percent of those were in Western Washington. According to researchers at the University of Washington, just 20 years from now, we will see the median annual burned area in the Northwest double from what we have seen in the last 50 years.

We know we need more tools to combat these challenges, and the legislation we have already passed in the Senate and that is before the House today will provide these new technology and training tools to empower the Forest Service to help our communities and our firefighters: real-time fire mapping, more drone technology to give us real-time information about the fires, using NASA data to help us plan postfires, and giving us more smoke forecasting information to better help our communities and to deal with those who are impacted by heavy smoke.

I hope our colleagues will act expeditiously on this legislation. We know that wildland fire funding, as we increased it in an agreement last year, was so important, but we need to keep working on this problem.

I thank my colleague from Colorado for helping to sponsor the inclusion of this legislation and hope that the President will sign this legislation very quickly so that tools can be put in place for this upcoming fire season.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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 President, I ask unanimous consent that the order for the quorum call be rescinded.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

RECESS

Mr. CRUZ. Under the previous order, the Senate stands in recess until 2:15 p.m.

Thereupon, the Senate, at 12:45 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mrs. CAPITO).

EXECUTIVE CALENDAR—Continued

The PRESIDING OFFICER. The Senator from Texas.

S. 311

Mr. CORNYN. Madam President, yesterday evening the Senate had an opportunity to go on record and show our constituents that we supported the most vulnerable among us. The Born-Alive Abortion Survivors Protection Act would require doctors to treat a baby, once it is born, with ordinary medical assistance, something they would do under any other circumstances, even though this entailed surviving an abortion.

If you ask the American people, they would say this is just common sense. In a recent poll, more than three-fourths of Americans said they support providing medical treatment for babies who survive abortions. I can't imagine what the other 25 percent are thinking. But there are no Federal laws requiring healthcare providers to care for these babies just as they would any other infant in their care, and for some Members of the opposing party, they are just fine with that.

We all know that a few weeks ago, Virginia Governor Ralph Northam made disturbing comments about how to not care for certain newborns. He was asked: What would you do with a child with birth defects?

He said: Well, the infant would be delivered. The infant would be kept comfortable. The infant would be resuscitated, if that is what the mother and the family desired, and then a discussion would ensue between the physicians and the mother.

Let me be clear. The Governor, who is a pediatrician, by the way, essentially advocated for infanticide—killing a child who was born alive. Instead of saying, ''well, it is my duty as a physician under the Hippocratic Oath to provide care to save the child,'' he believes the child ought to be made comfortable, and then the mother and doctor sit down and decide whether the child should live or die.

That is not healthcare. That is murder. I believe the Senate has a duty to act and ensure that no child born alive is subjected to the treatment described by Governor Northam.

The bill we voted on last night would protect newborns who have survived abortions and ensure that they receive the same level of care that any other newborn baby would. It builds upon a previous law, which the Senate passed unanimously, called the Born-Alive Infant Protection Act. That bill passed unanimously in 2002, and it clarified that every infant born alive at any stage of development is a person, regardless of the manner in which they were born. Yet yesterday, 44 Senators voted to allow that same person's life to be ended with impunity.

The legislation we voted on yesterday would simply clarify that the infants who survive abortions are entitled to the same lifesaving care that other babies should receive. That is why it is so shocking to me that 44 of our colleagues chose to vote against even proceeding to a debate and a vote on the matter.

I am trying to think of a historical counterpart to this. I was reminded of a book I read not long ago called ''Eichmann in Jerusalem.'' This is about the trial of Adolf Eichmann after the atrocities of the holocaust, during which 5 million Jews were killed. The author, Hannah Arendt, was trying to figure out what kind of monster could basically provide for the machinery that ultimately would take the lives of 5 million Jews.

What she saw when she looked at Eichmann was not some monster that looked different from you or me. Unfortunately, what she saw was somebody who looked exactly like you and me. She wrote about the moral collapse associated with the holocaust. She noted that ''in the Third Reich, evil lost its distinctive characteristic by which most people had, until then, recognized it.'' She said that the problem is that at that point it became a ''civil norm.''

