a not very good idea—the original association health plan—a better idea. But between doing nothing and the modified HP legislation from Senators ENZI and NELSON is a third way. The third way has already been outlined here by Senator LINCOLN.

I wish to ask my colleagues to think about it. I don't care whether it is a Democratic idea or Republican idea. It is actually an opportunity to take the best from what the Government, the public sector, can bring and to take maybe the best the private sector can bring.

One of the common values that are shared by the Enzi-Nelson legislation and the Lincoln-Durbin legislation is the notion that we have a lot of smaller employers, they have a lot of employees, and together is there some way we could pool their purchasing power? Maybe we could increase the number of health insurance options available to them and maybe we could bring down the cost of those options. They propose to do it in one particular way which, as Senator LINCOLN pointed out, has a number of problems, one of which affects us negatively in Delaware.

We have had a very high rate of cancer mortality. Finally, we have brought it down over the last 10 years or so, in part by having mandatory cancer screening—mammography, for cervical cancer, prostate screening, for colorectal cancers—and that has helped to bring down our cancer mortality rate. From the top in the country, we have finally now dropped to the top five. We are moving in the right direction. I will talk about that tomorrow, and I will even bring some charts to rival the chart of my colleague, I hope.

But I suggest to my colleagues, think about this. We have all these disparate Federal agencies across the country. Collectively, we have a couple of million employees, family members, and retirees, and all we do through the Federal health benefit plan is we pool our collective purchasing power. It doesn't matter if you work for the VA or Homeland Security or some other Federal agency—EPA—basically we could come together and use our collective might to negotiate better rates and, frankly, better coverage than would otherwise be the case if we were just negotiating for ourselves. We do it all through the Office of Personnel Management.

What Senator LINCOLN is suggesting is it works great for us, provides reasonably good coverage for Federal employees, including us as U.S. Senators. We have to pay our portion. It is not that we get it for free. We have to pay our share. But it works pretty darn well. She has come up with a way where we take that Government idea and transpose it and transfer it to the private sector. She would have the Office of Personnel Management effectively provide the service or play the role in the private sector that it currently plays in the public sector, to allow a lot of employees, whether you work for the local hardware store or restaurant or small manufacturer or technology company, to say: We would like our employees to be able to pull together from Arkansas, from Delaware, even from Minnesota, in order to get a chance to buy better insurance products, have more variety, and bring down our costs to our small business employees.

It has worked. It is proven. It is time tested, and I believe it is worth trying. The worst thing that I think could happen, coming out of this week, is for us to do nothing.

It is a big problem. It is a big problem for small employers, and it is a big problem for large employers. It is a big problem for America.

I think what would be the worst thing that could happen, and what would basically ensure that we do nothing is for our Republican friends to basically allow no amendments to the Enzi-Nelson legislation. I think that would be awful. That would be a huge mistake. It would pretty much basically ensure we end up not getting this bill done or some variation and not even having a chance for debate and vote on the Lincoln-Durbin legislation. We can do better than that.

Frankly, the Senate deserves a lot better than that.

I say to my colleague from Arkansas, who has been good enough to relinquish her time, I thank her on behalf of all us for pointing out a different course, a third way in this regard. I thank her.

Mrs. LINCOLN. Mr. President, I thank my colleague from Delaware.

The PRESIDING OFFICER. Minority time has expired.

Mrs. LINCOLN. Thank you, Mr. President.

I ask unanimous consent to continue until other Members arrive.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mrs. LINCOLN. Thank you, Mr. President.

I will be glad to yield the floor when others are ready to speak.

I would like to add that the experience of many of our colleagues, whether they are former insurance commissioners, former Governors and others, brings to this table the understanding what the American people want, what our working families want. I think the debate is that small businesses definitely want more affordable health care. They also want to make sure that what they are providing for themselves and their families and their employees is quality service, quality coverage. That is what they deserve. That is what they want.

Even for those who feel so young and invincible, we also know that they may be one car accident or one diagnosis away from needing more comprehensive health insurance for the rest of their lives.

That is why we want to make sure—as I said in the beginning—that whatever we do is right, that we don't move forward on something that is going to be less productive and in the long run, unfortunately, put more people at risk.

My goal is to help small businesses while not jeopardizing the quality of health care for the 68 million Americans in State-regulated group plans that are already out there. We don't want to do harm there.

The fact is if we move forward on what Senator ENZI wants to do, which is preempting those State regulations and State mandates, we could do tremendous harm for those who are currently insured and the 16.5 million Americans with individual health insurance coverage who would probably lose some quality of coverage which they have.

If it is good enough for Federal employees, and if it good enough for Members of Congress, I think it should be good enough for millions of small business employees who are the economic backbone of communities throughout this Nation.

I applaud my colleagues for coming to the floor for this debate, and I hope we will have a serious debate so we can

move forward and actually do what is right for the American people.

Mr. CARPER. Mr. President, will the Senator yield once again?

Mrs. LINCOLN. Yes, absolutely.

Mr. CARPER. Mr. President, we do not often think of the Federal Government in the way we are trying to harness market forces and competition and put them to work. We try to hold down Federal outlays. That is what we do with respect to the Federal. It is literally what we do with respect to the Federal Employee Health Benefit Plan. What we are trying to do, with respect to what the Senator has outlined, is harness market forces and competition and put them to work for small businesses as well.

Mr. ENZI. Mr. President, reclaiming our time, I didn't realize they would be allowed to use part of it.

It would be helpful if the other side would actually share the details of their amendment with us so that we can take a look at it. The details of our bill have been through the committee, out here, and had hearings. We don't know what is going to be in there. The last time I looked at it, there was, I think, $9 billion of cost in it each year, and the huge bureaucracy that would be built up. I make that request to the other side—that we sure would like to take a look at their bill. It is hard to do until we have a copy.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Mr. STEVENS. Mr. President, I thank the Chair.

CAPE WIND FACILITY IN NANTUCKET SOUND

Mr. President, I am here to discuss the provision in the Coast Guard and Maritime Transportation Act of 2006 and the provision which allows the State of Massachusetts to have a say in the siting of a 24-square-mile, 130-wind turbine energy facility.

I have a chart I want to use and describe.

First, let me say why the Senator from Alaska is involved in this issue. What I am trying to say is that this is a tremendous precedent.

We have a series of areas of various States where there is a gap in State jurisdiction and where Federal waters are adjacent to and sometimes almost surrounding State waters. That is particularly true in my State. With the Cook Inlet on either side of Kalgin Island, there are gaps of Federal waters surrounded by the mainland of Alaska going down the inlet.

The Minerals Management Service tells us there are roughly 2.5 million acres of Federal waters going down that inlet that could be used for projects such as I am going to discuss today.

A similar situation exists with Chandeleur Island, LA; the Channel Islands in California; the Farallon Islands in California; the Hawaiian Islands in many instances; and in Puerto Rico.

What I am here to talk about is the precedent that would be established by locating this facility in Nantucket Sound, less than 2 miles beyond the State of Massachusetts' jurisdiction.

If we look at this chart, you can see very clearly the area with the darkest color on the chart, which is the proposed site of this power facility. It is 9 miles from one part of Massachusetts, 13.8 miles from the other side, and 6 miles from the other direction.

When you look at the situation, we realize the State has jurisdiction over at least 3 miles in that area.

This is very close to the area of Massachusetts where people have a right to be concerned over this project. Before the Federal Government claimed ownership of this area, there was a judicial dispute over which government had jurisdiction over it. I am informed that the State of Massachusetts had established a marine park in this area. As a matter of fact, it was listed as part of a proposed marine sanctuary, even in the Federal listings. It is now the proposed site for the largest and most expansive offshore wind energy project ever undertaken in the world.

This facility would include turbines that stand 417 feet tall.

This is a chart that describes it. Those windmills would be 417 feet tall, taller than the Statue of Liberty. The one little point at the bottom shows a 30-foot sailboat. You can see the size of it. People sail their boats that size on Nantucket Bay, and the Great Point Lighthouse is supposed to keep sailors and mariners warned about the area. It is only 73 feet tall.

When you look this area, it is 24 miles across, more than half the size of Boston Harbor itself. It is going to be the site of this enormous facility.

As I said, it is larger than any similar kind of wind energy project in the world.

It is a very small area of Federal jurisdiction, completely surrounded by the mainland and islands of Massachusetts.

Some in the media have insinuated that by including this provision in the Coast Guard and Maritime Transportation Act, I am doing it as an old friend to Senator TED KENNEDY. He is an old friend. It is true that Senator KENNEDY and the Governor of Massachusetts support the provision in the Coast Guard bill, but this is my amendment. They have agreed with me. I didn't seek their agreement. It is not an issue based on friendship or on past favors or future favors. It is strictly a provision based upon my long-held belief that States should have the final say on projects which will directly impact their lands, resources, and constituents.

Some in the press have claimed this provision is embedded in ''obscure legislation to be passed in the dead of the night.'' We hear this all the time. But the Coast Guard authorization bill is hardly obscure legislation, and there is nothing secretive about this bill.

The version of this bill that passed the House of Representatives included a provision related to offshore wind farms. It was in the House-passed bill to start with. The House and the Senate, in a bicameral, bipartisan group of Members of a conference committee, discussed and negotiated language to provide the State of Massachusetts a greater voice in the siting of this windmill farm in Nantucket Sound.

This bicameral, bipartisan group also negotiated language requiring the Coast Guard to assess the potential navigational impacts of the proposed offshore powerplant.

This is the normal legislative process for passing legislation of this type through the Congress.

Again, let me point out this chart. I don't live in this area, but I have studied it very well. This is the path the ferries take coming out of these areas and going through this sound, and it is the path which the commercial traffic, steamships, and cargo ships use going into that port.

As a consequence of this location, this line demonstrates the State's jurisdiction and how close it is to the State's jurisdiction. As a matter of fact, the area that is has been lined shows the previous plan which would have gone partially into the State's jurisdiction. The project was amended, so it does not touch the State waters or State jurisdiction areas at all.

It is this area of solid brown on this chart.

By the way, this is the very shallow portion of this area. There is no question about it. Nantucket Island is out here. But there are equally shallow portions outside of the sound that could have been used. But, of course, it is deeper going in there, and that access to this interior part of this sound I think is strictly a financial decision.

At the heart of the debate on the issue is States' rights. The fact is this project will be located entirely in the sound—in this small doughnut hole of the Federal water surrounded by islands and mainland of the State of Massachusetts.

The debate over this project is similar to the fights those of us in Alaska have been engaged in for decades. Our State lands are surrounded by Federal lands, and we often don't have any decision regarding the development of our resources or projects which will be located in our State.

This is one of those situations where Congress ought to listen to the Governor. They ought to listen to the senior Senator, in my opinion.

Those in Massachusetts have raised legitimate concerns about the impact of this wind farm and what its impact will be on maritime navigation, aviation, and radar installations critical to our homeland security.

This proposed site is an area already known for its treacherous flight conditions, and this facility could make those conditions much worse. According to the National Air Traffic Controllers Association, this facility will be located in the flight path of thousands

of small planes. Both the Barnstable and Nantucket Airport Commissions are opposed to the construction of this facility, as are the major ferry lines that operate in Nantucket Sound.

As the chart I have described shows, ferry routes pass within a mile of the proposed location for this project on two sides. The 24-square-mile footprint for this facility is nearly half the size of Boston Harbor, a 471-foot wind farm.

Again, those windmills are larger than this building. Those windmills are larger than the Capitol.

You have to get the specter of this size being built in the center of this sound. It is a 24-square-mile footprint for this facility. As I have said, it is half the size of Boston Harbor and has shipping and ferry channels bordering on three sides.

There is not a single local fishing group from Massachusetts that supports this project, I am informed. It would effectively close a 24-mile-square-mile footprint of many kinds of fishing that has taken place in this sound for generations. Horseshoe Shoal, where the facility will be built, is one of the most productive fishing grounds in the area. That means this area produces offspring. This is where the fish spawn.

The impact of the shoal will be significant. The piling for each one of these windmills—there are 130 of them—are 16 feet in diameter and will be bored down into the shoal to a depth of about 80 feet. This productive area will be littered with 130 drilled holes. Each piling will occupy 2 acres of productive fishing ground. Navigating in and around 130 turbines will make fishing and fishing reproduction in this area nearly impossible.

In addition, these turbines will make Coast Guard search and rescue missions much more difficult in this area, already known for severe weather and sea conditions in parts of the year.

Those in Massachusetts raise another important point. Developing a wind farm of this size and scale offshore has never been done before, let alone in an environment as extreme as the waters of the North Atlantic.

To put this challenge in perspective, it helps to compare the Massachusetts project to the wind farm currently operating in Palm Springs, CA. I know a little bit about this. I have gone into that town several times by air. That facility stands 150 feet at the tallest point. The blades are half the length of a football field, but they are one-third of this size. Even on dry land and a relatively calm desert climate, the Palm Springs wind farm has been plagued by serious maintenance complications. Many of the turbines require constant maintenance and repair.

Put that in the Massachusetts Sound. They require maintenance and repair constantly. This Massachusetts project would require maintenance and repair to take place in icy waters of Nantucket Sound. The size of the windmills for this facility would dwarf the existing land-based wind projects. The windmills in Nantucket Sound would stand nearly three times as tall as those in Palm Springs, with wind blades over a football field in length. Just the blade is a football field in length.

Now, given the legitimate issues raised by the people of Massachusetts and their representative, I believe it is only fair to allow the State to have an equal voice in the debate over the siting of this project. Nantucket Sound, as I have said, is not the only place where a project of this kind can be built. In Europe, deepwater wind energy technologies are currently being developed as far out as 15 miles in 138 feet of water. Placing wind energy facilities further from their shore reduces their impact on maritime navigation.

If this 24-square-mile wind farm is built further away from shore, there would be a number of benefits. It would be removed from boating, fishing, ferrying, shipping channels, reducing the risk of collision and reducing the potential impact on the navigation which we have asked the Coast Guard to look into.

I do support America's use of alternative energy sources, including wind farms and wind power. I have supported wind projects in the past during my time as chairman of the Senate Committee on Appropriations. Our committee appropriated over $105 million for wind projects in fiscal year 2002 to fiscal year 2006. There was even one in my State around Kotzebue.

It is the right of a State to determine if this type of project is consistent with its efforts to protect its resources. I believe Congress should defer to the judgment of the Massachusetts congressional delegation, the Governor of Massachusetts, and the people of Massachusetts on this matter. States should have a say in the activities taking place in the waters adjacent to their shores. This location, in particular, deserves special consideration due to the geographic peculiarities of the region.

California blocked oil platforms, Oregon and Washington blocked them before they were even built.

We now have a dispute before the Congress over a potential development of gas resources 170 miles off the State of Florida. This is 3 miles. This is within a sound that is one of the—I have only been there two or three times, but it is a place if you ever go to it you would not forget. It is not a place that deserves to have this impact. The residents of Massachusetts will have to live with the impact of this project. They must have a greater role in determining the fate of this treasured area.

This bill, H.R. 889, as agreed to by the conference committee, rightly awards the State of Massachusetts this greater authority in the decisions regarding this project. So I am here today to urge the House and the Senate to listen to the people of Massachusetts and particularly to listen to their senior Senator.

I am pleased to yield whatever time I have remaining. I think I have only another 10 minutes or so. I yield to the Senator from Massachusetts.

I think we have 30 minutes on this side and 30 minutes on that side, is that correct?

The PRESIDING OFFICER. There is 14 minutes remaining on the majority side.

Mr. STEVENS. Is there time on the Democratic side for the Senator from Massachusetts?

Mr. KENNEDY. We are rotating back and forth. I am happy to work that out.

Mr. STEVENS. We will work that out.

Mr. KENNEDY. We will stay on the subject matter.

Mr. ENZI. We had some latitude here to allow 20 minutes on this and we were 5 minutes late from that one.

Mr. STEVENS. I talked too long.

Mr. ENZI. And Senator THUNE does not have the time for his speech.

Mr. THUNE. Mr. President, I cannot yield, but if the Senator from Massachusetts requests time and wants to use the Democratic time for that, we have 14 minutes on the majority side I would like to use to talk about the small business health plan. But if the Senator from Massachusetts wants to use Democratic time, that is fine.

Mr. KENNEDY. I ask to be yielded 8 minutes on the Democratic time.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I thank my friend and colleague, the Senator from Alaska.

I hope to have an opportunity to get into this in greater detail than I will for the few minutes I have this afternoon.

There are certain points I want to make. That is, the waters around the area described by the Senator from Alaska, the Nantucket-Martha's Vineyard-Cape Cod area, has been designated a state ocean sanctuary and it is an unreplaceable asset to the people of Massachusetts. Up to 1986, it was generally recognized to be under the jurisdiction of the Commonwealth. In the 1970s, Massachusetts was concerned about potential development threats and made the entire area a protected state ocean sanctuary—where no structures could be built on the seabed and where no offshore electricity generation facilities could be constructed.

The legislation was passed easily through the State House. And the specific part of Nantucket Sound that is no longer protected by the state laws, because of a Supreme Court decision, is under consideration for national marine sanctuary status.

My second point, Mr. President, is that I am for wind energy. We all know we need it to meet our future needs, and we've seen the successes that onshore wind energy farms can be. We ought to have offshore wind energy, but we need to get it right.

The problem in Massachusetts is that we have a developer who's basically staked a claim to 24 square miles of Nantucket Sound back when there were no rules on offshore wind development, and then got the project written into the new law so the new rules won't apply to this project.

And the practical effect is that there will be no competition for the developer and that his application is being reviewed and processed before the Department of the Interior can even complete a national policy.

In the Energy bill, section 388 says:

. . . the Secretary shall issue a lease, easement or right-of-way under paragraph (1) on a competitive basis unless the Secretary after public notice of a proposed lease, easement or right-of-way that there is no competitive interest.

