the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with Kevin J. Anderson and ending with Edward P. Wojnaroski, Jr., which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Navy nomination of Steven J. Shauberger, to be Lieutenant Commander.

Navy nomination of Karen M. Stokes, to be Lieutenant Commander.

Navy nominations beginning with Craig W. Aimone and ending with Matthew M. Wills, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. DURBIN (for himself, Mr. WHITEHOUSE, Mr. AKAKA, Mr. BROWN, and Mr. SANDERS):

S. 330. A bill to amend title XVIII of the Social Security Act to deliver a meaningful benefit and lower prescription drug prices under the Medicare program; to the Committee on Finance.

By Mr. SCHUMER (for himself, Mr. SHELBY, Mr. DURBIN, Mrs. FEINSTEIN, Mr. BAYH, Mr. TESTER, Mr. GRAHAM, Mr. SESSIONS, and Mr. ROBERTS):

S. 331. A bill to increase the number of Federal law enforcement officials investigating and prosecuting financial fraud; to the Committee on the Judiciary.

By Mrs. FEINSTEIN (for herself and Mr. BROWNBACK):

S. 332. A bill to establish a comprehensive interagency response to reduce lung cancer mortality in a timely manner; to the Committee on Health, Education, Labor, and Pensions.

By Ms. MIKULSKI (for herself, Ms. STABENOW, Mr. CARDIN, and Mr. WEBB):

S. 333. A bill to amend the Internal Revenue Code of 1986 to allow an above-the-line deduction against individual income tax for interest on indebtedness and for State sales and excise taxes with respect to the purchase of certain motor vehicles; to the Committee on Finance.

By Mr. LUGAR:

S. 334. A bill to authorize the extension of nondiscriminatory treatment (normal trade relations treatment) to the products of Moldova; to the Committee on Finance.

By Mrs. GILLIBRAND:

S. 335. A bill to amend part D of title IV of the Social Security Act to repeal a fee imposed by States on certain child support collections; to the Committee on Finance.

By Mr. INOUYE:

S. 336. An original bill making supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and State and local fiscal stabilization, for the fiscal year ending September 30, 2009, and for other purposes; from the Committee on Appropriations; placed on the calendar.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. VITTER (for himself and Ms. LANDRIEU):

S. Res. 22. A resolution recognizing the goals of Catholic Schools Week and honoring the valuable contributions of Catholic schools in the United States; considered and agreed to.

By Mr. CASEY (for himself, Mr. SPECTER, Ms. SNOWE, and Ms. COLLINS):

S. Res. 23. A resolution honoring the life of Andrew Wyeth; considered and agreed to.

ADDITIONAL COSPONSORS

S. 66

At the request of Mr. INOUYE, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 66, a bill to amend title 10, United States Code, to permit former members of the Armed Forces who have a service-connected disability rated as total to travel on military aircraft in the same manner and to the same extent as retired members of the Armed Forces are entitled to travel on such aircraft.

S. 85

At the request of Mr. VITTER, the name of the Senator from Oklahoma (Mr. COBURN) was added as a cosponsor of S. 85, a bill to amend title X of the Public Health Service Act to prohibit family planning grants from being awarded to any entity that performs abortions.

S. 96

At the request of Mr. VITTER, the name of the Senator from Oklahoma (Mr. COBURN) was added as a cosponsor of S. 96, a bill to prohibit certain abortion-related discrimination in governmental activities.

S. 133

At the request of Mrs. FEINSTEIN, the name of the Senator from South Dakota (Mr. THUNE) was added as a cosponsor of S. 133, a bill to prohibit any recipient of emergency Federal economic assistance from using such funds for lobbying expenditures or political contributions, to improve transparency, enhance accountability, encourage responsible corporate governance, and for other purposes.

S. 213

At the request of Mrs. BOXER, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 213, a bill to amend title 49, United States Code, to ensure air passengers have access to necessary services while on a grounded air carrier, and for other purposes.

S. 256

At the request of Mrs. FEINSTEIN, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of S. 256, a bill to enhance the ability to combat methamphetamine.