She wrote:

> Evil comes from a failure to think. It defies thought, for as soon as thought tries to engage itself with evil and examine the premises and principles from which it originates, it is frustrated because it finds nothing there.

''That,'' she said, ''is the banality of evil.''

She concluded by saying:

> Nearly everybody who attended the trials of mass killers after the war, some of them respected doctors and pharmacists, came away with the disconcerting impression that the killers looked pretty much like you and me.

So while Republicans and Democrats disagree on a range of issues, this should not be one of them. If we have one shred of our humanity left, we ought to agree that protecting human life is essential. This should have been a simple vote for every single Member of this body. I can't tell you how disappointed I am that 44 of our colleagues decided to vote no. I was proud to vote yes on the bill, yes to protecting these newborn babies, yes to equal medical care for all infants, and yes to life.

PRESCRIPTION DRUG PRICES

Madam President, this morning, the Senate Finance Committee held the second in a series of hearings on prescription drug pricing. We all know that across the country, the rising costs of prescription drugs is placing a strain on families.

A survey last summer found that many Texans are struggling to afford the rising cost of healthcare, and three out of five people surveyed reported foregoing or postponing care because of the cost. That includes cutting pills in half, skipping or rationing doses, or not filling a prescription because they simply can't afford to do so. Some, though, are taking even more drastic steps.

Last year, a widow in Austin considered selling her house to pay for the expensive drugs she needed to treat hepatitis C, which had killed her husband years earlier. Many Texas families have begun the dangerous practice of buying their drugs in Mexico—even though they may be counterfeit—because they think they are more affordable than filling a prescription in the United States.

With healthcare costs continuing to press more and more of our hard-working families, things aren't expected to get any easier any time soon. The Centers for Medicare and Medicaid Services estimated that between 2018 and 2027, consumers could expect to see prescription drug spending increase by an average of 6.1 percent a year. That is a

faster increase than hospital stays, doctors' visits, or any other cost in the healthcare sector.

This spending doesn't just have an impact on patients. It accounts for a large portion of our national economy. In 2017, the national health expenditures totaled $3.5 trillion. That is 18 percent of our gross domestic product. Prescription drugs account for 10 percent of our total health expenditures, more than $330 billion. They have an impact on our entire country.

The Senate Finance Committee is digging into the reason behind those rising costs. The journey a drug takes from research and development to the manufacturing plant, to pharmacy shelves, and to our medicine cabinet is enormously complicated. I wonder whether it is complicated by design. Once a consumer has purchased a drug, figuring out who gets each dollar spent practically requires the forensic skills of a Sherlock Holmes.

What I find particularly concerning, and something we spoke about at length today, are the rebates and other discounts provided by manufacturers. Pricing from one pharmacy to another can be wildly inconsistent, and rebates are often the root of the problem. In another context, what is now called a rebate might be called a kickback. Rebates are the key to determining if a particular drug is covered by your insurance, and that can impact therapies that you have access to. Despite the impact they have, the terms of rebates are mostly cloaked in secrecy. I don't think that is an accident. If you ask pharmacy benefit managers and plans about rebates, they will argue that overall they are a good thing and can help lower insurance premiums across the board. The issue, though, is that the extra money has to come from somewhere. So list prices are often raised to cover the difference. When that happens, the consumers are the ones who take the hit. For everything you pay within your deductible—and many deductibles in this post-Affordable Care Act era are up in the thousands of dollars—you pay 100 percent of the retail cost. You get zero benefit from the rebate. As the list price goes up, your out-of-pocket costs go up. That is why the stories of families struggling to cover costs are becoming more and more prevalent.

Some of the people who suffer the most from the rebate system are people who take insulin. Diabetes is one of the most common and pernicious illnesses in our healthcare system in America today. Because we eat too well and exercise too little, many people develop diabetes, and the only treatment is to take insulin. Unlike most of the prescription drugs out there, insulin is a biologic, meaning it is generally more expensive to make and more expensive to buy.

A few weeks ago, I spoke here on the Senate floor about a woman from Indiana who came to the first hearing we had on prescription drug costs, Kathy Sego. She told us about her family's struggle to pay for her adult son's insulin. Even though this drug has been around for nearly a century, a 1-month supply for Kathy's son Hunter costs her family $1,700 out of pocket.