The next provision says:

Nothing in the amendment made by subsection (a) requires the resubmittal of any document that was previously submitted or the reauthorization of any action that was previously authorized with respect to a project for which, before the date of enactment of this Act—

(1) an offshore test facility has been constructed;

Well, where in the country was there a project that had an offshore test facility?—only in Nantucket Sound. So this was a real special interest provision.

Because of this ''savings provision,'' the developers are pushing Interior to complete this review before the rules of the game are even established and before the ocean is zoned.

So while Interior is setting a uniform program—and deciding which sites should be used—this project is on the fast track. The developer and the developer alone picked the site.

And this is a serious problem. Look at what the EPA said about this project's draft environmental impact statement. They called it ''inadequate.'' That's from the EPA, the agency charged with protecting the environment.

And the EPA wasn't alone. Look at what the US Geological Survey said about Cape Wind's draft environmental impact statement:

. . . the DEIS is at best incomplete, and too often inaccurate and misleading.

Inadequate—Incomplete—and too often inaccurate and/or misleading. Does this sound like project that should be on the fast track?

But because they've been written into the law, the interests of our state have been basically submerged to a special interest developer.

They complain about the provision in this bill that Senator STEVENS negotiated with the House. He's right. He's trying to at least bring this back up for review under the sunlight and ensure that the interests of the state for safety and for environmental protection aren't run roughshod over.

The project's developer is the one that got the special interest legislation. This Coast Guard provision is designed to check that and preserve the public interest.

The provision Senator STEVENS crafted tries to remedy an injustice the developer created, and at least let the people of our State be heard.

We wish this provision wasn't necessary, and it wouldn't be if the developer was content with following the rules that apply to everyone else.

That would have been satisfactory, but no, we are denied that equal treatment. We are prohibited from that. That is not right.

Our State went out and created the Cape and Islands Ocean Sanctuary as a protected area. Then the Supreme Court cut a hole in those protections, and now the interests of the State to preserve the fisheries and environment of the whole region is being undermined. It is being handed off to private interests. It's not right. We deserve to have at least a little fairness in this.

I will not take the time to list the various national marine sanctuaries, including the Channel Islands, all the Florida Keys, and other national treasures, like Stellwagen Bank outside of Boston, which I am so happy we have protected into the future.

The law says you can't build energy facilities in those sanctuaries and we shouldn't—and Nantucket Sound is just as important as those.

For 400 years the Sound was considered Massachusetts waters, and it was a protected by the people of our state.

In preparation for the 1986 Supreme Court decision that would specify that this narrow area would be carved out as Federal land, we took special care to get on the national marine sanctuary site evaluation list. We didn't want to take any chances then, and we're still on the list. At a minimum, no industrial project should be built there until we can resolve that status.

And now we have a developer who wants complete control over 24 miles in the middle of the Sound, even though no government agency has zoned it for energy development yet.

We know that the U.S. Commission on Ocean Policy called for a comprehensive siting policy, and that Interior is now working on it. We endorse that approach completely, but this developer is undermining that.

And the American people should know just what this developer is getting for this no-bid, no-compete contract. There will be at least $28 million a year in federal tax benefits available to the developer that's $280 million over 10 years.

And in Massachusetts, the developer will be eligible for between $37 million and $82 million a year in price subsidies under the renewable energy credit program. That's $370 million to $820 million in price subsidies over 10 years.

Then there's the fact that the company will be able to write off the $800 million cost of this project off in just 5 years.

This is a boondoggle, and it's an outrage the developer's getting a no-bid contract to a public resource. We've seen what no-bid contracts can do, Mr. President.

Who pays when we talk about subsidies? It comes out of the taxpayers' pockets when we talk about subsidies.

It is a great deal for this developer. It is a great deal for his investors. It is a great deal for the venture capitalists. They will get so much money they will not be able to count it. But it shouldn't be done without the voice, without the consideration, and without the interest of the State, let alone the many groups that oppose this project and fear that it will undermine the safety, environment, and economic interests of the region for years to come.

I thank the Senator from Alaska for his hard work on this bill and this provision.

Let me ask the Senator—and I know the time is up—I understand if this proposal were for an LNG facility in Nantucket Sound, the Governor of Massachusetts would have the same authority under the Deepwater Port Act that we're seeking here for this project. Am I correct?

Mr. STEVENS. That is right.

Mr. KENNEDY. We need LNG and we need more energy sources, but if they had decided here to do an LNG on this site, the Governor would have a voice in that, am I correct?

Mr. STEVENS. I believe the Senator is correct.

Mr. KENNEDY. So this idea about having a voice on this makes a good deal of sense.

I thank the Senator from Alaska.

I yield the floor.

The PRESIDING OFFICER (Mr. MARTINEZ). The Senator from South Dakota.

Mr. THUNE. Mr. President, how much time is remaining on this side?

The PRESIDING OFFICER. Ten minutes remains.

Mr. THUNE. Mr. President, I ask unanimous consent, if necessary, that I have a couple of additional minutes beyond that. I believe the other side was granted a little bit of extra time when they were addressing this issue as well.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered. The Senator will have an additional 2 minutes.

Mr. THUNE. Mr. President, last week the Robert Wood Johnson Foundation sponsored ''Cover the Uninsured'' week, a call for this country to wake up and address a huge and growing problem in our Nation. In 2004, approximately 19.1 percent of nonelderly Americans did not have health insurance. That number is growing.

Why do we have this problem in one of the wealthiest nations in the world? It is because nearly one-half of the 45 million uninsured individuals in the United States are either employees of small firms or family members of small business employees.

The primary reason cited by small businesses themselves for not offering health benefits is simply the high cost of health insurance. We can do something about that beginning today. We

also have this problem because Congress has repeatedly failed to do its job in the past. We can also do something about that, beginning today.

Today the Senate voted on a motion to proceed to S. 1955, which is a bipartisan bill addressing the issue of the working uninsured. This legislation allows the creation of small business health plans to help lower the cost of health care for small business owners and their employees.

Our colleagues on the other side have also offered some legislation today to address this issue. Senators DURBIN and LINCOLN have talked about their particular proposal, which is a Government approach. In fact, they say it saves money, but it shifts the costs over to the taxpayers, to the tune of $73 billion over a 10-year period. Why would we ask for taxpayers to foot the bill before we have allowed the small businesses of this country to take advantage of a market-based approach and to use the market forces that exist out there in a way that would drive health care costs down for them and their employees? It is very simply a difference of philosophy.

Our philosophy—the approach contemplated under S. 1955—deals with a market-based solution to this issue. The proposal, S. 2510, by our colleagues on the other side is a Federal Government solution to this issue, at a great cost, I might add, to the taxpayers of $73 billion over a 10-year period.

S. 1955, the Enzi bill, which, as I said earlier, we were able to move to proceed to today, would lower the cost of care for employers and employees. In addition, the Congressional Budget Office estimates S. 1955 would reduce net Federal spending for Medicaid by about $790 million over the next 10 years. It would also save the States of this country about $600 million in the cost of Medicaid over a 10-year period. That is in addition, as I said, to the savings that would be achieved for small businesses.

The Congressional Budget Office has analyzed this particular piece of legislation and concluded it would save somewhere between 2 and 3 percent for small firms in this country on the cost of their health insurance. What is significant about this, as well, in contrast to the proposal by our colleagues on the other side, which would cost an additional $73 billion over the course of the next 10 years, is the Congressional Budget Office said that the Enzi bill, S. 1955, would increase tax revenues coming into the Government by $3.3 billion over 10 years because lower spending on health insurance would increase the share of employee compensation paid in taxable wages and salaries versus tax-excluded health benefits. In other words, lower spending on health insurance would translate into higher wages and salaries and actually would also generate more revenue for the Federal Government rather than less, which is what would happen under the proposal by the Democrats, which would cost the taxpayers $73 billion, according to the Congressional Budget Office, over a 10-year period.

So I believe it is important we move forward and we vote to send S. 1955 out of the Senate to conference with the House. As a Member of the House of Representatives, I voted for the creation of small business health plans numerous times. In fact, that particular proposal has been voted on no fewer than eight times in the House of Representatives.

Every time I voted when I was a Member of the House, and every time it has been passed by the House of Representatives, it has come to the Senate and has been unable to be voted on because it has been filibustered, obstructed by the other side. I would say, that is in spite of the fact that if it were allowed an up-or-down vote in the Senate, I believe there would be a decisive bipartisan majority in favor of this legislation.

Unfortunately, due to obstructionism, the Senate, until today, has never voted on legislation creating small business health plans. As a Congressman and now Senator, I have listened to many accusations about the harm that S. 1955 or similar legislation would do if it were enacted.

What harm would be caused by decreasing the cost of health care for small employers by 12 percent and increasing the coverage of the working uninsured by 8 percent? Lower cost and more coverage for those who are currently uninsured: That is not harm. That is exactly what we ought to be accomplishing here by enacting legislation that would make health care coverage more affordable and more available to more Americans.

South Dakota has an estimated 72,949 small businesses as of 2004, which is an increase of 2.4 percent from the previous year in 2003. South Dakota also had an estimated 90,000 uninsured individuals or 12 percent of our population in the year 2004. Fifty-two percent of South Dakotans had employer-based health insurance, 8 percent below the national average.

Small businesses are the backbone of South Dakota's, as well as our Nation's, economy. It is time these businesses were placed on a level playing field and allowed to pool together to purchase health insurance, like large employers and unions.

I have heard from many provider groups in my State of South Dakota concerned about coverage for their specific services. S. 1955 allows small business health plans to offer a basic benefit plan that would be exempt from State mandates as long as the small business health plan also offers an enhanced benefits option that includes at least those covered benefits and providers that are covered by a State employee health benefit plan in one of the five most populated States in this country.

According to the Council for Affordable Health Insurance, all of these States—all of these States—require coverage for alcoholism, breast reconstruction, diabetes self-management, diabetic supplies, emergency services, mammograms, mastectomy stays, maternity stays, general mental health, chiropractors, optometrists, podiatrists, psychologists, and social workers.

Small business owners want to give their employees the best health coverage possible under their budgets to recruit and retrain their workforce. Facts suggest self-insured large company health plans, currently exempt from State mandates, generally cover services important to their employees.

This legislation would create new options for small businesses and the potential for a choice in health plans for their employees. Today, only 10 percent of firms with 50 or fewer employees offer their workforce a choice of more than one health plan. Lowering the administrative costs of health insurance plans will give small firms new and better coverage choices for their workers.

Additionally, the GAO found that the added cost of mandates to a typical plan is between 5 and 22 percent. CBO estimates that every 1-percent increase in insurance costs results in 200,000 to 300,000 more uninsured Americans. When the cost of health insurance goes up, coverage and access go down.

The concept behind S. 1955 is very simple: to provide health insurance to small businesses that is both affordable and accessible. Small businesses not only in my State of South Dakota but across the Nation have been fighting for the creation of small business health plans for over 10 years. It is high time that the obstruction end in the Senate, that the Senate step aside and allow an up-and-down vote on this very important legislation.

As I said before, it is legislation that, if you look at just the Congressional Budget Office findings, would cover nearly a million more people, would allow three out of every four small business employees to pay lower premiums than they currently pay under current law, and would see small firms' premium costs decline by 2 to 3 percent. The average decrease per firm would likely be greater, since the CBO estimate is a total that factors in the costs of other benefits added by firms in response to the reduction in premiums.

It would also allow annual spending on employer-sponsored health insurance to be reduced by about $2 billion in a 5-year period. As I said earlier, it would increase Federal tax revenues by $3.3 billion over 10 years because lower spending on health insurance would increase the share of employee compensation paid in taxable wages and salaries versus tax-excluded health benefits—more coverage; lower costs; more revenue to the Federal Treasury, not less. The alternative offered by our colleagues on the other side, as I said earlier, comes at a high cost to the taxpayers: $73 billion over a 5-year period.

We can do better. We can allow the market forces of this country to be used. We can take a market-based approach to this issue and do something that has been done a long time ago, something that has, as I said, been voted on repeatedly in the House of Representatives, never to have been voted on here in the Senate, because it has been blocked.

It is high time for the small businesses of this country, for their employees, for families who lack coverage today, to have another tool at their disposal, a tool that takes into account and takes full advantage of market forces, by allowing small businesses to group together to leverage their size, to drive down the rates they pay for health insurance and, thereby, cover more of their employees.

That, again, is in stark contrast to the model and the proposal that is being offered by our colleagues on the other side, which consists of a government-based solution, that comes at a very high cost to the taxpayers, that calls for more bureaucracy and redtape, and does nothing in the end to bring down the cost of health care for small businesses in this country.

It is long overdue. I hope, as we have the chance to debate this now in the Senate, once that debate is concluded, we will be able to proceed to a vote because the one thing that has always been missed here in the Senate, despite action on eight different occasions in the House, is an actual up-and-down vote in the Senate that would allow the Senate to speak on the issue of whether we want to do something meaningful to reduce the cost of health care for small businesses in this country, to provide more coverage for those who are currently uninsured, and also to do something that would reduce the cost to the Government, the cost of Medicaid, as well as the other costs that are associated, as I said earlier, by increasing the amount that would come into the Treasury.

For those reasons, Mr. President, I ask my colleagues to support this legislation.

I yield back the remainder of my time.

The PRESIDING OFFICER. The time until 4:30 is controlled by the minority.

The Senator from Iowa.

Mr. HARKIN. Mr. President, here we are on day 2 of Health Week, and there are still no plans to bring up H.R. 810, the stem cell research bill.

This bill was passed by the House of Representatives 351 days ago—almost a year ago now—with still no action here in the Senate. Yet the majority of Senators are for it. I do not understand how in the world we can have a Health Week in the Senate and not vote on the American public's No. 1 health research priority: lifting the President's restriction on embryonic stem cell research.

That seems to be what we are doing. We are wasting our time on bills that everyone knows are not going to pass. We are passing up a golden opportunity to promote one of the most promising areas of research in our lifetimes.

Most people by now have heard of the enormous potential of embryonic stem cells. These cells have the remarkable ability to turn into every other type of cell in the human body—brain cells that could replace those lost in Parkinson's disease, islet cells to replace those lost in type 1 diabetes, and on and on. Adult stem cells don't have that power, only embryonic stem cells. That is why the world's best scientists think embryonic stem cell research has so much promise to save lives and ease human suffering. It is also why they are so frustrated by the President's arbitrary restrictions on stem cell research.

Under the President's guidelines, Federal funding can be used for research only on those stem cell lines that were created before August 9, 2001, at 9 p.m. Where did that date come from? Out of thin air? If the stem cell lines were created at 8:30 p.m., they are fine, they are moral, they are OK. If they were created at 9:30 p.m., all of a sudden they missed the cutoff. It is totally arbitrary.

Shortly after the President announced his policy, he said 78 stem cell lines were eligible under his guidelines. It turns out that only 22 are. In fact, it is even worse. Only a handful of those are even healthy enough and readily available. More importantly, all of the 22 lines that are available have been contaminated by mouse cells. They have been grown in a mouse feeder cell environment. It is unlikely they will ever be used for any kind of human intervention, which is supposed to be the whole point of the research anyway.

Dozens more stem cell lines have been created since August 9, 2001. They are healthier. Many have never been contaminated with mouse cells. But thanks to President Bush, they are off limits to our best scientists.

Yet opponents of H.R. 810 sometimes argue that embryonic stem cell research has no potential. Last week, Senator BROWNBACK presented a list of diseases that are being treated with adult stem cells and asked why that hasn't happened yet with embryonic stem cells. Let me address that directly. Scientists have been doing research on adult stem cells for over 30 years. There are no arbitrary restrictions on research with adult stem cells. Scientists and private companies don't have to be skittish about doing this research. They don't have to worry that all of a sudden the Federal Government is going to ban it or limit it.

Let's compare that situation with human embryonic stem cells. Scientists didn't even know how to derive them until 1998. The first Federal grant for these stem cells wasn't awarded until 2002. Even now, only a tiny fraction of the total Federal budget for stem cell research is used for embryonic stem cells. The vast majority goes for adult stem cell research, and every scientist who enters this field is taking a risk that Congress will pass a law to shut down the lab. They also risk that they won't get any 1 of the 22 lines contaminated by mouse feeder cells which they will then not be able to use for human therapy. So it is no wonder that more diseases are being treated today with adult stem cells. Adult stem cell research had a 30-year head start. Meanwhile, scientists have been studying embryonic stem cells for just 5 years with one arm tied behind their back.

The fact is, it doesn't matter what I think about the potential of embryonic stem cell research. It doesn't matter what Senator BROWNBACK thinks either. What matters is what the scientists think. And I defy anyone to find a single reputable biomedical scientist whose doesn't believe we should pursue embryonic stem cell research.

I have a letter from Dr. J. Michael Bishop who won the Nobel Prize in medicine in 1989. He writes:

> The vast majority of the biomedical research community believes that human embryonic stem cells are likely to be the source of key discoveries related to many debilitating diseases. . . . In fact, some of the strongest advocates for human embryonic stem cell research are those scientists who have devoted their careers to the study of adult stem cells.

A letter from Dr. Alfred G. Gilman, who won the Nobel Prize for medicine in 1994:

> It has become obvious, however, that the number of stem cell lines actually available under current policy is too small and is controlled by a limited monopoly, which has made it significantly more difficult and expensive for research to be conducted. These limits have hindered the important search for new understanding and treatment of devastating diseases.

I have similar letters from Dr. Ferid Murad, who won the Nobel Prize for medicine in 1998; Dr. Arthur Kornberg, who won the Nobel Prize in medicine in 1959; and dozens more of our Nation's top researchers—all of whom believe in the potential of embryonic stem cell research. I ask my friend from Kansas, in response to his speech of late last week: Are there any Nobel Prize winners in medicine who oppose embryonic stem cell research? Name one.