S. 271

At the request of Ms. CANTWELL, the names of the Senator from California (Mrs. BOXER), the Senator from Rhode Island (Mr. REED) and the Senator from Rhode Island (Mr. WHITEHOUSE) were added as cosponsors of S. 271, a bill to amend the Internal Revenue Code of 1986 to provide incentives to accelerate the production and adoption of plug-in electric vehicles and related component parts.

S. 298

At the request of Mr. ISAKSON, the names of the Senator from Texas (Mr. CORNYN) and the Senator from Idaho (Mr. RISCH) were added as cosponsors of S. 298, a bill to establish a Financial Markets Commission, and for other purposes.

S. 326

At the request of Mr. MCCONNELL, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 326, a bill to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program through fiscal year 2013, and for other purposes.

S. 328

At the request of Mr. ROCKEFELLER, the names of the Senator from Arkansas (Mr. PRYOR), the Senator from Wisconsin (Mr. KOHL), the Senator from Vermont (Mr. SANDERS), the Senator from Pennsylvania (Mr. CASEY) and the Senator from Iowa (Mr. HARKIN) were added as cosponsors of S. 328, a bill to postpone the DTV transition date.

S. RES. 9

At the request of Mr. LUGAR, the name of the Senator from Oklahoma (Mr. INHOFE) was added as a cosponsor of S. Res. 9, a resolution commemorating 90 years of U.S.-Polish diplomatic relations, during which Poland has proven to be an exceptionally strong partner to the United States in advancing freedom around the world.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. DURBIN (for himself, Mr. WHITEHOUSE, Mr. AKAKA, Mr. BROWN, and Mr. SANDERS):

S. 330. A bill to amend title XVIII of the Social Security Act to deliver a meaningful benefit and lower prescription drug prices under the Medicare program; to the Committee on Finance.

Mr. DURBIN. Mr. President, in the 6 years since Congress passed the Medicare Modernization Act, life for seniors has become increasingly difficult. The majority of seniors live on a fixed income, but face the challenge of paying more with less as the costs for everything continue to rise. Housing costs, basic nutrition, and healthcare needs are more expensive.

The addition of a prescription drug benefit to Medicare was long overdue, and many senior citizens and people with disabilities are relieved to finally have drug coverage. But the drug benefit was not structured like the rest of Medicare. For all other Medicare benefits, seniors can choose whether to receive benefits directly through Medicare or through a private insurance plan. The overwhelming majority choose the Medicare-run option for their hospital and physician coverage.

Unfortunately, no such choice is available for prescription drugs. Medicare beneficiaries must enroll in a private insurance plan to obtain drug coverage and with that are subjected to the multiple changes drug plans are allowed to impose on seniors year after year.

Each drug plan has its own premium, cost-sharing requirements, list of covered drugs, and pharmacy network. After you have identified the right drug plan, you have to go through the whole process again at the end of the year because your plan may have changed the drugs it covers or added new restrictions on how to access covered drugs.

Seniors are having trouble identifying which of the dozens of private drug plans works best for them. The complexity of the program has made beneficiaries more vulnerable to aggressive and deceptive marketing practices as some insurers try to steer seniors into more profitable Medicare Advantage plans. Some seniors have been signed up for Medicare Advantage plans without their knowledge, and, unfortunately, there have also been dishonest insurance agents who have misrepresented what benefits would be covered. Anyone who has visited a senior center or spoken with an elderly relative knows that the complexity of the drug benefit has created much confusion.

Drug plans often do not tell beneficiaries that they can appeal a drug plan's decision to deny coverage for a drug, even though they are required to do so. Beneficiaries who do appeal soon find that it is a long and difficult process.

Multiple studies have shown that private drug plans have not been effective negotiators, which means seniors end up paying more than they should. A report by Avalere Health released in late 2008 revealed that the average beneficiary will see a 24 percent increase in their monthly premiums for 2009. The top 10 most popular plans by enrollment will increase their premiums by more than 30 percent.

Today, I am introducing the Medicare Prescription Drug Savings and Choice Act. The bill would create a Medicare-operated drug plan that would compete with private drug plans and would give the Health and Human Services Secretary leverage to negotiate with drug companies to lower drug prices.