Unlike many brand-name prescription drugs that have lower-cost alternatives, like a generic, insulin does not. Part of our discussion at today's hearing was the topic of ''biosimilars,'' or what could be considered a generic version of a biologic type of drug. As the FDA is moving to make insulin subject to biologic competition in the future, I asked our witnesses about this move and how it could potentially serve as a solution for families like Kathy's, who struggle with the out-of-pocket costs and copays as a result of the insulin with which they treat their diabetes.

As part of that effort, last week, Chairman GRASSLEY and Ranking Member WYDEN launched a bipartisan investigation into insulin prices. In letters to leading insulin manufacturers, they requested information on the recent price increases—some as high as 585 percent.

As I expressed today to one of the representatives from the drug company, I understand the need for drug companies to do research and development and that because they are granted patents for these innovative cures that they come up with, they have the exclusive right to sell those drugs during the terms of the patents. Yet I don't understand why a drug that has been around for decades, like insulin, still costs $1,700 for somebody to pay each month on an out-of-pocket basis, and where we have seen recent price increases as high as 585 percent, it makes absolutely zero sense to me. I am eager to hear from these manufacturers and other players in the pharmaceutical system about why these prices are rising so rapidly and how we, in working together, can provide relief to families who bear the brunt of manufacturers' decisions.

I conclude by saying that I also had an interesting conversation with one of the witnesses from the drug companies, the manufacturer of HUMIRA. HUMIRA is one of the best-selling drugs in the world for the treatment of rheumatoid arthritis and other things. The company that makes HUMIRA earns $18 billion a year in revenue from the sale of HUMIRA. When I asked why it was necessary for the company to have more than 100 different patents to cover that drug when the drug is essentially the same molecule, the gentleman representing the drug company did not give me a satisfactory answer.

I can understand the importance of recouping those R&D costs and the benefits of providing a patent for a reasonable period of time to recoup those costs and make a profit. I am OK with that. Yet, when you see the patent system being manipulated in a way that maintains that exclusive right to sell that best-selling drug by a drug company, that causes me grave concern. I have talked to Chairman GRAHAM of the Judiciary Committee, which has jurisdiction over patent-related issues, and he told me he would work with me to find a solution to gaming the patent system in order to protect that exclusive right to sell a drug beyond the normal patent period because it is, ultimately, the consumers who are being cheated and being denied access to the lower cost drugs.

As with insulin, there is no good reason why, after all of these years, consumers have to see price increases approaching 585 percent. We need answers to those questions, and we will get answers to those questions.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. Madam President, I ask unanimous consent that the order for the quorum be rescinded.

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

NOMINATION OF ERIC D. MILLER

Mr. DURBIN. Madam President, I rise in opposition to the pending nomination of Eric Miller to serve on the Ninth Circuit Court of Appeals in a seat based out of the State of Washington.

If the Senate chooses to confirm Mr. Miller, it will be a historic decision because it will be the first time ever since the introduction of blue slips over 100 years ago that the Senate has confirmed a nominee who is not supported by either of the home State Senators from the State in which he will be seated.

What is a blue slip? It is basically a consultation with the Senate before we move forward on a nomination. It is a courtesy that has been extended. It is an effort to try to find some common ground, some understanding, perhaps some moderation when it comes to the choice of nominees. It has been abused in some cases, but the two Senators here—Senator CANTWELL and Senator MURRAY—are well known in this body for being reasonable people who try to find solutions to problems and work well with both sides of the aisle. Yet, in this case, the Trump White House has decided that they are going to push this nominee for the Ninth Circuit in their home State of Washington against their wishes. If Mr. Miller is confirmed, we will have taken away yet another guardrail in the Senate advice and consent process.

If you follow what has happened in the Senate over the last 2 years and a few months, you know that the highest single priority of Senator MCCONNELL's—the Republican leader—is to fill the Federal judgeships, to put in place men and women who will serve literally for a lifetime, as long as they live. He is determined to do it. There is a template for the people who they find acceptable. If you have been a law