In fact, I challenge him further: Are there any reputable biomedical researchers at all who think we should be studying adult stem cells only and not embryonic stem cells? Name one.

I don't think he will find one. Every scientist I have spoken to says stem cell research should not be an either/or endeavor. We should not be talking about stem cell research or embryonic stem cell research. We should study both. We should open all doors in the pursuit of therapies that can save lives and ease human suffering. The breakthroughs are coming, but they take time. To clamp down on embryonic stem cell research before it even has a chance to start shows a total lack of understanding about how science

works. More importantly, it denies hope to millions of Americans who suffer from Parkinson's, ALS, juvenile diabetes, spinal cord injuries, and dozens of other terrible diseases and conditions.

We are rapidly approaching the 1-year anniversary of the vote in the House on H.R. 810. It has been 351 days since the House passed it on a strong bipartisan vote. If the Senate were allowed to vote on H.R. 810, we would win here, too. We have the votes. We would pass this bill and send it on to the President. Regrettably, however, the Republican leadership has not let that happen. So here we are, we are going through this farce—it is farcical—comedy, gimmickry of a so-called Health Week without taking up the American public's No. 1 health research priority.

It is Tuesday. Health Week lasts for 3 more days. We could pass H.R. 810 in a matter of hours. I urge the majority leader, take up the bill. Let the Senate have a quantified amount of time to debate it. We will pass it, and we will give millions of Americans who are suffering from diseases the hope they deserve.

I yield the floor.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Mr. President, before he leaves the floor, I say to my colleague from Iowa, Senator HARKIN, how much I appreciate his leadership in the area of health care. His analysis of where we stand on the stem cell issue is so appropriate, and he is so right. Here we have a whole area of scientific research that is waiting to take off. We have States, such as mine and others, that are taking the lead instead of following the lead of the Federal Government.

I say to my friend, does he ever remember a time in history when this country was plagued by disease that the Federal Government didn't step to the plate, whether there was a Republican President or a Democratic President? Isn't it shocking that as we face these epidemics of Alzheimer's and Parkinson's and cancer and heart disease and all the others my friend mentioned, isn't it amazing—I am sure it is to him as well as to me—that we have a lack of leadership in Washington?

Mr. HARKIN. I say to the Senator from California, it is not just amazing, it is shameful. It is shameful what is happening now with the lack of support for biomedical research, especially embryonic stem cell research. As I said, every Nobel Prize winner in medicine, all the reputable scientists say we should be on it and we should be on it strongly. Yet the President, through this arbitrary cutoff, is denying this for scientists, denying it to people who are suffering. I say to my friend from California, God bless California. They took the lead out there. Her State has taken the lead. They are forging ahead. Other States are following their lead. If only we could get the Federal Government to follow their lead.

Mrs. BOXER. As my friend pointed out in his statement, we have the votes for stem cell research, even with the President's opposition. If we asked for a show of hands in any roomful of people: Have you been touched by cancer, have you not personally or someone you know been touched by heart disease, by stroke, by Alzheimer's, Parkinson's, paralysis, all these things, we know how many hands would go up.

Mr. HARKIN. Juvenile diabetes.

Mrs. BOXER. That is clearly one. And I have met with juvenile diabetics. I have met with the children, the parents and the families. They are counting on us. Here we are in Health Week, as my friend points out. We have the votes. Yet what do they bring up? A bill that is actually going to take away health care from people, the Enzi bill.

Mr. HARKIN. Exactly. I appreciate my colleague from California. She is right on target. I know my friend from California, the distinguished Senator, has been in the forefront of fighting for the things that will help people have better lives, especially in health care, and to ease the pain and suffering of people, especially juvenile diabetics.

As the Senator knows, the families tell us that perhaps one of the first therapies that could come from embryonic stem cell research would be for these kids suffering from juvenile diabetes. What a great day that would be.

I thank the Senator for her comments and strong leadership in all the areas of health care, and I thank California, through her, for the leadership they have shown.

Mrs. BOXER. I am very proud of my State.

In my State the gentleman who took the lead in putting the stem cell research initiative on the ballot has a child with juvenile diabetes. Watching that child suffer and struggle motivated him. He ignited this wonderful movement in our State. Shockingly, here we are in Health Week and this thing is nowhere to be seen. It is another example of why we need change around this place. I thank my friend.

This Health Week Republican style is really fascinating when you look at the bills that have come before us. The first two bills would have hurt patients who were injured by malpractice, patients who might have been made infertile or harmed in many ways. Those two bills took away the rights of patients.

The PRESIDING OFFICER. The minority's time has expired.

Mrs. BOXER. I ask unanimous consent to speak another 15 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. ENZI. I object.

The PRESIDING OFFICER. Objection is heard.

Mrs. BOXER. I ask unanimous consent to suggest a quorum call.

Mr. ENZI. Mr. President, under the unanimous consent agreement, we are alternating every 30 minutes.

The PRESIDING OFFICER. Under the precedents of the Senate, the Senator must control at least 10 minutes in order to suggest the absence of a quorum.

Mrs. BOXER. I ask unanimous consent that at 5 o'clock I be given the floor for 10 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. ENZI. Mr. President, reserving the right to object, the Senator's side controls the time at that time. So if they want to give the Senator the 10 minutes, there would be no objection to that. It would come out of the Democratic time.

Mrs. BOXER. I thank the Chair.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Wyoming.

Mr. ENZI. Mr. President, first, I apologize for the confusion over the unanimous consent that we had. It was designed early this morning to make sure each side had an opportunity to have an equal amount of say on the 30 hours that we are working on in order to actually get to amendments on this bill. Now that we have had cloture and everybody has agreed, or almost everybody, that we needed to proceed on the bill, we are talking about an issue that is huge to small businesses out there and wanting to find some kind of solution. We even suggested that perhaps they would like to reduce the number of hours of debate about the right to proceed so that we could actually get to offering amendments. But we have a 30-hour time requirement. That could be reduced by unanimous consent, or even eliminated by unanimous consent. But it has not been, so we will try to keep on a half-hour rotating basis so that as many people as possible can have something to say on the bill.

I am going to take a few minutes at this point to talk about this issue. We have been talking about health care. One advantage of having this 30 hours is to have some additional health care debate. I need to talk a little bit about prescription drugs Part D. That is not part of the motion to proceed, but it has been talked about a number of times on the Senate floor today. There are some confusing things out there for seniors that I would like to clear up.

I have been taking the last two recesses to travel across Wyoming and hold meetings with senior citizens to explain the prescription drug plan to get them signed up so they can get the benefit. There is some confusion out there. When we were designing the plan, we were worried that there would not be any plan interested in our small population in Wyoming. We have less than 500,000 people in our State. Our biggest city has 52,000 people. So we have a little bit of trouble finding a big enough pool for anything and to encourage interest. So I asked that there be kind of a Federal backup plan on it, and that was put in the bill.

But when the time came around for companies to offer plans in Wyoming, obviously, they were even excited about 500,000 people because we had 41

plans respond. That is competition. That competition brought the prices down by 25 percent before the people even applied for the benefit. A huge decrease in cost; that is cost by competition. The downside is that 41 plans create confusion. If you have ever tried to buy insurance and talk to a number of different insurance salesmen, every package is designed slightly different to make it a little bit more confusing so that their plan looks better, but it is also harder for you to make comparisons.

There is an easy way to make comparisons. Medicare saw that coming and set up a computer analyzation so that all you have to know is what your prescriptions are and what the doses are. You can put them in over the Internet or you can talk to somebody live by an 800 number or there are a lot of volunteers across America who are helping to get this information out. It lets Medicare do the math. They will present you with three or four plans that meet your prescription, your doses, and your criteria for where you want to buy it. You can look at these line by line. All the lines match up and you can compare them and find the best one for you. It has been a tremendous help.

My mother asked me to help her on her decision. There are kids across the United States—kids like me—who need to be helping their moms on these kinds of decisions. I was happy to do it because it gave me an opportunity to try out the telephone method, the Internet method, and I talked to a number of volunteers and the local pharmacist. We owe the local pharmacist a great deal of thanks for the way this is working and the difficulties that they have had doing a new program. We have not had a big change in the program in decades. When we first had Medicare, there were problems. They got worked out. When we started this one, there were problems, and I think they have mostly been worked out.

Occasionally, at these hearings, somebody was having a problem. A hour and a half was the longest it took us to straighten out any problem for anybody. I ran this process and came up with these four best at the least cost for my mom.

One of the things that people raise in those sections is they say: I don't need any drugs so I should not have to do this. I should not have to pay a penalty later.

The way insurance works is that you buy into the plan usually before you get sick. You pay a premium and when you get sick, then you have the coverage for the things that can happen to you in the future.

Medicare prescription Part D is completely different because you can already have a huge medical problem and a lot of prescriptions and you can sign up for this now and have a maximum guaranteed cost. I know of people who are actually saving thousands of dollars because they signed up. If you don't have anything the matter with you and you don't want to buy into a big plan, you run the evaluation and you can find a small plan you can buy into.

One in Wyoming is $1.87 a month. What if the $1.87 a month doesn't cover me if I have something really bad happen to me? Well, every November 15 to December 31 you can change your mind. You can change your company, and they cannot stop you. Tell me where else insurance works like that. Every November 15 to December 31, you can change your mind and sign up for a plan that has new kinds of benefits for you that match new illnesses that you might have.

This is working for the people who have paid attention. It is easy to have Medicare do the math. So everybody out there who hasn't signed up needs to talk to the volunteers, probably at their senior citizen center or call the 1–800 number or get on the Medicare Internet site and have that plan figured out for you. It takes a few minutes and you can be set so that you, first of all, won't have any penalties, but, secondly, you will have some tremendous benefits as you need the medication. It has made a huge difference.

Some people have talked about negotiating the price. When I was doing these hearings, I had some difficulty with people who showed up and said: You know, there are some medications I really want to have, that I am supposed to have, and I cannot get them. Well, when I checked, those were the veterans, and the veterans' prices are negotiated, and when they negotiate prices, they pick a similar drug and get the best price by kind of fixing the price on it and driving the price down through this bidding war. But it eliminates medications. Yes, there are medications you can take. It may not be the medication your doctor thinks is absolutely the best. But that is what happens with negotiated prices.

So what we relied on in the Medicare prescription Part D was competition, and competition has happened. Prices came down 25 percent, and then people who signed up for the program who are using medications found out that they are also saving another 25 percent as the least amount, or 37 percent as the average amount, and some people are getting 83 percent—I say some people. I know some people who are getting several thousand times more than what they are paying in because they are into the catastrophic care. I wasn't even listing the catastrophic care.

The important thing is that we need to tell people and help people to sign up by May 15. It is a tremendous benefit. We have had more people sign up than we had anticipated signing up. That means, again, a bigger market; that means lower costs. So it works for all of us when people sign up. Remember, there are plans out there. If they have them for $1.87 a month in Wyoming, I bet they have that at $1.87 or less every place in the country. Look at those if you are not using any medication.

So that is what competition does. That is the purpose of the bill that we are talking about and that we have actually had the motion to proceed on, not the ones that fall under other committees' jurisdictions, such as Medicare or stem cells or some of the other things that have been talked about here. Those are things that actually—this falls under the jurisdiction of the Health, Education, Labor and Pensions Committee. We took the bill through committee that has never been through the Senate before. The House passed a bill that is considerably more liberal and difficult than the one that we passed. They passed it eight times over there in a very bipartisan way. If we have the same Democratic Senators over here vote for it that had Democrats in the House vote for it, we will pass this bill easily. Even if there is a filibuster, we will pass it because it is a concept that small businesses have been asking for. This is the first opportunity we have had to provide it for them.

We did it by being very conservative in the approach and going to a situation where we could work across State borders, so that associations could build a big enough pool that they could effectively work with their insurance companies to get these multiple competition bids. We are certain that it will work. One of the reasons we are certain that it will work is because it has been tried within States. But those who have tried it within States have found that it works very well, and they know it would work even better if they could go across State borders. So even those who are doing it are asking to do it on a wider scale than what they have been. For a lot of the States that have less population, yes, they want to be able to do it at all. They don't have big enough pools within their States to do it, so they want to be able to go across the State borders.

I want to discuss a little bit why we need to pass S. 1955 and allow for the creation of these small business health plans. First of all, the concept of allowing small businesses to join together to find better prices for health insurance is not new, as I mentioned. Many organizations have offered nationwide health plans to members in the past. But States continued to add mandated benefits and other regulations to their insurance markets during the 1980s and 1990s, and the administrative hassles and costs associated with the mandates and regulations became too much of a burden for existing plans that could no longer offer an affordable benefit on a national basis. So they discontinued the plans.

The Associated Builders and Contractors organization, known as ABC, is an unfortunate example of this problem. Their insurance carrier refused to continue doing business with the ABC insurance trust in the late 1990s because

the panoply of 50 different State regulations and excessive benefit mandates made it impractical and unattractive for the insurance company to continue the program. ABC was unable to find another carrier to pick up their business.

This chart kind of shows how health care costs have gone. I don't think there is any argument on either side of the aisle that this is what has happened. There has been a rapid escalation, and compared to what it used to be, there has been a rapid escalation for a long time, oddly enough. We are up to a national average cost per employee of about $8,000 a year. That doesn't include the part the individuals are paying, which brings it up to about $11,000 a year. That is the amount we have been talking about on both sides of the aisle today.

What is truly unfortunate is that workers at ABC's member companies were benefiting from this program, and the companies were saving money on their health care expenses. The health plan sponsored by ABC for nearly 45 years had total administrative expenses of about 13 cents for every dollar in premium. These costs included all marketing administration, insurance company risk, claim payment expenses, and State premium taxes. Compare this to the small business employers who purchase coverage directly from an insurance company. The total expenses for most small businesses today can approach 35 cents for every dollar of premium. So saving nearly 25 cents on a dollar is real money, especially in today's health insurance prices.

The other benefit to ABC's member companies and employees is that any profit generated by their health plan stays in the plan. This also helped keep costs down. So the idea isn't new, and it has worked before.

But Congress needs to act before small business organizations can resurrect their defunct programs and before other organizations can start new ones. Congress considered fixing this problem during debate over the Health Insurance Portability and Accountability Act in 1996—it is better known as HIPAA—but the small business affordability provisions in the House bill were dropped during the conference between the House and the Senate in the final bill. As a result, HIPAA only addressed access to health insurance and not affordability. So now everyone has access to health insurance policies, but the policies themselves are unaffordable to many. When I became chairman of the Committee on Health, Education, Labor, and Pensions last year, I announced that I would bring a health insurance affordability bill before the committee so we could finish the job we started 10 years ago—in other words, to make it possible for all Americans to have access to a health insurance policy that is affordable.

Many were skeptical then, and some may still be skeptical now, but the time for more of the same is over. America's working families want change, and they are tired of excuses from Congress.

Small businesses and working families are demanding relief from high health insurance costs. And it is no wonder. This year, employers are paying twice what they were paying in the year 2000 for health insurance. That is correct. What businesses paid for health insurance has doubled over the past 6 years. That is a pace we can't keep up.

This cost squeeze hurts small businesses the most. The highest rates of uninsured workers can be found in businesses with 25 or fewer workers. Only 60 percent of the Nation's businesses are offering health insurance these days, down from nearly 75 percent just 5 years ago.

Small businesses and working families are stuck on the escalator of rising health insurance costs, with no end in sight. And in a tight labor market, small business owners don't want to jump off this fast-moving escalator because dropping health insurance puts them at a major disadvantage in competing for the best workers. We need to give them a safe place to get off this escalator of rising costs, somewhere where it is more affordable for themselves and working families, and the small business health plan will give them that option.

Mr. President, I yield the floor to the Senator from North Carolina.

The PRESIDING OFFICER. The Senator from North Carolina is recognized.

Mr. BURR. Mr. President, the chairman has brought a carefully crafted piece of legislation to the Senate floor, one that took a tremendous amount of skill to negotiate and one that has incredible support—more support when the bill passed out of committee than it does today. Why? Because people now fear it might become law. People fear this might pass, and they never believed it would. What does it do? It brings additional competition to the marketplace, but more importantly, it brings health care coverage to Americans who have no coverage today.

Why are we here today, on Tuesday afternoon at almost 5 o'clock? Because the Senate is in a 30-hour debate about whether we are going to be willing or able to proceed. We are not even on the bill yet; we are in a procedural mode which requires us to have a vote to proceed to consider whether we are going to have a debate on this bill, S. 1955, a bill that changes the choices of the uninsured population in America.

The choices they have today are nothing and nothing. Under any scenario, you would have unanimous support to change that. But there are actually people who are against that up here, but not across the country. As a matter of fact, in this poll done by Public Opinion Strategies in March of this year, over 80 percent of the people polled overwhelmingly support small business health plans; in other words, they support this legislation—the effort to bring new choices of products that are affordable to small businesses, to employers, and, more importantly, to the employees they hire.

In North Carolina, we have 671,000 small businesses. Ninety-eight percent of firms with employees are small businesses in North Carolina. Don't let anybody come to the floor and tell you that this bill does not have an effect except on a select group of people. It may be a select group of people, but it is 98 percent of the employers of North Carolina. Women-owned small businesses have increased 24 percent in North Carolina since 1997, Hispanic-owned small businesses have increased 24 percent since the same date, Black-owned small businesses have increased 31 percent since 1997, and Asian-owned small businesses have increased 74 percent since 1997. These are companies which benefit from this legislation. These are companies which today can't afford the premium costs of health insurance; therefore, their employee base goes without. They are in that category of uninsured that so many people come and talk about on this floor, but they talk about uninsured without the solution as to how to cover them.