The Health and Human Services Secretary would have the tools to negotiate with drug companies, including the use of drug formulary. The best medical evidence would determine which drugs are covered in the formulary, and the formulary would be used to promote safety, appropriate use of drugs, and value.

The bill would establish an appeals process that is efficient, imposes minimal administrative burdens, and ensures timely procurement of non-formulary drugs or non-preferred drugs when medically necessary.

This is the kind of drug plan that Medicare beneficiaries are looking for. According to a survey by the Kaiser Family Foundation, two-thirds of seniors want the option of getting drug coverage directly from Medicare, and over 80 percent favor allowing the Government to negotiate with drug companies for lower prices.

Seniors want the ability to choose a Medicare-administered drug plan and deserve a simpler, more dependable, and less costly program that prioritizes their needs. Let's give them this option—just as they have this choice with every other benefit covered by Medicare.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 330

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Prescription Drug Savings and Choice Act of 2009''.

SEC. 2. ESTABLISHMENT OF MEDICARE OPERATED PRESCRIPTION DRUG PLAN OPTION.

(a) IN GENERAL.—Subpart 2 of part D of the Social Security Act is amended by inserting after section 1860D–11 (42 U.S.C. 1395w–111) the following new section:

''MEDICARE OPERATED PRESCRIPTION DRUG PLAN OPTION

''SEC. 1860D–11A. (a) IN GENERAL.—Notwithstanding any other provision of this part, for each year (beginning with 2010), in addition to any plans offered under section 1860D–11, the Secretary shall offer one or more medicare operated prescription drug plans (as defined in subsection (c)) with a service area that consists of the entire United States and shall enter into negotiations in accordance with subsection (b) with pharmaceutical manufacturers to reduce the purchase cost of covered part D drugs for eligible part D individuals who enroll in such a plan.

''(b) NEGOTIATIONS.—Notwithstanding section 1860D–11(i), for purposes of offering a medicare operated prescription drug plan under this section, the Secretary shall negotiate with pharmaceutical manufacturers with respect to the purchase price of covered part D drugs in a Medicare operated prescription drug plan and shall encourage the use of more affordable therapeutic equivalents to the extent such practices do not override medical necessity as determined by the prescribing physician. To the extent practicable and consistent with the previous sentence, the Secretary shall implement strategies similar to those used by other Federal purchasers of prescription drugs, and other strategies, including the use of a formulary and formulary incentives in subsection (e), to reduce the purchase cost of covered part D drugs.

''(c) MEDICARE OPERATED PRESCRIPTION DRUG PLAN DEFINED.—For purposes of this part, the term 'medicare operated prescription drug plan' means a prescription drug plan that offers qualified prescription drug coverage and access to negotiated prices described in section 1860D–2(a)(1)(A). Such a plan may offer supplemental prescription drug coverage in the same manner as other qualified prescription drug coverage offered by other prescription drug plans.

''(d) MONTHLY BENEFICIARY PREMIUM.—

''(1) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The monthly beneficiary premium for qualified prescription drug coverage and access to negotiated prices described in section 1860D–2(a)(1)(A) to be charged under a medicare operated prescription drug plan shall be uniform nationally. Such premium for months in 2010 and each succeeding year shall be based on the average monthly per capita actuarial cost of offering the medicare operated prescription drug plan for the year involved, including administrative expenses.

''(2) SUPPLEMENTAL PRESCRIPTION DRUG COVERAGE.—Insofar as a medicare operated prescription drug plan offers supplemental prescription drug coverage, the Secretary may adjust the amount of the premium charged under paragraph (1).

''(e) USE OF A FORMULARY AND FORMULARY INCENTIVES.—

''(1) IN GENERAL.—With respect to the operation of a medicare operated prescription drug plan, the Secretary shall establish and apply a formulary (and may include formulary incentives described in paragraph (2)(C)(ii)) in accordance with this subsection in order to—

''(A) increase patient safety;

''(B) increase appropriate use and reduce inappropriate use of drugs; and

''(C) reward value.

''(2) DEVELOPMENT OF INITIAL FORMULARY.—

''(A) IN GENERAL.—In selecting covered part D drugs for inclusion in a formulary. the Secretary shall consider clinical benefit and price.