This is a population which in some cases today is on Medicaid. They work full-time. Their income level qualifies them for Medicaid. And what would be the incentive for them to get off of Medicaid? It would be if their employer has the option to offer them health care the way the majority of America is now provided health care: through their employer. But we are here in 30 hours of debate trying to decide whether we are going to allow Members to come to the floor and debate a bill and offer amendments which will allow us to switch from nothing and nothing to nothing and something, which will allow us to inject something, some ray of hope into the millions of Americans who don't have coverage today.

Let me read a few letters. I think it is always helpful to hear from people whom this affects, the human face behind the issues that sometimes we lose on this floor simply because we don't want to talk about names or pictures.

This is a woman from Sunbury, NC. She wrote me in mid-April of this year. I am just going to read some pieces. She says:

> Support SBHP legislation, S. 1955. I feel that this is very important because I haven't had health insurance in many years, because my employer doesn't have access to affordable insurance to offer us.

Some suggest on this Senate floor that is not the case, that everybody has the opportunity to have health insurance. ''I haven't had health insurance in many years.'' Why? ''Because my employer can't afford what is available.''

Another letter received in April of this year from a young lady in Elizabeth City, NC:

> Please support Senate bill 1955, the Health Insurance Marketplace Modernization and

Affordability Act. My employer cannot afford health insurance for their employees. My husband works for Ford. They are closing his plant soon. We will have no insurance unless my employer offers it. I have premature twins. They were born 3 months early. It costs me $2,000 a month to feed them. That does not include any doctor's appointments we have to go to. I feel that this is a great bill.

What is America looking for? They are looking for hope. They are looking for us to produce a product out of this institution that actually fulfills their needs. I don't know how it can be any clearer.

It is not offered to me today, because my employer can't afford the options that are in our marketplace.

What do we do? We create new options that are affordable. That is, in fact, what the chairman is trying to do with this bill.

Here is a third letter, also from Elizabeth City but a different business. It says:

Small businesses need help with insurance—

In big bold letters—

I am now paying $986 per month for my wife and myself. This is for only 60 percent coverage and a $2,500 deductible. I know people with group insurance who are paying $600 a month for 80 percent coverage and a $250 deductible. Many of those have dental insurance as well. My policy provides none. Please vote for this bill. Allow small businesses to have coverage equal to employers of other companies.

That is all we are doing. We are using the scale of what people who have a tremendous amount of employees can do, and that is they can go to insurance carriers and they can negotiate for products based upon the volume of their employees. But how does a small business owner do that when he has five or six or seven employees? Well, it is real simple. We allow them to band together. We allow them to band together into a common association, and we allow that association to then market their entire association based upon the volume.

Another letter that I received on April 6 says:

As a small business owner, it is important to enable some economy of scale in allowing franchises to obtain more affordable health care coverage.

The last one I am going to read is quite unique.

As a professional photographer, I have seen firsthand the difficulty that my fellow professional photographers face when attempting to purchase health insurance on their own. S. 1955 would allow photographers and other independent business owners to band together across State lines and purchase health insurance. Having this as an option and choice will improve our access to quality health care and help control costs through competition.

These letters are from people on the front lines. They are from employees whose employers can't offer coverage today because it is not affordable. They are from individuals who own businesses and would like to offer coverage to their employees. They are even from photographers, people whose lives are in their hands every day in a camera, but they cannot afford the individual costs of health insurance in today's marketplace.

In North Carolina, we have 1.3 million uninsured North Carolinians. Of that 1.3 million, almost 900,000 uninsured individuals are in families or are on their own where one person at least works full-time. With the passage of this bill, 900,000 of the 1.3 million uninsured in North Carolina could potentially be offered health insurance. We can narrow it down from 1.3 million to 400,000 individuals who are uninsured in North Carolina with the passage of one simple bill, or at least they would have the option to be able to purchase it for once. Ninety-one percent of workers in large firms of 1,000 employees or more have health insurance, yet 66 percent of workers in small businesses defined as 10 employees or fewer have health insurance. Well, if you remember the North Carolina numbers, I said 98 percent of firms with employees were small businesses. Think of the millions of Americans who are going to be touched by the passage of this one piece of legislation that provides them choice. Where today their choice is between nothing and nothing, tomorrow their choice is between nothing and something.

Why are we here? We are here for 30 hours of debate—not debate on the bill, not debate about the amendments, debate about whether we are going to move forward. We do that at a time when—I just went back and did a quick calculation on the back of my calendar—we have 76 legislative days left between now and adjournment. That is assuming we have productive days on Fridays and Mondays, and as the chairman knows, Fridays and Mondays are not always productive in the Halls of Congress. People are either slow to get here or quick to leave. If you take out Fridays and Mondays, we are down to 45 days. But we are going to spend 30 hours trying to decide whether we are going to move forward to debate this bill, and we will spend another 30 hours after we file cloture on the bill to get to a point where we can have an up-or-down vote, if, in fact, we get that far.

Last night, we voted on two medical liability bills—medical liability that covers the entire medical professional world—and last night, we were denied the ability to proceed and to debate the legislation, much less amend it. The second bill is legislation in which—and I think the American people would be shocked at this—we were denied the ability to move forward to debate or amend legislation that limited the liability to OB/GYNs in America, a specialty we are losing specialists out of every day, where every year people aren't continuing to practice. But we will spend 30 hours debating whether we proceed to debate not necessarily the merits of the bill—and my hope is that the chairman will be successful, and I will be beside him arguing every step of the way, because without this, these Americans don't have hope of a choice of anything other than nothing and nothing.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. ISAKSON). Under the previous order, the Senator from California is recognized.

Mrs. BOXER. Mr. President, my understanding is that Senator DORGAN had time at 5 o'clock set aside, so if he wishes to take it now, then I will wait until his conclusion.

I ask unanimous consent that at the conclusion of Senator DORGAN's remarks I be permitted to speak at that time. Since it is controlled by the Democrats, I can make that request by myself.

The PRESIDING OFFICER. The Senator from North Dakota will be recognized, and at such time as he completes his statement, the Senator from California will be recognized.

Mr. ENZI. That is assuming it comes within the 30-minute parameters?

The PRESIDING OFFICER. The Senator is correct.

Mr. DORGAN. Mr. President, I have listened to some of the debate today. It has been very interesting. The last speaker spoke about choice and choices. I want to talk about choices in health care a bit. This is Health Week, we are told. It is an opportunity, for a change, at long last to talk about some health care issues on the floor of the Senate.

The intent, I believe, of the chairman who brings this bill to the floor is that we should speak only about and address only the issues dealing with small business health plans. However, he knows and I know there are many other health issues that have been long delayed by this Chamber and that need to be debated. I intend to offer a number of amendments. They are in order under the rules of the Senate. They are amendments that deal explicitly with health care issues.

The issue before the Senate is not unimportant. The question of rising health care costs is very significant to everybody—individuals, businesses, governments. Everyone who is a consumer has to deal with increased costs of health care and we should, indeed, address the issue of health care costs for business associations and for small businesses. There is no question about that. I wish to be a part of the group that works on that in a bipartisan way, in a way that expands opportunity, not narrows opportunity; in a way that expands coverage, not narrows coverage; in a way that covers everyone, not just a few. I do not agree that we should make health care unaffordable for the older and sicker and then make profit out of insuring people who are younger and healthier. That is not the right way to do this.

But having said all of that, let me describe some other things that have been long delayed on the floor of the Senate that need to be addressed. Let me talk about the first one. It is the

issue of reimportation of prescription drugs. A bipartisan piece of legislation has been long ago introduced and discussed here on the floor of the Senate, and we have not had the opportunity to vote on it.

The reimportation of prescription drugs, why is that important? Because the American people are charged the highest prices in the world for prescription drugs; it is not even close—the highest prices in the world. Consumers in every other country are paying lower prices. Try to buy Lipitor and if you buy it in the United States you pay a higher price than in any country in the world—France, Germany, England, you name it. You pay the highest prices in the United States. Why should U.S. consumers be charged the highest prices?

With consent, I want to show a couple of things on the floor of the Senate. Let me show, if I might, two bottles of Lipitor. I ask consent to show these on the floor of the Senate.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DORGAN. As you can see, they look identical: identical labels, identical pills in the same bottle made by the same company—shipped to two different places. One is shipped to Canada and one is shipped to the United States. The difference? One is half the price of the other. Guess which. It is the Canadian consumer who gets the benefit of paying half the price for the identical prescription drug.

Let me also show a couple of containers of Prevacid. This is a drug that is widely used for ulcers. Once again, as you can see, it is essentially the same bottle, same pill, made by the same company, made in an FDA-approved plant and shipped to two different locations, one to Canada and one to the United States. The difference? This one costs twice as much. Who buys this one? The U.S. consumer; twice as much for the same pill.

An old fellow sitting on a hay bale in North Dakota at a farm meeting said, my wife has been fighting breast cancer for 3 years. She took Tamoxifen for breast cancer. Every 3 months we drove to Canada to get Tamoxifen because it was the only way we could afford it, and we paid about 80 percent less than it would have cost us to buy that prescription drug to treat her breast cancer. We paid 80 percent less by driving to Canada to get it.

The fact is, they allow a small amount of drugs to come across the border for personal use. But other than that, a U.S. consumer cannot access an FDA-approved prescription drug nor can a U.S. pharmacist access that same FDA-approved prescription drug. That is unbelievable. We have a bipartisan group of Members of the Senate who say consumers ought to be able to purchase FDA prescription drugs by reimporting them from other countries. That would put downward pressure on prescription drug prices in this country. A bipartisan group of Senators wants to do that, but we are prevented from doing it by current law. We want to change the law.

Yet we are prevented from changing the law because the majority leader won't bring this legislation to the floor of the Senate. This is something we can offer as an amendment to the bill on the floor. It is well within the rules of the Senate, it deals with health care, and I am serving notice now that this is an amendment we will offer and vote on during the conduct of this discussion, providing we are allowed to offer amendments. I am hearing rumors that perhaps the majority leader will decide to fill the tree legislatively and allow no amendments. If that is the case, it will be a long week, but my hope is he will not do that. If amendments are allowed, I will offer this amendment and will get a vote.

Let me go back to about midnight on the night of March 11, 2004. That is a little over 2 years ago—midnight. The reason I remember it was midnight, I was sitting right back here and I reached an agreement with the majority leader, Senator FRIST. Here is what Senator FRIST announced that evening after our negotiations, and after which I agreed to release the name of Dr. Mark McClellan to be promoted from the head of FDA to the Centers for Medicare and Medicaid Services. As a result of that, Senator FRIST came to the floor and put this in the RECORD.

> I announce for the information of my colleagues that, with consultation with the chairman of the Senate Committee on Health, Education, Labor, Pensions, Senator DORGAN, Senator STABENOW, Senator MCCAIN, Senator COCHRAN, and other interested Senators, the Senate will begin a process for developing proposals that would allow for the safe reimportation of FDA-approved prescription drugs.

Two years later, nothing: No vote on the floor of the Senate, nothing. My colleague, Senator VITTER, sent a letter around a year ago. It says:

> . . . in the context of the Lester Crawford FDA nomination, I obtained an agreement with Majority Leader FRIST regarding drug importation legislation. . . .The Senate will probably hold some floor vote on a reimportation amendment soon, probably on the Agriculture Appropriations bill. Should that vote demonstrate that reimportation has 60-vote support on the floor, then Leader FRIST will be open to and work in good faith toward a floor debate and vote on a reimportation bill. . . .

What happened as a result of that? Nothing. No action, no votes, nothing.

This bill on the floor of the Senate is amendable. This bipartisan amendment deals with health care. It has been long delayed—and no more. I intend to offer this amendment this week.

Finally, at long last, perhaps the American consumers will no longer be charged the highest prices in the world for prescription drugs because they will be able to access FDA-approved drugs by reimporting them from virtually any other country in which the consumers are paying a lesser price for the identical prescription drug. That is unfair to the American people. The only reason we have not changed it yet is there are, regrettably, a few people in this Chamber who have blocked that opportunity, I assume on behalf of the pharmaceutical industry. But that blocking is about done. This week this bill is open for amendment. I intend to come and offer this as an amendment.

That is one.

Let me talk for a moment about another issue, once again long promised here to the Senate. We are told we are going to have an opportunity to do this—again and again and again—and we are not. We don't get the opportunity. It is called stem cell research. It is controversial; there is no question about that. I understand the controversy. But is it important? Yes, it is. We have all these people who talk about life. This is about life. This is about life-giving medical research, to find ways to unlock the mysteries and to cure some of the worst diseases known to people: Alzheimer's, diabetes, cancer, heart disease, Parkinson's. There is an unbelievable opportunity for medical research to unlock the cures for some of these diseases. But we need to proceed with stem cell research.

We have been long promised the opportunity to have a vote on stem cell research on the floor of the Senate, and guess what. No such vote. On May 24, almost 1 year ago, the House of Representatives passed a bill on stem cell research. We are still waiting to have a vote on that here on the floor of the Senate—once again, a bill with bipartisan support.

Let me describe, if I might, the importance of this in the eyes of a young woman. I met with this young girl about 2 weeks ago. It is not the first time I met her. She is a young lady, Camille Johnson, 13 years old, diagnosed with type 1 diabetes at age 4. She is the one in the middle, playing the clarinet. She has had some very serious health problems, some very serious problems in her young life. She would like very much to live her life without diabetes. She would like diabetes to be cured for her and millions of others.

In 2002, scientists at Stanford University used special chemicals to what is called transform undifferentiated embryonic stem cells of mice into cell masses that resemble islets found in the mouse pancreas. When this tissue is transplanted into the diabetic mice, it produces insulin in response to high glucose levels in animals. Wouldn't it be wonderful if, through this stem cell research, we cure diabetes; if we could tell this young woman your life is not going to be a life of diabetes. We can cure that disease.

I have been involved in political campaigns recently and have been told by opponents that my proposal and my position on stem cell research is one that

murders embryos. Nothing could be further from the truth, nothing at all. Do you know there are 1 million people living among us, walking, breathing, talking—1 million people who were conceived through in vitro fertilization? One million people. When that in vitro fertilization takes place, the uniting of a sperm and an egg in a petri dish, more than a single embryo is created. A number of embryos are created in that process. Some are implanted into the uterus of a woman and some become a human being. Some are cryogenically frozen and stored in the event they should be used again if this did not result in a pregnancy.

There are some 400,000 of those embryos frozen at in vitro clinics right now, 400,000 of them, and 8,000 to 11,000 are discarded, thrown away, every year. They become hospital waste.

Should some perhaps be used for stem cell research with the hope of saving lives? The answer clearly is yes. This is not about murdering an embryo. If in fact this is the murder of an embryo, then the discarding of the embryos at the in vitro fertilization clinic, 8,000 to 11,000 a year, is also murder.

We had one person testify at the Commerce Committee a couple of years ago who said those 1 million people who are here as a result of in vitro fertilization should not be here; it was wrong to create these people. Tell that to the parents who had those children; the childless parents who, through in vitro fertilization, discovered the miracle of having a child.

The question of stem cell research is not about murdering an embryo, it is about an opportunity to cure some of the dreaded diseases.

The other issue—and the reason I am talking about this is this is a big issue that we are not allowed to vote on in the Senate. This, too, should be an amendment on this bill. This, too, during Health Week is a very important issue dealing with health.

The other side of this research is something called somatic cell nuclear transfer. Simply it is this: Let us assume a patient takes a skin cell from their own earlobe and that skin cell from their earlobe is then put in an evacuated egg and stimulated to become a blastocyst of a couple of hundred cells.

That blastocyst now has predictor cells. They use the predictor cells for heart muscle, to inject back into the heart muscle to grow a stronger heart, to repair a heart attack.

Some would say you have destroyed or murdered an embryo. There is no fertilized egg. There is only the skin cell from the person who had the heart attack whose cell is now being used, through somatic cell nuclear transfer, to save that person's life. This is about lifesaving. Yet we have so many here who said: Let's not worry about these diseases. Let's shut off this research because we think it is about murdering embryos.

That is not what this is about. It is about this young girl and whether we decide we want this young girl to live her life as a diabetic, a life filled with hope at this point that Congress will finally do the right thing.

The House of Representatives did it. The Senate needs to vote on it. Perhaps this week is as good a week as any. We have been promised. A year ago we were promised, just like drug reimportation. This Chamber is full of promises, but we never quite get to vote on important issues.

I am not suggesting that when I talk about stem cell research that there are not ethical considerations, without serious concerns and serious issues to which we should be attentive. We should. I don't dismiss all the other concerns. But I do say this: If you have lost a child, if you have lost a loved one, and you have watched someone die from Parkinson's or cancer or heart disease, if you have been through that and then say to yourself: But I want to shut down promising research that could potentially cure diseases, then you have not been through it the way a number of people in this Chamber have been through it. I think it is so important for us to do the right thing and to continue this breathtaking research that can save lives.

There are so many other issues. There are just a couple of minutes remaining. Then I will yield the time to my colleague from California.

We passed recently in the Senate a piece of legislation that provides prescription drug benefits to senior citizens. But we did nothing to put downward pressure on drug prices. There is a special provision in the bill which my colleagues, Senators WYDEN and SNOWE, were talking about earlier today, that actually prevents the Federal Government from negotiating for lower prices with the pharmaceutical industry. That is unbelievably ignorant. A provision like that is unbelievably ignorant, and it ought to be repealed.

All we need is a vote on that on the Senate floor. That, too, is a health issue. There is no excuse for this Congress to say: By the way, the Federal Government cannot negotiate for a lower price. We already do it in the VA. We end up with far lower prices as a result of the negotiations.

In this case, with this bill, there is a provision that says: Don't you dare negotiate. It would be against the law for you to try to get lower prices and reduce Government spending. That, too, is a health issue. That, too, will be in order this week.

I hope very much that we will have a vote on that. Yes, the underlying bill is important. We ought to find a bipartisan way to fix it. No, it doesn't work the way it is. It will restrict choice, in my judgement, increase prices for some, and make others completely uninsurable. We ought to fix it in a bipartisan way.

But on the other three issues—reimportation of prescription drugs, stem cell research, repeal the law that prevents negotiation of lower prices with the pharmaceutical industry to save taxpayers money—shouldn't we do all three of those? We ought to do all three of those this afternoon, right now. We have been blocked for far too long.

If there is, in fact, an amendable vehicle—and I hope it will be; we will know that tomorrow morning—then I have just described three amendments that I believe should be offered, and when offered I believe will be approved in the coming days. If not, if this is a charade, and tomorrow we discover there is a legislative approach called ''filling the tree,'' which is simply setting up a little blocking device to say we are not going to allow anybody to offer anything, then I think the Senate will have sent a very strong message that this isn't Health Week. This is a week in which you want to trot out a little proposal of your own and avoid votes on serious issues that we should be taking in the Senate.

I yield the floor.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Mr. President, I appreciate Senator DORGAN's remarks. I have been on the floor of the Senate a lot today waiting to get the time, and I have been fortunate to hear many colleagues. I thank him for very succinctly pointing out that in a real health care week you wouldn't close your eyes to hope—hope that we are going to find cures for the terrible diseases that plague our families—Parkinson's, Alzheimer's, diabetes, spinal cord injuries, stroke, heart attack, you just name them. The fact is, we know stem cell research is promising. We know a lot of States have gotten out ahead of the Federal Government because this President and this Congress have restricted the number of stem cell lines we can fund research on. And many of those stem cell lines are, frankly, no good at all because they have been impacted by mice cells. And they lack the diversity needed for robust research.

I have talked to leaders in this field. I am not a scientist. I was educated in economics. But I have spoken to leading scientists, among whom is a gentleman named Dr. Peterson who worked at USFC in San Francisco. He is one of the leading pioneers in stem cell research who left to go to England because this President and this Congress put up a big stop sign in front of stem cell research. It is tragic.

Our families need the hope of a cure. How many of us have met with these youngsters who have juvenile diabetes, and we have seen how difficult their lives are and how they suffer, even with the strides that have been made in this area. They are still in great danger.

Health Week is here. We have a vehicle, as Senator DORGAN calls it, the Enzi bill, which tries to deal with the health insurance problems that small businesses face. I am going to talk about a better alternative to the Enzi

bill that will really do something. But we also have a chance to raise these issues during the debate on the Enzi bill.

We have bipartisan support for drug importation from countries such as Canada, where drugs are sold at half the price of what drug companies charge in the U.S. We have bipartisan support for stem cell research, fixing the Medicare prescription drug issue so we could actually say to Medicare: You have the ability and the right just as the VA has to negotiate with the pharmaceutical companies for lower prices. But I have to say Health Care Week Republican style is really Insurance Company Week.

If you look at the bills that have been brought before us, they all help the insurance companies. They don't help average Americans. They do not help us.

The first two bills said we are going to restrict the right of patients—whether they are very wealthy, whether they are middle income, whether they are poor—we are going to stop them from recovering damages if they are harmed by medical malpractice.

I was very pleased that the Senate chose not to limit debate on those two bills which would have taken away the rights of patients while giving a gift to the insurance companies. And hopefully we can change the Enzi bill.

I don't like bills that take away benefits from my people in California. I don't like bills that take away benefits from all Americans. That is why the Enzi bill is a bad bill. It does just that. I will go through with you the list of benefits that are taken away.

Mr. President, the Republicans bring us Health Care Week. They bring us the Enzi bill. What they do not tell us and you don't find out until you look is that all the States' protections that have been put into place will be wiped out upon passage of the Enzi bill.

Those are harsh words. What do I mean? What benefits will be taken away from my people in California? According to the report put together by Families U.S.A, ''The Enzi Bill, Bad Medicine for America,'' those benefits include AIDS vaccines, alcoholism treatment, blood lead screening. You know that is important because if you don't screen kids for lead in their blood they could have learning disabilities—bone density screening. We know about osteoporosis. In California we guarantee that your insurance will pay for that; no guarantee in the Enzi bill whatsoever. As a matter of fact, the Enzi bill overrides all of this—cervical cancer screening, clinical trials, colorectal screening, contraceptives, diabetic supplies and education.

We just talked about how it is so important for diabetics to have their meds—drug abuse treatment, emergency services, home health care, hospice care, infertility treatment, mammography screening, maternity care, mental health parity.

In my State, if you have a mental health problem and you need help, your insurance coverage will cover your treatment, just the same as if you had a physical problem. We know it works. The list goes on—metabolic disorders, minimal mastectomy, off-label drug use. In California, we have a law that says you can't kick a woman out of a hospital the same day she has a mastectomy. What, you may say? This happens? It does—off-label drug use, orthotics, prosthetics, prostate cancer screening. We know that prostate cancer is a scourge—reconstructive surgery, second medical surgery opinion.

If somebody tells you you need serious surgery, you can get a second opinion in California. That is covered—special footwear, telemedicine, well child care, so that we prevent diseases. That is my State.

Every single State in the Union gets overridden, whether it is Alabama, Colorado, Georgia, Idaho.

I know my friend from Georgia would be interested because he is sitting in the Chair. These are the things that your State offers. It protects your consumers. It is as long a list as California, I am proud to say—alcoholism treatment, ambulatory surgery, bone density screening, bone marrow transplants are covered in the State of Georgia. Cervical cancer screening, contraceptives, dental anesthesia, diabetic supplies, drug abuse treatment, emergency services, heart transplants are covered in Georgia. Infertility treatment, mammography screening, mental health parity, minimal mastectomy stay, morbid obesity care—which is very important now with the obesity epidemic—off-label drug use, ovarian cancer screening, telemedicine, and well child care. Georgia has a very inclusive and wonderful list of guaranteed protections for people.

In the State of Georgia there are 2.347 million people affected by this who would not have those guarantees under the Enzi plan. The Enzi plan essentially says to insurance companies: You can choose. You have to offer one plan. What do they call that plan? One premium plan. You have to offer one premium plan based on a state plan of their choosing, but there is no guarantee at all that what is in that premium plan is what is in the Georgia plan or the California plan or the North Dakota plan.

The fact is, all of the work that has been done in our States—and I find it somewhat amusing given this is a Republican debate, that the Republican bill preempts the States. What is wrong with this picture? I thought our Republican friends loved decisionmaking at the State level. No, not here in the Senate. They would prefer the insurance companies decide it rather than the States.

This is why I call my colleagues' attention to a study done on the impact on all the States, with letters compiled from attorneys general from many of the States and Governors.

From Oregon, they register their opposition, first their benefits are not guaranteed any longer. In addition, they are very worried about what happens to premiums. The Enzi bill disadvantages older people. As far as the research I have done, it disadvantages women. It certainly disadvantages people who come in with a preexisting condition such as high blood pressure. That includes a lot of Americans.

The bottom line is, the Enzi bill, the star rollout production of the Republican Health Care Week, will make null and void all protections that our States have given their citizens and replace them with some kind of riverboat gamble where insurers will choose some plan, from some State, and apply it to my State. I don't want a so-called premium plan from another State.

Here is a good example. In Connecticut, there is a terrible epidemic of Lyme disease. A tick bites your body and it can make a person very ill. We have some of that in California, but we do not have as much per capita as Connecticut. In Connecticut, the State legislature and the Governor say insurers have to cover Lyme disease because it is an epidemic in the State. In other States, it may not be necessary. However, we will wipe that Connecticut requirement off the books, and we will say, through the Enzi bill, insurance companies are going to decide.

Something is wrong. This is not Health Care Week, this is ''insurance company week.'' That is not good for consumers.

My own State has built a comprehensive State health insurance system that encourages affordable and equitable coverage for all, while ensuring consumers are protected and guaranteed benefits. The Enzi bill takes away a State's power to regulate health insurance. It is a gift to the insurers, as I said. It preempts benefits, as I said. It also is going to lead to way higher premiums for all in America who are covered by health insurance.

Insurance companies, not the States, will now decide what benefits the consumers. That is why we have letter after letter after letter from Governors, from attorneys general, warning us not to pass the Enzi bill.

There appears to be no limits on the cost shares an insurer can charge nor are there requirements that plans treat consumers equitably or offer comprehensive coverage.

As I said, if you are a little older—maybe you have high blood pressure, maybe you have some other health problems—you are in trouble. You are not going to have an affordable plan and you will lose the benefits you have. You may be priced out of the market. It will be catastrophic.

We have serious problems with the Enzi bill. Here is the great news. There is a wonderful alternative out there, the Durbin-Lincoln bill, of which I am a cosponsor. I thank my friends for working so hard on this.

As I go around my State, people nod in agreement with the Durbin-Lincoln bill's premise. Senators have very good

health insurance. We pay half of the premium and the Government matches the other half. There is a Federal Employee Health Benefits Program. There are basic benefits required and private companies come in and offer various plans. People such as me and my employees can choose from a broad array of plans. It works beautifully.

I ask unanimous consent, at 5:45, the Senator from Oregon, Senator MURRAY, be recognized for 15 minutes, until 6 o'clock.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. BOXER. Senators DURBIN and LINCOLN take this Federal plan and open it up to small businesses with 100 employees down to a single self-employed person.

This plan will work because there will be a huge pool set up. Everyone can buy into it from any business in this country with less than 100 employees. It would be a very diverse pool of people. They will be insured. The pricing is going to be very fair and reasonable. The plan will be administered in the same way our Federal benefits are administered.

I heard Senator THUNE say: That is a government plan. No, it isn't. It is a plan that is administered by the Federal Employees Health Benefit Plan, but it is coverage provided by private insurers. Because the administrative costs are kept so low, this is going to be very affordable and will solve the problem.

And guess what. This alternative, the Durbin-Lincoln alternative, does not take away the protections States have given all who live in those States. If you are in California, you still get the benefits. By law, you are protected. If you live in Washington State, you will get those benefits. The alternative that the Democrats are behind will cost less. It will protect benefits. It will work beautifully.

I say to my colleagues, if it is good enough for you, it ought to be good enough for small businesses and their employees. This bill is a wonderful and practical alternative.

In my concluding 6 or 7 minutes, I will say that this so-called Health Care Week is a major disappointment, unless we find out tomorrow we can amend the Enzi bill. If we can amend Enzi and pass stem cell research and prescription drug reimportation, if we can make sure there is hope for patients with Alzheimer's, diabetes, heart condition, stroke, cancer because we move ahead with science, then Health Care Week will have mattered. If we can offer the Durbin-Lincoln substitute, it will not preempt the protections of State law as the Enzi bill does. The Enzi bill has more opposition than any bill I remember. AARP is against it. The Cancer Foundation is against it. There are 224 organizations against it.

I ask unanimous consent to have printed in the RECORD those organizations opposed to the Enzi bill.

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

National Partnership for Women & Families, 9 to 5, Association for Working Women, Action Alliance of Senior Citizens of Greater Philadelphia, Alabama Psychological Association, Alliance for Advancing Nonprofit Health Care, Alliance for Justice, Alliance for the Status of Missouri Women, American Academy of Child & Adolescent Psychiatry, American Academy of HIV Medicine, American Academy of Pediatrics.

American Academy of Pediatrics—Nebraska Chapter, American Academy of Physician Assistants, American Association for Geriatric Psychiatry, American Association for Marriage and Family Therapy, American Association of People with Disabilities, American Association on Mental Retardation, American Chiropractic Association, American College of Nurse-Midwives, American Counseling Association, American Diabetes Association.

American Federation of State, County and Municipal Employees, American Federation of Teachers, American Foundation for the Blind, American Nurses Association, American Occupational Therapy Association, American Optometric Association, American Pediatric Society, American Podiatric Medical Association, American Psychiatric Association, American Psychological Association.

American Speech-Language-Hearing Association, Arizona Action Network, Arizona Business and Professional Women, Arizona Psychological Association, Asociacion de Psicologia de Puerto Rico, Assistive Technology Law Center, Association of Medical School Pediatric Department Chairs, Association of University Centers on Disabilities, Association of Women's Health, Obstetric and Neonatal Nurses, B'nai B'rith International.

Bazelon Center for Mental Health Law, C3: Colorectal Cancer Coalition, California Coalition for PKU and Allied Disorders, California Black Health Network, California Psychological Association, Campaign for Better Health Care—Illinois, Capital District Physician's Health Plan, Inc., Catholics for a Free Choice, Center for Civil Justice, Center for Justice and Democracy.

Center for Women Policy Studies, Children's Alliance, Citizen Action/Illinois, Citizen Action of New York, Clinical Social Work Guild 49, OPEIU, Coalition on Human Needs, Colorado Center on Law and Policy, Colorado Children's Campaign, Colorado Progressive Action, Colorado Psychological Association.

Committee of Ten Thousand, Communications Workers of America, Connecticut Citizen Action Group, Consumers for Affordable Health Care, Delaware Alliance for Health Care, Delaware Psychological Association, Department for Professional Employees, AFL–CIO, Disability Rights Wisconsin, District of Columbia Psychological Association, Easter Seals.

Empire Justice Center, Epilepsy Foundation, Excellus Blue Cross Blue Shield, Families USA, Families with PKU, Family Planning Advocates of New York State, Florida Consumer Action Network, Georgia Rural Urban Summit, Guttmacher Institute, HIP Health Plan of New York.

Hawaii Psychological Association, Health and Disability Advocates, Hemophilia Federation of America, Idaho Psychological Association, Illinois Alliance for Retired Americans, Illinois Psychological Association, Indiana Psychological Association, Institute for Reproductive Health Access, International Association of Machinists & Aerospace Workers, International Brotherhood of Electrical Workers.

International Longshore & Warehouse Union, Iowa Citizen Action Network, Iowa Psychological Association, Kansas Psychological Association, Kentucky Task Force on Hunger, League of Women Voters, Maine Children's Alliance, Maine Dirigo Alliance, Maine People's Alliance, Maine Psychological Association.

Maine Women's Lobby, Massachusetts Psychological Association, Maternal and Child Health Access, Mental Health Association in Michigan, Mental Health Legal Advisors Committee (Commonwealth of Massachusetts), Michigan Association for Children with Emotional Disorders, Michigan Campaign for Quality Care, Michigan Citizen Action, Minnesota COACT, Minnesota Psychological Association.

Missouri Association of Social Welfare, Missouri Progressive Vote Coalition, Montana Psychological Association, Montana Senior Citizens Association, Inc., NAADAC—The Association for Addiction Professionals, NETWORK, a National Catholic Social Justice Lobby, National Alliance on Mental Illness, National Association for Children's Behavioral Health, National Association of Anorexia Nervosa and Associated Disorders, National Association of Social Workers.

National Association of Social Workers, Arizona Chapter, National Association of County Behavioral Health and Developmental Disability Directors, National Coalition for Cancer Survivorship, National Consumers League, National Council for Community Behavioral Health Care, National Council of Jewish Women, National Council on Independent Living, National Disability Rights Network, National Family Planning and Reproductive Health Association, National Health Care for the Homeless Council.

National Health Law Program, National Hemophilia Foundation, National Mental Health Association, National Multiple Sclerosis Society, National Organization for Women, National Rehabilitation Association, National Research Center for Women & Families, National Urea Cycle Disorders Foundation, National Women's Health Network, National Women's Law Center.

Nebraska Psychological Association, Nevada State Psychological Association, New Hampshire Citizens Alliance, New Jersey Citizen Action. New Jersey Psychological Association, New Mexico PACE, New Mexico Psychological Association, New York Civil Liberties Union Reproductive Rights Project, New York State Health Care Campaign, New York State Psychological Association.

North Carolina Justice Center's Health Access Coalition, North Carolina Psychological Association, North Dakota PKU Organization, North Dakota Progressive Coalition, North Dakota Psychological Association, Northwest Health Law Advocates, Northwest Women's Law Center, Ohio Psychological Association, Oklahoma Psychological Association, Oregon Action.

Oregon Advocacy Center, Oregon Psychological Association, Organic Acidemia Association, Patient Services, Inc., Pediatrix Medical Group, Pennsylvania Council of Churches, Pennsylvania Psychological Association, Philadelphia Citizens for Children and Youth, Philadelphia Coalition of Labor Union Women, Planned Parenthood Federation of America.

Planned Parenthood of New York City, Population Connection, Progressive Maryland, Public Citizen, RESULTS, Religious Coalition for Reproductive Choice, Reproductive Health Technologies Project, Rhode Island Ocean State Action, Rhode Island Psychological Association.

Sargent Shriver National Center on Poverty Law, Save Babies Through Screening Foundation, Senior Citizens' Law Office,

Small Business Majority, Society for Pediatric Research, South Dakota Psychological Association, Suicide Prevention Action Network USA, Summit Health Institute for Research and Education, Inc., Tennessee Citizen Action, Tennessee Psychological Association.

Texas Psychological Association, The Arc of the United States, The Black Children's Institute of Tennessee, The Disability Coalition of New Mexico, The Institute for Reproductive Health Access, The Senior Citizens' Law Office, The Virginia Academy of Clinical Psychologists, Triumph Treatment Services, US Action, US Action Education Fund.

U.S. PIRG (Public Interest Research Group), Union for Reform Judaism, United Association of Journeymen and Apprentices in the Plumbing and Pipe Fitting Industry, United Cerebral Palsy, United Food and Commercial Workers, United Senior Action of Indiana, United Steelworkers International Union, United Vision for Idaho, Univera Healthcare, Universal Health Care Action Network.

Utah Health Policy Project, Vermont Coalition for Disability Rights, Vermont Office of Health Care Ombudsman, Voices for America's Children, Voices for Virginia's Children, Washington Citizen Action, Washington State Coalition on Women's Substance Abuse Issues, Washington State Psychological Association, West Virginia Citizen Action Group, West Virginia Psychological Association.