''(B) ROLE OF AHRQ.—The Director of the Agency for Healthcare Research and Quality shall be responsible for assessing the clinical benefit of covered part D drugs and making recommendations to the Secretary regarding which drugs should be included in the formulary. In conducting such assessments and making such recommendations, the Director shall—

''(i) consider safety concerns including those identified by the Federal Food and Drug Administration;

''(ii) use available data and evaluations, with priority given to randomized controlled trials, to examine clinical effectiveness, comparative effectiveness, safety, and enhanced compliance with a drug regimen;

''(iii) use the same classes of drugs developed by United States Pharmacopeia for this part;

''(iv) consider evaluations made by—

''(I) the Director under section 1013 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003;

''(II) other Federal entities, such as the Secretary of Veterans Affairs; and

''(III) other private and public entities, such as the Drug Effectiveness Review Project and Medicaid programs; and

''(v) recommend to the Secretary—

''(I) those drugs in a class that provide a greater clinical benefit, including fewer safety concerns or less risk of side-effects, than another drug in the same class that should be included in the formulary;

''(II) those drugs in a class that provide less clinical benefit, including greater safety concerns or a greater risk of side-effects, than another drug in the same class that should be excluded from the formulary; and

''(III) drugs in a class with same or similar clinical benefit for which it would be appropriate for the Secretary to competitively bid (or negotiate) for placement on the formulary.

''(C) CONSIDERATION OF AHRQ RECOMMENDATIONS.—

''(i) IN GENERAL.—The Secretary, after taking into consideration the recommendations under subparagraph (B)(v), shall establish a

formulary, and formulary incentives, to encourage use of covered part D drugs that—

''(I) have a lower cost and provide a greater clinical benefit than other drugs;

''(II) have a lower cost than other drugs with same or similar clinical benefit; and

''(III) drugs that have the same cost but provide greater clinical benefit than other drugs.

''(ii) FORMULARY INCENTIVES.—The formulary incentives under clause (i) may be in the form of one or more of the following:

''(I) Tiered copayments.

''(II) Reference pricing.

''(III) Prior authorization.

''(IV) Step therapy.

''(V) Medication therapy management.

''(VI) Generic drug substitution.

''(iii) FLEXIBILITY.—In applying such formulary incentives the Secretary may decide not to impose any cost-sharing for a covered part D drug for which—

''(I) the elimination of cost sharing would be expected to increase compliance with a drug regimen; and

''(II) compliance would be expected to produce savings under part A or B or both.

''(3) LIMITATIONS ON FORMULARY.—In any formulary established under this subsection, the formulary may not be changed during a year, except—

''(A) to add a generic version of a covered part D drug that entered the market;

''(B) to remove such a drug for which a safety problem is found; and

''(C) to add a drug that the Secretary identifies as a drug which treats a condition for which there has not previously been a treatment option or for which a clear and significant benefit has been demonstrated over other covered part D drugs.

''(4) ADDING DRUGS TO THE INITIAL FORMULARY.—

''(A) USE OF ADVISORY COMMITTEE.—The Secretary shall establish and appoint an advisory committee (in this paragraph referred to as the 'advisory committee')—

''(i) to review petitions from drug manufacturers, health care provider organizations, patient groups, and other entities for inclusion of a drug in, or other changes to, such formulary; and

''(ii) to recommend any changes to the formulary established under this subsection.

''(B) COMPOSITION.—The advisory committee shall be composed of 9 members and shall include representatives of physicians, pharmacists, and consumers and others with expertise in evaluating prescription drugs. The Secretary shall select members based on their knowledge of pharmaceuticals and the Medicare population. Members shall be deemed to be special Government employees for purposes of applying the conflict of interest provisions under section 208 of title 18, United States Code, and no waiver of such provisions for such a member shall be permitted.

''(C) CONSULTATION.—The advisory committee shall consult, as necessary, with physicians who are specialists in treating the disease for which a drug is being considered.

''(D) REQUEST FOR STUDIES.—The advisory committee may request the Agency for Healthcare Research and Quality or an academic or research institution to study and make a report on a petition described in subparagraph (A)(ii) in order to assess—

''(i) clinical effectiveness;

''(ii) comparative effectiveness;

''(iii) safety; and

''(iv) enhanced compliance with a drug regimen.