Wisconsin Citizen Action, Wisconsin Psychological Association, Women of Reform Judaism, WorId Institute on Disability, Wyoming Psychological Association.

Mrs. BOXER. Mr. President, this bill is going to hurt American health care by cancelling out all the hard-won State protections and by raising premiums so high they will price consumers out of the market. That is why across the board there is opposition. I have not seen this many organizations come out against a bill.

By the way, this bill, when it was first presented, sounded reasonable. It was only when we looked at the small print that we realized how dangerous it is.

Instead of working on this misguided bill, we could have done the alternative, we could have done the stem cell, we could have fixed the Medicare prescription drugs, we could have allowed drug importation.

If we didn't want to do real health care reform, there are a lot of other things we could have done, such as raise the minimum wage. We could have finished the job on immigration reform, strengthening the enforcement at the border and stopping illegal immigration, but getting people on a path and out of the shadows.

What about Superfund sites? We have some of the most polluted sites in the country still awaiting cleanup. We have one in four people in America, including 10 million children, living within 4 miles of a Superfund site.

What about debating the war Iraq? That is on everyone's mind. There is still no exit strategy. There is still no plan. We see suffering on the ground there every single day.

We have issues with a potential nuclear Iran. We should debate that. In Afghanistan, the situation is deteriorating and we have all but forgotten about it. We have not followed the recommendations of the 9/11 Commission to this date. We have failed fiscal policies. We have debt as far as the eye can see. We ought to debate pay-as-you-go. If Members want to spend money, they should show how they going to pay for it instead of putting the burden on the backs of America's children.

There are many other things we could do, but since we are on Health Care Week, let's fix our health care system. Let's not pass a bill that will not help people with serious diseases or fix the problems with the Medicare prescription drug program.

We have so much work to do and this Enzi bill is masquerading as a bill that will help our citizens. When we read the fine print, we find out it is only going to make matters worse.

I am proud to yield the floor to my friend from Washington.

The PRESIDING OFFICER. The Senator from Washington is recognized for 15 minutes.

Mrs. MURRAY. Mr. President, I ask unanimous consent the next Democratic speakers in order be Senator DAYTON, Senator DURBIN, and Senator AKAKA.

The PRESIDING OFFICER (Mr. CHAMBLISS). Without objection, it is so ordered.

Mrs. MURRAY. Mr. President, at this hour, families are struggling with health care. Seniors are facing a critical deadline for drug coverage. Businesses are grappling with the high cost of insurance. And patients are being denied the cutting-edge research that could save their lives. Those are critical issues. And what is the Senate doing? We are dealing with a distraction instead of real solutions to make health care affordable, more accessible, and more innovative.

I am on the Senate floor this evening to talk about what we should be doing to help families and businesses and communities meet their health care needs. I also want to talk this evening about why the Republican proposal, S. 1955, could do more harm than good.

This is a bill which takes a good idea—pooling the risk in health insurance—and distorts it with a plan that will raise the cost of health care, strip away patient protections, and hurt many of our small businesses. But do not take my word for it. Attorneys general from 41 States, including my own, have written to outline the serious problems with the Republican bill. I have heard from doctors with the Washington State Medical Association and from my own Governor about the damage this bill will inflict on patients and on our economy.

Simply put, this proposal is a distraction. Instead of dealing with real solutions to real problems, the Republican leadership is wasting time on one narrow proposal that is only going to make things worse. We can do better. The truth is that patients and seniors, doctors and nurses, and all of our communities deserve better.

If we were serious about reducing the cost of health care, helping to improve access, and driving innovation, we would be talking about the critical issues that the Republican leadership is trying to avoid. We should be focusing on everything from the Medicare drug program, to stem cell research, to community health care. Frankly, we do not have a day to waste.

On Monday, millions of seniors and disabled will be hit with a deadline that means higher premiums for their prescription drugs. That May 15 deadline is just 6 days away. I am hearing from seniors that they are very worried about this deadline. They are worried they are going to pick the wrong plan, and they do not think it is fair to be punished if they need more time so they can make an informed choice.

I have been traveling throughout my home State of Washington, meeting with seniors and holding roundtables with patients, with pharmacists, with advocates.

Three weeks ago, I was in Chehalis, at the Twin Cities Senior Center. I can tell you, seniors are worried. They are angry. They are frustrated. They are frightened about this May 15 deadline, and that deadline is just one of the problems this flawed drug program is presenting.

The week before that, I was in Silverdale, and I have held Medicare roundtables in Kent, Vancouver, Ballard, Shelton, Spokane, Anacortes, Bellevue, Aberdeen, Olympia, Lakewood, Seattle, and Everett. Everywhere, I have heard from seniors about just how bad the Medicare Part D Program is. I have heard their frustration about dealing with such a confusing system. I have heard their anger that this program does not meet their needs. And I have heard from many who just want to throw their hands up in the air and ignore the whole program.

If we were serious about improving health care, we would be fixing the problems they have outlined. Instead, we are going to let an unfair deadline hurt our seniors even further. In just 6 days—in just 6 days—they are going to have to pick a plan or face high penalties whenever they do enroll, and the penalties grow larger the longer they wait. To me, that is just not fair.

Right now, this Senate could be extending the deadline so our seniors are not pressured into making the wrong choice in such a complicated system. Right now, we could be lifting the penalty so that seniors are not punished if they need more time to make the right choice. Right now, we could be providing help to millions of vulnerable Americans who have been mistreated by this flawed Republican plan. But, instead, this Congress is leaving seniors to fend for themselves. The Secretary of Health and Human Services has said he opposes extending the deadline or lifting the penalties, and this

Republican Congress seems to agree with him by a shameful lack of action.

Seniors deserve better. The disabled deserve better. Our most vulnerable neighbors deserve better. If we really wanted to make health care more affordable and more accessible and more innovative, we would be on this floor fixing the Medicare drug program and helping seniors who are facing that unfair deadline.

Now, that is just one example of what a real focus on health care on this floor would include.

If we were serious about helping patients, we would be expanding lifesaving research. For patients who are living with diseases such as Parkinson's or multiple sclerosis or Alzheimer's or diabetes, stem cell research holds the potential to help us understand and to treat and someday perhaps cure those devastating diseases.

Nearly a year ago, the House of Representatives passed legislation to lift the restrictions that hold back this promising research. The House of Representatives has acted, but for an entire year the Senate has not. My colleagues, Senator SPECTER and Senator HARKIN, are well known for their leadership on this fight. They were promised a vote on stem cell research, and that vote has still not taken place. Every delay means missed opportunities for patients with devastating diseases.

If this Senate is serious about health care and saving lives, we should be voting on stem cell legislation today. That is why, last week, I joined with 39 other Senators in writing to the majority leader urging him to bring up H.R. 810, the Stem Cell Research Enhancement Act. But instead of real solutions, the Senate is focusing on a distraction. Patients with life-threatening diseases deserve a lot better.

If we were serious about improving health care, we would be investing in local efforts that boost access to health care.

Two weeks ago, through the Johnson & Johnson Community Health Care Awards, I had a chance to honor leaders from across the country who are doing innovative work to break down the barriers to care. If we were serious about improving health care, we would be building more Federal support for their work. Instead, we are moving in the opposite direction.

Perhaps the best example is the Bush administration's 5-year effort to kill the Healthy Communities Access Program, which is known as HCAP. This is a program which helps our local organizations coordinate care for the uninsured. I have seen it make a tremendous difference in my home State. Well, every year since taking office, this Bush administration has tried to kill that successful program. I have been out here on the floor leading the fight for our local communities every year, and most years we have won. But this past year, the White House and the Republican Congress ended the support for Healthy Communities and thus made health care less accessible for families from coast to coast.

If we were serious about improving health care, we would be investing in local programs that make a difference. But, instead, the Republican leadership is focused on distractions. We can do better than that.

So let me take a few minutes to turn to the specific problems with the bill that is before us, S. 1955, and explain why so many experts across this country are warning us that this bill will eliminate critical patient protections, it will lead to unfair premiums and insurance practices, and it will raise the cost of health care.

First of all, this bill will eliminate many of the important protections that keep patients healthy and lower the cost of health care.

In my home State of Washington, we have enacted a number of State patient protections that require health plans to cover services such as diabetic care, mental health services, breast and cervical cancer screening, emergency medical services, and dental procedures. But under this bill, small business health plans or association health plans would not be required to cover those important benefits. Allowing insurers to abandon mandated benefits, many of which are preventive and are diagnostic, will result in a sicker population and higher health costs for everyone.

When this legislation was debated in the HELP Committee, I offered a number of amendments to provide for coverage of several important women's health benefits. Unfortunately, every one of those amendments was defeated. So now, here we are, and we have a bill on this floor that will strip away the protections on which our patients across this country rely.

A new report by Families USA shows just how many families in my home State will be hurt by this bill. That report found that 1,861,000 residents of Washington State may lose protections if this bill is passed. And what could they lose? Emergency services, home health care, drug and alcohol treatment, contraceptives, diabetic supplies and education, hospice care, mammography screening, maternity services, mental health care—the list goes on. I am not going to tell nearly 2 million people in my home State whom I represent that we are going to take a gamble and risk losing those hard-won protections for a plan that will likely raise the cost of health care for many of our families and small businesses.

Secondly, this bill will encourage insurance companies to charge higher premiums for less healthy consumers. This bill will preempt strong laws and protections in our State that limit the ability of insurers to vary premiums based on health status, age, gender, or geography. I am very concerned this will result in adverse selection or what we call cherry-picking, leading to higher premiums for less healthy consumers. In fact, rates will likely become unaffordable for those who need it the most, potentially increasing the number of uninsured Americans.

Now, Mr. President, I would like to share some letters I have received from leaders in my home State who all speak against this flawed proposal. I ask unanimous consent that these two letters be printed in the RECORD following my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mrs. MURRAY. Mr. President, recently I received a letter from the Governor, Governor Christine Gregoire of my home State of Washington, in which she expressed many of her concerns regarding this legislation and its impact on the people who live in my home State.

This chart behind me contains the full text of the Governor's letter. As you can see, she has many serious concerns. I wish to highlight for the Senate some of the main points our Governor has raised with me.

Governor Gregoire alludes to the harmful aspects of this bill, and she says:

> [S. 1955] stands to harm our small group insurance market, which is a critical component of [Washington State's] current health care system. . . .
>
> Instead of promoting more affordable health care, this legislation would cause a serious increase in rates for consumers—possibly two or three times over what they now pay.

Governor Gregoire also warns in her letter to me that:

> [this] bill threatens consumer protections that the state of Washington strives to guarantee to [all of] our residents.

The Governor also warns that this bill:

> would foster a proliferation of health plans that do not cover preventive services that are absolutely vital to the health and well-being of Washington residents. . . .

Mr. President, I would also like to share a letter that I have received from the 9,000-member Washington State Medical Association that wrote to me in strong opposition to S. 1955.

Now, this chart shows the full letter, and I want to read just a portion of it:

> This legislation will have a severe impact on all the consumer health gains that have been made in Washington State over the past decade.
>
> S. 1955 will:
>
> Undermine Washington State's many gains in advancing health care quality;
>
> Pull people from existing insurance coverage rather than attract the uninsured;
>
> Lead to higher costs for consumers;
>
> Strike down Washington's Mental Health Parity law, which took eight years of work to be enacted;
>
> Eliminate other mandated benefits that help consumers such as mammography services; and,
>
> Leave Washington's citizens at risk for unpaid medical bills in the event of an AHP insolvency.

That is from the head of the Washington State Medical Association, which has 9,000 members in my home

State. I think their words should be heeded by the Members of this Senate.

Third, this proposal does nothing to address increasing health care costs.

In fact, it builds on the sorry record of this administration and this Congress in not addressing the rising costs that Americans face. Because of the flaws I mentioned, this bill does nothing to contain those costs. In fact, it could dramatically increase costs for many businesses and families in Washington State. It could well mean that people in the State of Washington who have affordable coverage today could end up worse off than they are right now.

I know my State has been a leader in working to expand access to affordable health insurance for working families and small businesses. Many of the reforms that worked to control costs in my State would be jeopardized if this legislation is enacted. Washington State has a proud tradition of strong consumer protections and integrated managed care that has improved health outcomes and controlled cost increases. We should not jeopardize what my State has fought hard for by dangerous Federal legislation.

I do support the concept of pooling. I believe we can implement policies that provide stability in health insurance premiums. In fact, I am currently working with a number of my colleagues on legislation to create Federal and State catastrophic cost pools to spread out the risks and address what is driving health care costs. We can help spread the risk in ways that will lower costs and still protect patients. The legislation before us could raise costs for consumers and small businesses. We can do better than that.

There are serious challenges facing our country when it comes to health care. This Senate needs to get serious. Instead of focusing on a distraction, we should be helping seniors with prescription drugs. We should be expanding lifesaving research, and we should be supporting community health care. Those are some of the things we should be working on to reduce the cost of health care and to improve access and to accelerate innovation. We can do all of those things, but we need the Republican leadership to get serious if we are going to provide serious solutions. We don't have a day to waste. I hope we can get to work on the real solutions that our American families deserve.

EXHIBIT 1

CHRISTINE O. GREGOIRE,
OFFICE OF THE GOVERNOR,
Olympia, WA, April 27, 2006.

Hon. PATTY MURRAY,
U.S. Senate, Washington, DC.

DEAR SENATOR MURRAY: I am writing with great concern about S. 1955, the Health Insurance Marketplace Modernization and Affordability Act, and its potential to further erode our ability to provide sound health coverage to citizens in Washington State. This bill stands to harm our small group insurance market, which is a critical component of our current health care system. Furthermore, the bill threatens consumer protections that the State of Washington strives to guarantee to our residents. For these reasons, I ask that you oppose the bill in its current form.

When it comes to providing health care, the federal government has been putting an ever-Increasing burden on the states. The Deficit Reduction Act, alone, paves the way to eliminate nearly $50 billion over the next five years for the Medicaid program. Fresh on the heals of signing the Deficit Reduction Act, the President unveiled his Fiscal Year 2007 budget proposal, which proposes eliminating $36 billion from the Medicare program over the next five years. Additionally, the implementation of the Medicare Part D prescription drug program has had enormous impacts on the states. Nearly every state in the Nation—Washington included—felt compelled to step in to ensure that our most needy citizens, our dual eligible population, continue to receive their medications due to fundamental flaws in the Medicare Modernization Act. Against this backdrop now comes S. 1955.

If passed, S. 1955 would establish a small group rating mechanism that would further erode the possibility of pursuing reasonable health care costs in the states. Instead of promoting more affordable health care, this legislation would cause a serious increase in rates for consumers—possibly two or three times over what they now pay. At its worst, the bill could result in the total collapse of our small group insurance market, something we must fight to prevent.

Additionally, I am concerned that S. 1955 would foster a proliferation of health plans that do not cover preventative services that are absolutely vital to the health and well-being of Washington residents, such as mammography, colonoscopies, diabetic care services, and newborn coverage. In 2005, the Washington State Legislature passed, and I signed, legislation providing mental health parity. If Congress passes S. 1955, the bill could also fully abrogate this effort to ensure mental health coverage in Washington State.

It is surprising to me that S. 1955 is moving forward, given that it is patterned, in part, on a flawed National Association of Insurance Commissioner's 1993 Model Rating Law, actually adopted by the state of New Hampshire in 2003. This proved to be an unfortunate experiment for the people of New Hampshire. Just this year, that state's Legislature repealed provisions of its 2003 law due to the astronomical jump in rates that occurred in only a two-year period after it was implemented. Given this history that he knows only too well, my colleague, Governor John Lynch of New Hampshire, recently registered his opposition to S. 1955 in a letter to his federal delegation, dated March 28, 2006. New Hampshire's experience is illustrative and a harbinger of what could come to all states, should Congress adopt S. 1955.

As Washington State's Attorney General from 1993–2005, I, along with the majority of my colleagues within the National Association of Attorneys General (NAAG), opposed several precursor bills to S. 1955. Introduced in each of the last several Congresses, these bills allow for the federal regulation of association health plans (AHPs), and have passed out of the U.S. House more than once. I appreciate that S. 1955, in its current form, does away with one fatal flaw of the earlier AHP bills—that being the wholesale obliteration of state regulation over national AHPs. But, as I have articulated, S. 1955 still goes too far in preempting other basic consumer protections. It is heartening to see that a majority of current members of NAAG, including Washington State Attorney General Rob McKenna, have now weighed in with their concerns and opposition to S. 1955.

As a nation, we need innovative solutions that provide high quality, sustainable and affordable health care access to our un- and under-insured populations. With the help of the Washington State Legislature, I have embarked on a five-point strategy to promote evidence-based medicine; better manage chronic diseases; increase prevention and wellness initiatives; require data transparency; and expand the reach of health information technology. These strategies invite strong partnerships between states and the federal government that I remain committed to pursuing with you. Unfortunately, proposals like S. 1955, are counterintuitive to the notion of forging such partnerships and I ask that you reject the bill.

Sincerely,

CHRISTINE O. GREGOIRE,
Governor.

WASHINGTON STATE
MEDICAL ASSOCIATION,
April 25, 2006.

Hon. PATTY MURRAY,
U.S. Senate, Washington, DC.

DEAR SENATOR MURRAY: On behalf of the 9,000 members of the Washington State Medical Association, WSMA, I am writing to ask that you vote no on S. 1955—Association Health Plans, AHPs, when the bill comes to a vote in the U.S. Senate.

The WSMA is very concerned about the negative effect of this legislation on our State's citizens, purchasers, providers and health plans.

This legislation will have a severe impact on all the consumer health gains that have been made in Washington State over the past decade.

S. 1955 will:

Undermine Washington State's many gains in advancing health care quality;

Pull people from existing insurance coverage rather than attract the uninsured;

Lead to higher costs for consumers;

Strike down Washington's Mental Health Parity law, which took eight years of work to be enacted;

Eliminate other mandated benefits that help consumers such as mammography services; and,

Leave Washington's citizens at risk for unpaid medical bills in the event of an AHP insolvency

The Washington State Medical Association works hard every day to insure that Washington's citizens have access to the finest medical care in the country. This legislation will test our ability to continue in this endeavor.

For more information, please do not hesitate to contact Len Eddinger in our Olympia office.

Very Truly yours,

PETER J. DUNBAR, MD,
President.

The PRESIDING OFFICER (Mr. SMITH). The Senator from Kansas.

Mr. BROWNBACK. Mr. President, I rise to address some issues my colleagues have raised. I am appreciative of the debate and the chance to talk about health care. It is a critically important topic. It is one that we have to talk a lot more about, how we can provide as much health care as possible to everybody at the lowest price that we

can get it and get more people insured. That is at the root of what we are trying to get done with the proposal of Senator ENZI and others to get more health insurance, better coverage to more people across the United States. That is a worthy goal, something we need to do. We have far too many people uninsured. We need more people insured. That is central to us. It is central to the hospital and the provider community that we have people who are insured. Because of those who are not insured and then can't pay the price of their health care, that is spread across to other people, which is what we do today. That is what we need to do, but it would be better if we could get more people insured and have a direct system of payment.

Others have said that what we need to be talking about is different than this, rather than expanding health insurance coverage. I respect that. Some of my colleagues have raised the stem cell issue. I want to address the concerns my colleagues have raised on stem cells. I want to report to my colleagues what a tremendous positive story we have to tell about stem cells, an exciting story of people receiving treatments, living longer and healthier lives because of stem cell treatments. These are not the controversial ones. This does not involve the destruction of a young human in the embryonic stage. This involves the use of adult stem cells, which the Presiding Officer and others, everybody in this room has in their body, adult stem cells. It also involves cord blood stem cells. These are the stem cells that are in the umbilical cord between the mother and child, while the mother is carrying the child.

I want to show two charts to start off. I think it is best if we make this a personal debate. I challenge my colleagues who have challenged me about this topic to come forward with pictures of individuals who are being treated with embryonic stem cells. I would like to see the people who are being treated with embryonic stem cells. We have put nearly half a billion dollars of research money into embryonic stem cell research. We have known about embryonic stem cells for 20 years. I don't know of the people being treated by embryonic stem cells.

I can show people who are being treated with adult stem cells or cord blood. This is Erik Haines. He is 13 years old. He was diagnosed with Krabbes disease, the first patient to receive cord blood for this rare, inherited metabolic disease. The date of transplant was 1994. He is alive today. He would be dead without this having taken place.

Let me show you a picture of Keone Penn. I had him in to testify before a Commerce Committee hearing a couple years ago. He has sickle cell anemia. The date of transplant was December 11, 1998. He had been very sick. He wasn't expected to live. As a matter of fact, it says in a statement that he made: If it wasn't for cord blood, I would probably be dead by now. It is a good thing I found a match. It saved my life.

We have now many more people being treated for sickle cell, a whole host of diseases. As a matter of fact, I want to read off a few of these. These are human clinical trials, real people getting real treatments, living longer lives, if not being cured, by the use of adult stem cells and cord blood stem cells in 69 different disease areas.

My colleagues have heard this debate for a period of years. We have been debating stem cells for a number of years. We have been debating the controversial area of embryonic stem cells, which the Federal Government funds, which State governments fund, which private industry and the private sector is fully free to fund completely, every bit of the way that they want to do that. They can. They have been. And we have no human treatments from embryonic stem cells to date. We don't have any. They are funded globally. There is no prohibition against embryonic stem cell research in the United States.

My colleagues seek more than the nearly $500 billion that we have put into embryonic stem cell research, an area that has not produced any human treatments to date. I want to be clear that that is what we are talking about. When we started this debate, my colleagues pushing embryonic stem cells, who in their hearts absolutely believe they are doing the right thing and this will lead to cures, listed cancer, sickle cell anemia, Lou Gehrig's disease. We are going to deal with all of these things. With the promise of embryonic stem cells, we will cure these things. That is what they said on their side when we started this debate 6 years ago. Six years later—I could be off a year or 2—where are the cures? I say we have them. They are in adult and cord blood stem cells.

I ask unanimous consent to print in the RECORD at the end of my statement a sheet of human clinical applications using adult stem cells.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. BROWNBACK. I want to read a few of the 69 from this document: Sickle cell anemia, aplastic anemia, chronic Epstein-Barr infection, lupus, Crohn's disease, rheumatoid arthritis, juvenile arthritis, multiple sclerosis, brain tumors, different cancers, lymphoma, non-Hodgkins lymphoma, a number of solid tumors, cardiovascular. This is an exciting area that is taking place where we now have people with acute heart damage, chronic coronary artery disease being treated with adult stem cells. Primarily, this has been an adult stem cell treatment where they harvest stem cells out of their own body and inject them right back into the damaged heart tissue.

Now we are seeing people who couldn't walk up a flight of steps going up eight flights, having hard tissue being regenerated with the use of their own adult stem cells. There is no rejection problem. This is their own cells. They take these adult stem cells from your body, which are repair cells, grow them outside of the body, put them back into the damaged heart tissue area, and now instead of congestive heart failure, without any ability to get enough blood throughout the body, the heart is pumping harder and better. It is actually working. They are regenerating the heart in these people. This is actually taking place in human clinical trials today. It is a beautiful issue.

The list goes on: chronic liver failure, Parkinson's disease. I had a gentleman in to testify who had taken stem cells out of a part of his body, grew them, put them in the left part of the brain. The right side of the body started functioning without Parkinson's disease. Later it came back, after several years, but he had several years free and was starting to learn how better this can work with Parkinson's disease.

Again, continuing from the list: spinal cord injury, stroke damage, limb gangrene, skull bone repair. We have recently had advances. For example, they took the stem cells out of a person's body. They had a form around which the bladder could be grown, outside a new bladder could be grown. They took the stem cells, put them around this form, and actually grew a bladder out of a person's own stem cells. These are marvelous, miraculous things that are taking place in 69 different areas of human clinical trials, adult and cord blood. I ask my colleagues from the other side, the ones who promised all of the cures from embryonic stem cells, as this debate moves forward, we will bring out statements that people made 5, 6 years ago about the cures that would come from embryonic stem cells. The cures have come from these noncontroversial areas. This is where we ought to be funding. This is what we ought to be doing. This is where we are getting treatments.

I ask my colleagues from the other side, where are the treatments with embryonic stem cells? Colleagues on the other side, for whom I have great respect and I know in their hearts are doing what they believe is the right thing to do, asked about reputable scientists opposed to embryonic stem cells. I ask unanimous consent to print in the RECORD this letter at the conclusion of my statement.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 2.)

Mr. BROWNBACK. It is dated October 27, 2004. It is to Senator John F. Kerry, running for President at the time, signed by 57 scientists who have a real problem with embryonic stem cell research.

They say in this letter:

As professionals trained in the life sciences we are alarmed at these statements.

They are referring to what Senator KERRY was saying, that this would be a

centerpiece issue for him in moving forward with science. This is in 2004.

First, your statement misrepresents science. In itself, science is not a policy or a political program.

Second, it is no mere ''ideology'' to be concerned about the possible misuse of humans in scientific research.

Here we come to the real rub of the issue on embryonic stem cell research. Is the embryo human life or isn't it? It is one or the other. It is either a human life or it isn't. It is alive. It is human in its genetic form. Is it a human life or not? If it is not a human life, do with it as you choose. If it is a human life, it deserves protection and respect. We do it for everybody in this room, no matter what your State is, your physical condition. Why wouldn't we do it while you are in the womb?

I have a letter signed by 57 scientists with a real problem with embryonic stem cell research. My colleague asked me to produce scientists who are opposed to embryonic stem cell research. Here they are.

I finally say to my colleagues on this topic, the promises they have made about embryonic stem cell research have not been realized to date, and reputable scientists question whether they will ever be realized. We are half a billion dollars later after investment from the Federal Government on embryonic stem cell research, animal and human. Now you are seeing—this is just the Federal Government, not about the private sector or other governments around the world. I will read to you what other scientists who support embryonic stem cell research are saying about the prospects of embryonic stem cell research. A British stem cell research expert, named Winston, warned colleagues that the political hype in support of human embryonic stem cells needs to be reined in. This is dated June 20, 2005, where he says this:

One of the problems is that in order to persuade the public that we must do this work, we often go rather too far in promising what we might achieve. This is a real issue for the scientists. I am not entirely convinced that embryonic stem cells will, in my lifetime, and possibly anybody's lifetime, for that matter, be holding quite the promise that we desperately hope they will.

Let's look at another researcher talking in this field. I want to get testimony in here from Jamie Thompson, the first scientist to grow human embryonic stem cells. This is the question posed to him:

People who use nuclear transfer generally say that the technique is optimized for producing stem cells rather than making babies. They would not want to equate this with the process that produces embryos that were fit for implantation, and they argue that they are used in the reproductive process differently.

I am talking about the use of embryonic stem cell research in a cloning procedure, where you create a clone, take the embryonic stem cells from the clone.

This is what Professor Thompson says:

So you are trying to define it away and it doesn't work. If you create an embryo by nuclear transfer and you give it to somebody, you didn't know where it came from, there would be no test you could do on that embryo to say where it came from. It is what it is. It is an embryo. It is a young human life. It's true that they have much lower probability of giving rise to a child, but by any reasonable definition, at least at some frequency, you are creating an embryo. If you are trying to define it away, you are being disingenuous.

My colleagues started to raise the issue that if you create an embryo by process of cloning, it is not really a young human life. But if you create an embryo that is a sheep, like Dolly, and grow it up to be Dolly the sheep, is Dolly not a sheep? Would that be the contention? That is simply not the case when they are creating a cloned individual or cloned human being, and that goes into the next step in this debate, to discuss human cloning. The other side calls it somatic nuclear cell transfer—the same process that created Dolly.

My point is that that is the next step on this continuum. We are talking about embryonic stem cell research funding and the lack of production taking place there for human treatment. The next step is that we need to clone and then we need to clone the individual and not harvest it in a day or two, but we need to grow the fetus out several weeks so we have sort of fetal farming, which is a ghastly thing to even consider. Yet it is being talked about in some research circles.

I conclude with the statement that if we want to be successful in this area and treat people, which I believe is the measure that we should go by—the treatment of individuals—our best bet, if my colleagues want human treatments to take place, they want to cure people, if that is what their effort is, let's fund what is working, which is adult cord blood. Let's move off of this politicized debate which is about the definition of young human life. Let's move off this debate and do something that is curing people. And we can.

That is the way we ought to go in this debate. We ought to also pass the Enzi proposal that gets more people health insurance, which is where we should focus this debate now because that is what we are talking about, rather than a politicized issue of embryonic stem cell research, which has not worked and is not working.

I yield the floor.

EXHIBIT 1

ADULT & NON-EMBRYONIC STEM CELL RESEARCH

ADVANCES & UPDATES FOR APRIL 2006

HIGHLIGHT OF THE MONTH—STEM CELL HOPE FOR LIVER PATIENTS

British doctors reported treatment of 5 patients with liver failure with the patients' own adult stem cells. Four of the 5 patients showed improvement, and 2 patients regained near normal liver function. The authors noted: ''Liver transplantation is the only current therapeutic modality for liver failure but it is available to only a small proportion of patients due to the shortage of organ donors. Adult stem cell therapy could solve the problem of degenerative disorders, including liver disease, in which organ transplantation is inappropriate or there is a shortage of organ donors.''—Stem Cells Express, Mar. 30, 2006

ADVANCES IN HUMAN TREATMENTS USING ADULT STEM CELLS—

Buerger's Disease: Scientists in Korea using adult stem cell treatments showed significant improvement in the limbs of patients with Buergers disease, where blood vessels are blocked and inflamed, eventually leading to tissue destruction and gangrene in the limb. Out of 27 patients there was a 79% positive response rate and improvement in the limbs, including the healing of previously non-healing ulcers.—Stem Cells Express, Jan. 26, 2006

Bladder Disease: Doctors at Wake Forest constructed new bladders for 7 patients with bladder disease, using the patients' own progenitor cells grown on an artificial framework in the laboratory. When implanted back into the patients, the tissue-engineered bladders appeared to function normally and improved the patients' conditions. ''This suggests that tissue engineering may one day be a solution to the shortage of donor organs in this country for those needing transplants,'' said Dr. Anthony Atala, the lead researcher.—The Lancet, Apr. 4, 2006; reported by the AP, Apr. 4, 2006

Lupus: Adult Stem Cell Transplant Offers Promise for Severe Lupus—Dr. Richard Burt of Northwestern Memorial Hospital is pioneering new research that uses a patient's own adult stem cells to treat extremely severe cases of lupus and other autoimmune diseases such as multiple sclerosis and rheumatoid arthritis. In a recent study of 50 patients with lupus, the treatment with the patients' adult stem cells resulted in stabilization of the disease or even improvement of previous organ damage, and greatly increased survival of patients. ''We bring the patient in, and we give them chemo to destroy their immune system,'' Dr. Burt said. ''And then right after the chemotherapy, we infuse the stems cells to make a brand-new immune system.''—ABC News, Apr. 11, 2006; Journal of the American Medical Assn, Feb. 1, 2006

Cancer: Bush policy may help cure cancer—''Unlike embryonic stem cells . . . cancer stem cells are mutated forms of adult stem cells. . . . Interest in the [adult stem cell] field is growing rapidly, thanks in part, paradoxically, to President George W. Bush's restrictions on embryonic-stem-cell research. Some of the federal funds that might otherwise have gone to embryonic stem cells could be finding their way into cancer [adult]-stem-cell studies.''—Time: Stem Cells that Kill, Apr. 17, 2006

Heart: Adult stem cells may inhibit remodeling and make the heart pump better and more efficiently.—Researchers in Pittsburgh have shown that adding a patient's adult stem cells along with bypass surgery can give significant improvement for those with chronic heart failure. Ten patients treated with their own bone marrow adult stem cells improved well beyond patients who had only standard bypass surgery. In addition, scientists in Arkansas and Boston administered the protein G-CSF to advanced heart failure patients, to activate the patients' bone marrow adult stem cells, and found significant heart improvement 9 months after the treatment.—Journal of Thoracic and Cardiovascular Surgery, Dec., 2005; American Journal of Cardiology, Mar., 2006

Stroke: Mobilizing adult stem cells helps stroke patients—Researchers in Taiwan have shown that mobilizing a stroke patient's bone marrow adult stem cells can improve

recovery. Seven stroke patients were given injections of a protein—G-CSF—that encourages bone marrow stem cells to leave the marrow and enter the bloodstream. From there, they home in on damaged brain tissue and stimulate repair. The 7 patients showed significantly greater improvement after stroke than patients receiving standard care.—Canadian Medical Association Journal Mar. 3, 2006

69 CURRENT HUMAN CLINICAL APPLICATIONS USING ADULT STEM CELLS

ANEMIAS & OTHER BLOOD CONDITIONS

Sickle cell anemia, Sideroblastic anemia, Aplastic anemia, Red cell aplasia (failure of red blood cell development), Amegakaryocytic thrombocytopenia, Thalassemia (genetic [inherited] disorders all of which involve underproduction of hemoglobin), Primary amyloidosis (A disorder of plasma cells), Diamond blackfan anemia, Fanconi's anemia, Chronic Epstein-Barr infection (similar to Mono).

AUTO-IMMUNE DISEASES

Systemic lupus (auto-immune condition that can affect skin, heart, lungs, kidneys, joints, and nervous system), Sjogren's syndrome (autoimmune disease w/symptoms similar to arthritis), Myasthenia (An autoimmune neuromuscular disorder), Autoimmune cytopenia, Scleromyxedema (skin condition), Scleroderma (skin disorder), Crohn's disease (chronic inflammatory disease of the intestines), Behcet's disease, Rheumatoid arthritis, Juvenile arthritis, Multiple sclerosis, Polychondritis (chronic disorder of the cartilage) Systemic vasculitis (inflammation of the blood vessels), Alopecia universalis, Buerger's disease (limb vessel constriction, inflammation).

CANCER

Brain tumors—medulloblastoma and glioma, Retinoblastoma (cancer), Ovarian cancer, Skin cancer: Merkel cell carcinoma, Testicular cancer, Lymphoma, Non-Hodgkin's lymphoma, Hodgkin's lymphoma, Acute lymphoblastic leukemia, Acute myelogenous leukemia, Chronic myelogenous leukemia, Juvenile myelomonocytic leukemia, Cancer of the lymph nodes: Angioimmunoblastic lymphadenopathy, Multiple myeloma (cancer affecting white blood cells of the immune system), Myelodysplasia (bone marrow disorder), Breast cancer, Neuroblastoma (childhood cancer of the nervous system), Renal cell carcinoma (cancer of the kidney), Soft tissue sarcoma (malignant tumor that begins in the muscle, fat, fibrous tissue, blood vessels), Various solid tumors, Waldenstrom's macroglobulinemia (type of lymphoma), Hemophagocytic lymphohistiocyctosis, POEMS syndrome (osteosclerotic myeloma), Myelofibrosis.

CARDIOVASCULAR

Acute Heart damage, Chronic coronary artery disease.

IMMUNODEFICIENCIES

Severe combined immunodeficiency syndrome, X-linked lymphoproliferative syndrome, X-linked hyper immunoglobulin M syndrome.

LIVER DISEASE

Chronic liver failure.

NEURAL DEGENERATIVE DISEASES & INJURIES

Parkinson's disease, Spinal cord injury, Stroke damage.