''(E) RECOMMENDATIONS.—The advisory committee shall make recommendations to the Secretary regarding—

''(i) whether a covered part D drug is found to provide a greater clinical benefit, including fewer safety concerns or less risk of side-effects, than another drug in the same class that is currently included in the formulary and should be included in the formulary;

''(ii) whether a covered part D drug is found to provide less clinical benefit, including greater safety concerns or a greater risk of side-effects, than another drug in the same class that is currently included in the formulary and should not be included in the formulary; and

''(iii) whether a covered part D drug has the same or similar clinical benefit to a drug in the same class that is currently included in the formulary and whether the drug should be included in the formulary.

''(F) LIMITATIONS ON REVIEW OF MANUFACTURER PETITIONS.—The advisory committee shall not review a petition of a drug manufacturer under subparagraph (A)(ii) with respect to a covered part D drug unless the petition is accompanied by the following:

''(i) Raw data from clinical trials on the safety and effectiveness of the drug.

''(ii) Any data from clinical trials conducted using active controls on the drug or drugs that are the current standard of care.

''(iii) Any available data on comparative effectiveness of the drug.

''(iv) Any other information the Secretary requires for the advisory committee to complete its review.

''(G) RESPONSE TO RECOMMENDATIONS.—The Secretary shall review the recommendations of the advisory committee and if the Secretary accepts such recommendations the Secretary shall modify the formulary established under this subsection accordingly. Nothing in this section shall preclude the Secretary from adding to the formulary a drug for which the Director of the Agency for Healthcare Research and Quality or the advisory committee has not made a recommendation.

''(H) NOTICE OF CHANGES.—The Secretary shall provide timely notice to beneficiaries and health professionals about changes to the formulary or formulary incentives.

''(f) INFORMING BENEFICIARIES.—The Secretary shall take steps to inform beneficiaries about the availability of a Medicare operated drug plan or plans including providing information in the annual handbook distributed to all beneficiaries and adding information to the official public Medicare website related to prescription drug coverage available through this part.

''(g) APPLICATION OF ALL OTHER REQUIREMENTS FOR PRESCRIPTION DRUG PLANS.—Except as specifically provided in this section, any Medicare operated drug plan shall meet the same requirements as apply to any other prescription drug plan, including the requirements of section 1860D–4(b)(1) relating to assuring pharmacy access).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1860D–3(a) of the Social Security Act (42 U.S.C. 1395w–103(a)) is amended by adding at the end the following new paragraph:

''(4) AVAILABILITY OF THE MEDICARE OPERATED PRESCRIPTION DRUG PLAN.—A medicare operated prescription drug plan (as defined in section 1860D–11A(c)) shall be offered nationally in accordance with section 1860D–11A.''.

(2)(A) Section 1860D–3 of the Social Security Act (42 U.S.C. 1395w–103) is amended by adding at the end the following new subsection:

''(c) PROVISIONS ONLY APPLICABLE IN 2006, 2007, 2008, AND 2009.—The provisions of this section shall only apply with respect to 2006, 2007, 2008, and 2009.''.

(B) Section 1860D–11(g) of such Act (42 U.S.C. 1395w–111(g)) is amended by adding at the end the following new paragraph:

''(8) NO AUTHORITY FOR FALLBACK PLANS AFTER 2009.—A fallback prescription drug plan shall not be available after December 31, 2009.''.

(3) Section 1860D–13(c)(3) of such Act (42 U.S.C. 1395w–113(c)(3)) is amended—

(A) in the heading, by inserting ''AND MEDICARE OPERATED PRESCRIPTION DRUG PLANS'' after ''FALLBACK PLANS''; and

(B) by inserting ''or a medicare operated prescription drug plan'' after ''a fallback prescription drug plan''.

(4) Section 1860D–16(b)(1) of such Act (42 U.S.C.1395w–116(b)(1)) is amended—

(A) in subparagraph (C), by striking ''and'' after the semicolon at the end;

(B) in subparagraph (D), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(E) payments for expenses incurred with respect to the operation of medicare operated prescription drug plans under section 1860D–11A.''.