OCULAR

Corneal regeneration.

WOUNDS & INJURIES

Limb gangrene, Surface wound healing, Jawbone replacement, Skull bone repair.

OTHER METABOLIC DISORDERS

Sandhoff disease (hereditary genetic disorder), Hurler's syndrome (hereditary genetic disorder), Osteogenesis imperfecta (bone/cartilage disorder), Krabbe Leukodystrophy (hereditary genetic disorder), Osteopetrosis (genetic bone disorder), Cerebral X-linked adrenoleukodystrophy.

EXHIBIT 2

OCTOBER 27, 2004.

Senator JOHN F. KERRY,
John Kerry for President,
Washington, DC.

DEAR SENATOR KERRY: Recently you have made the promotion of embryonic stem cell research, including the cloning of human embryos for research purposes, into a centerpiece of your campaign. You have said you will make such research a ''top priority'' for government, academia and medicine (Los Angeles Times, 10/17/04). You have even equated support for this research with respect for ''science,'' and said that science must be freed from ''ideology'' to produce miracle cures for numerous diseases.

As professionals trained in the life sciences we are alarmed at these statements.

First, your statements misrepresent science. In itself, science is not a policy or a political program. Science is a systematic method for developing and testing hypotheses about the physical world. It does not ''promise'' miracle cures based on scanty evidence. When scientists make such assertions, they are acting as individuals, out of their own personal faith and hopes, not as the voice of ''science''. If such scientists allow their individual faith in the future of embryonic stem cell research to be interpreted as a reliable prediction of the outcome of this research, they are acting irresponsibly.

Second, it is no mere ''ideology'' to be concerned about the possible misuse of humans in scientific research. Federal bioethics advisory groups, serving under both Democratic and Republican presidents, have affirmed that the human embryo is a developing form of human life that deserves respect. Indeed you have said that human life begins at conception, that fertilization produces a ''human being.'' To equate concern for these beings with mere ''ideology'' is to dismiss the entire history of efforts to protect human subjects from research abuse.

Third, the statements you have made regarding the purported medical applications of embryonic stem cells reach far beyond any credible evidence, ignoring the limited state of our knowledge about embryonic stem cells and the advances in other areas of research that may render use of these cells unnecessary for many applications. To make such exaggerated claims, at this stage of our knowledge, is not only scientifically irresponsible—it is deceptive and cruel to millions of patients and their families who hope desperately for cures and have come to rely on the scientific community for accurate information.

What does science tell us about embryonic stem cells? The facts can be summed up as follows:

At present these cells can be obtained only by destroying live human embryos at the blastocyst (4–7 days old) stage. They proliferate rapidly and are extremely versatile, ultimately capable (in an embryonic environment) of forming any kind of cell found in the developed human body. Yet there is scant scientific evidence that embryonic stem cells will form normal tissues in a culture dish, and the very versatility of these cells is now known to be a disadvantage as well—embryonic stem cells are difficult to develop into a stable cell line, spontaneously accumulate genetic abnormalities in culture, and are prone to uncontrollable growth and tumor formation when placed in animals.

Almost 25 years of research using mouse embryonic stem cells have produced limited indications of clinical benefit in some animals, as well as indications of serious and potentially lethal side-effects. Based on this evidence, claims of a safe and reliable treatment for any disease in humans are premature at best.

Embryonic stem cells obtained by destroying cloned human embryos pose an additional ethical issue—that of creating human lives solely to destroy them for research—and may pose added practical problems as well. The cloning process is now known to produce many problems of chaotic gene expression, and this may affect the usefulness and safety of these cells. Nor is it proven that cloning will prevent all rejection of embryonic stem cells, as even genetically matched stem cells from cloning are sometimes rejected by animal hosts. Some animal trials in research cloning have required placing cloned embryos in a womb and developing them to the fetal stage, then destroying them for their more developed tissues, to provide clinical benefit—surely an approach that poses horrific ethical issues if applied to humans.

Non-embryonic stem cells have also received increasing scientific attention. Here the trajectory has been very different from that of embryonic stem cells: Instead of developing these cells and deducing that they may someday have a clinical use, researchers have discovered them producing undoubted clinical benefits and then sought to better understand how and why they work so they can be put to more uses. Bone marrow transplants were benefiting patients with various forms of cancer for many years before it was understood that the active ingredients in these transplants are stem cells. Non-embryonic stem cells have been discovered in many unexpected tissues—in blood, nerve, fat, skin, muscle, umbilical cord blood, placenta, even dental pulp—and dozens of studies indicate that they are far more versatile than once thought. Use of these cells poses no serious ethical problem, and may avoid all problems of tissue rejection if stem cells can be obtained from a patient for use in that same patient. Clinical use of non-embryonic stem cells has grown greatly in recent years. In contrast to embryonic stem cells, adult stem cells are in established or experimental use to treat human patients with several dozen conditions, according to the National Institutes of Health and the National Marrow Donor Program (Cong. Record, September 9, 2004, pages H6956–7). They have been or are being assessed in human trials for treatment of spinal cord injury, Parkinson's disease, stroke, cardiac damage, multiple sclerosis, and so on. The results of these experimental trials will help us better assess the medical prospects for stem cell therapies.

In the case of many conditions, advances are likely to come from sources other than any kind of stem cell. For example, there is a strong scientific consensus that complex diseases such as Alzheimer's are unlikely to be treated by any stem cell therapy. When asked recently why so many people nonetheless believe that embryonic stem cells will provide a cure for Alzheimer's disease, NIH stem cell expert Ron McKay commented that ''people need a fairy tale'' (Washington Post, June 10, 2004, page A3). Similarly, autoimmune diseases like juvenile diabetes, lupus and MS are unlikely to benefit from simple addition of new cells unless the underlying problem—a faulty immune system that attacks the body's own cells as though they were foreign invaders—is corrected.

In short, embryonic stem cells pose one especially controversial avenue toward understanding and (perhaps) someday treating various degenerative diseases. Based on the available evidence, no one can predict with

certainty whether they will ever produce clinical benefits—much less whether they will produce benefits unobtainable by other, less ethically problematic means.

Therefore, to turn this one approach into a political campaign—even more, to declare that it will be a ''top priority'' or receive any particular amount of federal funding, regardless of future evidence or the usual scientific peer review process—is, in our view, irresponsible. It is, in fact, a subordination of science to ideology.

Because politicians, biotechnology interests and even some scientists have publicly exaggerated the ''promise'' of embryonic stem cells, public perceptions of this avenue have become skewed and unrealistic. Politicians may hope to benefit from these false hopes to win elections, knowing that the collision of these hopes with reality will come only after they win their races. The scientific and medical professions have no such luxury. When desperate patients discover that they have been subjected to a salesman's pitch rather than an objective and candid assessment of possibilities, we have reason to fear a public backlash against the credibility of our professions. We urge you not to exacerbate this problem now by repeating false promises that exploit patients' hopes for political gain.

Signed by 57 doctors.

The PRESIDING OFFICER (Mr. CORNYN). The Senator from Minnesota is recognized.

Mr. DAYTON. Mr. President, I ask unanimous consent to speak for 15 minutes as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

REPORT ON HURRICANE KATRINA

Mr. DAYTON. Mr. President, last week the Senate Committee on Homeland Security and Governmental Affairs, of which I am a member, approved its report titled ''Hurricane Katrina, A Nation Still Unprepared.'' The committee's distinguished chairman set today as the deadline for additional views.

I reluctantly voted not to approve that draft of the report last week because it is seriously incomplete. While it is still lacking all of the information, documents, and testimony which President Bush and his subordinates denied the committee, last March 15 the ranking member asked the chairman to subpoena witnesses and documents that have been withheld by the White House. Regrettably, she declined to do so.

Earlier this year, on January 12, the chairman and ranking member wrote the White House Chief of Staff, Mr. Andrew Card, regarding the information they had previously requested. Their letter stated, in part:

This practice (of withholding information) must cease.

It continued:

We are willing to discuss claims of executive privilege asserted by the White House, either directly or through a Federal agency. But we will not stand for blanket instructions to refuse answering any questions concerning any communications with the EOP [Executive Office of the President].

Their insistence that either administration officials comply with this oversight committee's rightful demands or the President invoke his executive privilege not to do so was entirely appropriate. Unfortunately, when Mr. Card and his subordinates still refused to comply, the chairman denied the ranking member's request to issue subpoenas.

Regrettably, at its markup of the draft report, the Senate committee failed to support my motion to subpoena those documents and witnesses, which were being withheld by the White House without claim to executive privilege, and which were being wrongfully denied by executive agencies.

The administration's refusal to comply and cooperate with this investigation is deplorable, as is the Homeland Security Committee's failure to back the chairman and ranking member's proper insistence that the White House do so. That committee is charged by the full Senate with the responsibility to oversee the agencies, programs, and activities that are related to homeland security. The committee was expressly directed by the Senate majority leader to examine the Bush administration's failure to respond quickly or effectively to the disasters caused by Hurricane Katrina. This investigation is not complete without all of the information requested from the administration. Furthermore, the report's findings and conclusions can hardly be considered reliable if the White House has decided what information to provide and what information to withhold from the committee.

This unfortunate acquiescence confirms the judgment of the Senate Democratic leader that an independent bipartisan commission was necessary to ensure complete and unbiased investigation into the failed Federal, State, and local responses to Hurricane Katrina. His request has been repeatedly denied by the majority, with the assurance that the Senate committee would fulfill those responsibilities. Tragically and reprehensibly, it has failed to do so. Thus, the committee failed the Senate's constitutional obligations to be an independent, coequal branch of Government from the executive. It also failed the long-suffering victims of Hurricane Katrina, who deserve to know why their governments failed them, and all of the American people, who depend upon their elected representatives to protect their lives and their interests, without regard to partisan political considerations. That partisanship includes unjustified protection of an administration of the same political party, as much as undue criticism of one from another party.

That partisan protectionism is especially unwarranted given widespread agreement about the urgent need to understand the failures during and after Hurricane Katrina and to remedy them before another large-scale disaster, God forbid, should occur.

Now, 8 months after the hurricane, the lack of progress in cleanup, repair, and reconstruction in devastated areas provides further evidence of the Federal Government's continuing failure to respond efficiently or effectively. There is no time in which the helping hand of Government is more urgently needed and more surely deserved than during and after a disaster. Victims are damaged or devastated physically, emotionally, and financially.

Local officials and their public services are overwhelmed, if not destroyed. They need a Federal emergency response organization comprised of experienced, dedicated professionals, who have the resources necessary to alleviate short-term suffering and commence long-term recovery, and also have the authority to expeditiously commit those resources.

What the failed Federal response to Hurricane Katrina showed is the utter ineptitude of the Federal Emergency Management Agency, known as FEMA. Even worse, FEMA's indifference and incompetence in the aftermath of Katrina was not an isolated instance. In my direct experience with FEMA's disaster relief responses in Minnesota, the agency is too often a major obstruction to recovery projects rather than a principal ally.

Thus, I agree with the report's recommendation to create a new, comprehensive emergency management organization, to prepare for and respond to all disasters and catastrophes. I remain openminded about whether this new entity should remain within the Department of Homeland Security, as this recommendation intends, or be established as a separate Federal agency. The challenge for the committee, for all of Congress, and for the administration will be to actually recreate an existing Federal agency which has become dysfunctional and nonfunctional. Merely ''reforming'' FEMA by rearranging some boxes and lines in its organizational chart, revising it, and giving its head a new title, will be woefully inadequate. The new organization must be more streamlined, centralized, and compact than its predecessor. It must be less bureaucratic, less consumed with regulatory minutiae, and less resistant to local recovery initiatives. It must spend less time creating complex plans and cumbersome procedures, and more time in training and perfecting action responses to emergency situations.

History shows that ''if a student does not learn the lesson, the teacher reappears.'' This report describes some of the most important lessons from the failed response to Hurricane Katrina. The committee's and this Congress's subsequent actions to correct these serious deficiencies before the next catastrophe will indicate whether those lessons will be learned.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. AKAKA. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. AKAKA. Mr. President, I ask unanimous consent that I be allowed to speak for 10 minutes as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

NATIVE HAWAIIAN GOVERNMENT REORGANIZATION ACT OF 2005

Mr. AKAKA. Mr. President, I rise today to talk about bipartisan legislation that is of critical importance to the people of Hawaii. S. 147, the Native Hawaiian Government Reorganization Act of 2005, would extend the Federal policy of self-governance and self-determination to Hawaii's indigenous peoples, Native Hawaiians, by authorizing a process for the reorganization of a Native Hawaiian governing entity for the purposes of a government-to-government relationship with the United States.

Together with my senior Senator and the rest of Hawaii's congressional delegation, I first introduced this bill in 1999. The bill passed the House in 2000, but, unfortunately, the Senate adjourned before we could complete consideration of that bill.

Since then, I have introduced a bill every Congress. In every Congress, the committees of jurisdiction—the Senate Committee on Indian Affairs and the House Committee on Resources—have favorably reported the bill and its companion measure.

I thank the majority leader, the senior Senator from Tennessee, who is working to uphold his commitment to bring this bill to the Senate floor for a debate and rollcall vote. I must tell my colleagues that he did try to meet his commitment in September 2005 and did schedule it for the floor. But at that time, Katrina happened, and we took it off the calendar.

I also appreciate the efforts of my colleague from Arizona who opposes the bill on substance, but has worked with me to uphold his promise to allow the bill to come to the floor for debate and rollcall vote.

S. 147 does three things. First, it authorizes the Office of Native Hawaiian Relations in the Department of the Interior. The office is intended to serve as a liaison between Native Hawaiians and the United States. It is not intended to become another Bureau of Indian Affairs, as the current program for Native Hawaiians will remain with the agencies that currently administer those programs.

Second, the bill establishes the Native Hawaiian interagency coordinating group. This is a Federal working group to be composed of representatives from Federal agencies who administer programs and services for Native Hawaiians. There is no statutory requirement for these agencies to work together. This working group can coordinate policies to ensure consistency and prevent unnecessary duplication in Federal policies impacting Native Hawaiians.

Finally, the bill authorizes a process for the reorganization of the Native Hawaiian governing entity. And we ask: Why do we need to organize the entity? It is because the Native Hawaiian Government was overthrown with the assistance of U.S. agents in 1893. Rather than shed the blood of the people, our beloved queen, Queen Lili'uokalani, abdicated her throne after being arrested and imprisoned in her own home.

Following the overthrow, a republic was formed. Any reformation of a native governing entity has been discouraged. Despite this fact, Native Hawaiians have established distinct communities and retained their language, culture, and traditions. They have done so in a way that also allows other cultures to flourish in Hawaii. Now their generosity is being used against them by opponents of this bill who claim that because Native Hawaiians do not have a governing entity, they cannot partake in the Federal policy of self-governance and self-determination that is offered to their native brethren in the United States.

My bill authorizes a process for the reorganization of the Native Hawaiian governing entity for the purposes of a federally recognized government-to-government relationship. There are many checks and balances in this process which has the structure necessary to comply—to comply—with Federal law and still maintains the flexibility for Native Hawaiians to determine the outcome of this process.

Further, my bill includes a negotiations process between the Native Hawaiian governing entity, the State of Hawaii, and the United States to address issues such as lands, natural resources, assets, criminal and civil jurisdiction, and historical grievances. Nothing that is currently within the jurisdiction of another level of government can be conveyed to the Native Hawaiian Government without going through this negotiations process.

I am proud of the fact that this bill respects the rights of Hawaii's indigenous peoples through a process that is consistent with Federal law and it provides the structured process for the people of Hawaii to address the long-standing issues which have plagued both Native Hawaiians and non-Native Hawaiians since the overthrow of the Kingdom of Hawaii.

I want to reiterate to my colleagues that this bill is not race based. This bill is based on the Federal policies toward indigenous peoples. Those who characterize this bill as race based fail to understand the Federal policies toward indigenous peoples. Those who characterize this bill as race based fail to understand the legal and political relationship the United States had with the indigenous peoples and their governments preexisting the United States.

Finally, those who characterize this bill as race based are saying that Native Hawaiians are not native enough. I find this offensive. And I ask that my colleagues join me in my efforts to bring parity to Native Hawaiians by enacting my bill.

This effort will continue from day-to-day here. We will continue to bring forward the history of Hawaii and the reasons why we are trying to enact this bill, not only for the benefit of the indigenous people of Hawaii but for the benefit of the United States as well.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. VOINOVICH. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. THUNE). Without objection, it is so ordered.

MORNING BUSINESS

Mr. VOINOVICH. Mr. President, I ask unanimous consent that there now be a period of morning business with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

VOTE EXPLANATION

Mr. DURBIN. Mr. President, yesterday, the Senate voted on two motions to invoke cloture to proceed to legislation regarding medical malpractice. Due to a mechanical problem with the plane on my flight from Chicago, I was necessarily absent for this debate and the first vote. Had I been present for that vote, I would have voted against the motion to invoke cloture, and I did vote against the second motion.

Since 2003, the last time Congress considered this issue, 34 States have passed malpractice legislation. Four additional States have pending legislation in this year.

AMA counts 21 States as ''crisis'' States. Of those 21 States, 16 States passed legislation in the past 2 years, and two are currently considering bills.

Instead of considering ways to cap pain and suffering damages for injured patients, Congress should be working on other health care priorities.

Neither S. 22 nor S. 23 do anything to address medical errors, the underlying reason for medical malpractice lawsuits.

According to the Institute of Medicine, medical errors have caused more American deaths per year than breast cancer, AIDS and car accidents combined. It is equivalent to a jumbo jet liner crashing every 24 hours for 1 year.

When I sat on the Government Affairs Committee, Dr. Carolyn Clancy, Director of the Agency for Healthcare Research and Quality, testified about patient safety.