(5) Section 1860D–41(a) of such Act (42 U.S.C. 1395w–151(a)) is amended by adding at the end the following new paragraph:

''(19) MEDICARE OPERATED PRESCRIPTION DRUG PLAN.—The term 'medicare operated prescription drug plan' has the meaning given such term in section 1860D–11A(c).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

SEC. 3. IMPROVED APPEALS PROCESS UNDER THE MEDICARE OPERATED PRESCRIPTION DRUG PLAN.

Section 1860D–4(h) of the Social Security Act (42 U.S.C. 1305w–104(h)) is amended by adding at the end the following new paragraph:

''(4) APPEALS PROCESS FOR MEDICARE OPERATED PRESCRIPTION DRUG PLAN.—

''(A) IN GENERAL.—The Secretary shall develop a well-defined process for appeals for denials of benefits under this part under the medicare operated prescription drug plan. Such process shall be efficient, impose minimal administrative burdens, and ensure the timely procurement of non-formulary drugs or exemption from formulary incentives when medically necessary. Medical necessity shall be based on professional medical judgment, the medical condition of the beneficiary, and other medical evidence. Such appeals process shall include—

''(i) an initial review and determination made by the Secretary; and

''(ii) for appeals denied during the initial review and determination, the option of an external review and determination by an independent entity selected by the Secretary.

''(B) CONSULTATION IN DEVELOPMENT OF PROCESS.—In developing the appeals process under subparagraph (A), the Secretary shall consult with consumer and patient groups, as well as other key stakeholders to ensure the goals described in subparagraph (A) are achieved.''.

By Mrs. FEINSTEIN (for herself and Mr. BROWNBACK):

S. 332. A bill to establish a comprehensive interagency response to reduce lung cancer mortality in a timely manner; to the Committee on Health, Education, Labor, and Pensions.

Mrs. FEINSTEIN. Mr. President, I rise to introduce the Lung Cancer Mortality Reduction Act, calling for a new effort to combat this often deadly form of cancer. I am pleased to be joined by Senator BROWNBACK, the Co-Chair of

the Senate Cancer Coalition, and a strong voice on a variety of cancer issues.

This bill will renew and improve the Federal Government's efforts to combat lung cancer. It will affirm the goal of a 50 percent reduction in lung cancer mortality by 2015.

It will authorize a Lung Cancer Mortality Reduction Program, with interagency coordination, to develop and implement a plan to meet this goal.

It will authorize $75 million for lung cancer research programs in the National Heart Lung Blood Institute, National Institute of Biomedical Imaging and Bioengineering, National Institute of Environmental Health Sciences, and Centers for Disease Control.

It will create a new incentive program in the Food and Drug Administration to be modeled on the Orphan Drug Act for the development of chemoprevention drugs for lung cancer and precancerous lung disease. These are drugs that could prevent precancer from progressing into full-blown disease.

It will improve coordination disparity programs to ensure that the burdens of lung cancer on minority populations are addressed.

We have made great strides against many types of cancer in the last several decades. However, these gains are uneven.

When the National Cancer Act was passed in 1971, lung cancer had a 5-year survival rate of only 12 percent. After decades of research efforts and scientific advances, this survival rate remains only 15 percent. In contrast, the 5-year survival rates of breast, prostate, and colon cancer have risen to 89 percent, 99 percent and 65 percent respectively.

A lung cancer diagnosis can be devastating. The average life expectancy following a lung cancer diagnosis is only 9 months.

This is because far too many patients are not diagnosed with lung cancer until it has progressed to the later stages. Lung cancer can be hard to diagnose, and symptoms may at first appear to be other illnesses. As a result, only 16 percent of lung cancer patients are diagnosed when their cancer is still localized, and is the most treatable.

Lung cancer still lacks early detection technology, to find cancer when it is most treatable. Mammograms can find breast cancer, and colonoscopies can find dangerous colon polyps. But there is no equivalent test for lung cancer at this time.

Under this legislation, the National Cancer Institute has clear authority to work with other institutes on this early detection research. Coordination between all branches of the National Institutes of Health, including those with expertise on lungs, imaging, and cancer will be necessary to make this long overdue progress.

Lung cancer lags behind other cancers, in part, due to stigma from smoking. Make no mistake, tobacco use causes the majority of lung cancer cases. Tobacco cessation is a critical component of reducing lung cancer mortality. Less smoking means less lung cancer. Period.

But tobacco use does not fully explain lung cancer. Approximately 15 percent of the people who die from lung cancer never smoked. A study published in the Journal of Clinical Oncology in 2007 tracked the incidence of lung cancer in 1 million people ages 40 to 79. It found that about 20 percent of female lung cancer patients were nonsmokers and 8 percent of male patients were nonsmokers.

These patients may have been exposed to second hand smoke, or they may have been exposed to radon, asbestos, chromium, or other chemicals. There could be other causes and associations that have not yet been discovered, genetic predispositions or other environmental exposures.

Dana Reeve put a face on these statistics, with her brave fight against lung cancer. Dana Reeve was a nonsmoker, and still was diagnosed with lung cancer at the age of 44. She died a mere 7 months later, leaving a young son.

Dana Reeve's story shows that smoking cannot fully explain lung cancer. Everyone in this country could stop smoking today, and yet we would still face a lung cancer epidemic. According to the Lung Cancer Alliance, over 60 percent of new lung cancer cases occur in those who never smoked, or who quit smoking.

I believe that we have the expertise and technology to make serious progress against this deadly cancer, and to reach the goal of halving lung cancer mortality by 2015.

We need this legislation to ensure that our Government's resources are focused on this mission in the most efficient way possible.

Agency efforts must be coordinated, and every part of the National Institutes of Health that may have some ideas to lend should be participating. That is what the Lung Cancer Mortality Reduction Program will accomplish.

We can do better for Americans diagnosed with lung cancer. I ask my colleagues to support this legislation.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 332

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Lung Cancer Mortality Reduction Act of 2009''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Lung cancer is the leading cause of cancer death for both men and women, accounting for 28 percent of all cancer deaths.

(2) Lung cancer kills more people annually than breast cancer, prostate cancer, colon cancer, liver cancer, melanoma, and kidney cancer combined.

(3) Since the enactment of the National Cancer Act of 1971 (Public Law 92–218; 85 Stat. 778), coordinated and comprehensive research has raised the 5-year survival rates for breast cancer to 88 percent, for prostate cancer to 99 percent, and for colon cancer to 64 percent.

(4) However, the 5-year survival rate for lung cancer is still only 15 percent and a similar coordinated and comprehensive research effort is required to achieve increases in lung cancer survivability rates.

(5) Sixty percent of lung cancer cases are now diagnosed as nonsmokers or former smokers.

(6) Two-thirds of nonsmokers diagnosed with lung cancer are women.

(7) Certain minority populations, such as African-American males, have disproportionately high rates of lung cancer incidence and mortality, notwithstanding their similar smoking rate.

(8) Members of the baby boomer generation are entering their sixties, the most common age at which people develop lung cancer.

(9) Tobacco addiction and exposure to other lung cancer carcinogens such as Agent Orange and other herbicides and battlefield emissions are serious problems among military personnel and war veterans.

(10) Significant and rapid improvements in lung cancer mortality can be expected through greater use and access to lung cancer screening tests for at-risk individuals.

(11) Additional strategies are necessary to further enhance the existing tests and therapies available to diagnose and treat lung cancer in the future.

(12) The August 2001 Report of the Lung Cancer Progress Review Group of the National Cancer Institute stated that funding for lung cancer research was ''far below the levels characterized for other common malignancies and far out of proportion to its massive health impact''.

(13) The Report of the Lung Cancer Progress Review Group identified as its ''highest priority'' the creation of integrated, multidisciplinary, multi-institutional research consortia organized around the problem of lung cancer.

(14) The United States must enhance its response to the issues raised in the Report of the Lung Cancer Progress Review Group, and this can be accomplished through the establishment of a coordinated effort designed to reduce the lung cancer mortality rate by 50 percent by 2016 and through targeted funding to support this coordinated effort.

SEC. 3. SENSE OF THE SENATE CONCERNING INVESTMENT IN LUNG CANCER RESEARCH.

It is the sense of the Senate that—

(1) lung cancer mortality reduction should be made a national public health priority; and

(2) a comprehensive mortality reduction program coordinated by the Secretary of Health and Human Services is justified and necessary to adequately address and reduce lung cancer mortality.

SEC. 4. LUNG CANCER MORTALITY REDUCTION PROGRAM.

(a) IN GENERAL.—Subpart 1 of part C of title IV of the Public Health Service Act (42 U.S.C. 285 et seq.) is amended by adding at the end the following:

''SEC. 417G. LUNG CANCER MORTALITY REDUCTION PROGRAM.

''(a) IN GENERAL.—Not later than 6 months after the date of enactment of the Lung Cancer Mortality Reduction Act of 2009, the Secretary, in consultation with the Secretary of Defense, the Secretary of Veterans Affairs, the Director of the National Institutes of

Health, the Director of the Centers for Disease Control and Prevention, the Commissioner of the Food and Drug Administration, the Administrator of the Centers for Medicare & Medicaid Services, the Director of the National Center on Minority Health and Health Disparities, and other members of the Lung Cancer Advisory Board established under section 6 of the Lung Cancer Mortality Reduction Act of 2009, shall implement a comprehensive program to achieve a 50 percent reduction in the mortality rate of lung cancer by 2016.

''(b) REQUIREMENTS.—The program implemented under subsection (a) shall include at least the following:

''(1) With respect to the National Institutes of Health—

''(A) a strategic review and prioritization by the National Cancer Institute of research grants to achieve the goal of the program in reducing lung cancer mortality;

''(B) the provision of funds to enable the Airway Biology and Disease Branch of the National Heart, Lung, and Blood Institute to expand its research programs to include predispositions to lung cancer, the interrelationship between lung cancer and other pulmonary and cardiac disease, and the diagnosis and treatment of these interrelationships;

''(C) the provision of funds to enable the National Institute of Biomedical Imaging and Bioengineering to expand its Quantum Grant Program and Image-Guided Interventions programs to expedite the development of computer assisted diagnostic, surgical, treatment, and drug testing innovations to reduce lung cancer mortality; and

''(D) the provision of funds to enable the National Institute of Environmental Health Sciences to implement research programs relative to lung cancer incidence.

''(2) With respect to the Food and Drug Administration—

''(A) the establishment of a lung cancer mortality reduction drug program under subchapter G of chapter V of the Federal Food, Drug, and Cosmetic Act; and

''(B) compassionate access activities under section 561 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb).

''(3) With respect to the Centers for Disease Control and Prevention, the establishment of a lung cancer mortality reduction program under section 1511.

''(4) With respect to the Agency for Healthcare Research and Quality, the conduct of a biannual review of lung cancer screening, diagnostic and treatment protocols, and the issuance of updated guidelines.

''(5) The cooperation and coordination of all minority and health disparity programs within the Department of Health and Human Services to ensure that all aspects of the Lung Cancer Mortality Reduction Program adequately address the burden of lung cancer on minority and rural populations.

''(6) The cooperation and coordination of all tobacco control and cessation programs within agencies of the Department of Health and Human Services to achieve the goals of the Lung Cancer Mortality Reduction Program with particular emphasis on the coordination of drug and other cessation treatments with early detection protocols.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section—

''(1) $25,000,000 for fiscal year 2010 for the activities described in subsection (b)(1)(B), and such sums as may be necessary for each of fiscal years 2011 through 2014;

''(2) $25,000,000 for fiscal year 2010 for the activities described in subsection (b)(1)(C), and such sums as may be necessary for each of fiscal years 2011 through 2014;

''(3) $10,000,000 for fiscal year 2010 for the activities described in subsection (b)(1)(D), and such sums as may be necessary for each of fiscal years 2011 through 2014; and

''(4) $15,000,000 for fiscal year 2010 for the activities described in subsection (b)(3), and such sums as may be necessary for each of fiscal years 2011 through 2014.''.

(b) FOOD, DRUG, AND COSMETIC ACT.—Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by adding at the end the following:

''Subchapter G—Lung Cancer Mortality Reduction Programs

''SEC. 581. LUNG CANCER MORTALITY REDUCTION PROGRAM.

''(a) IN GENERAL.—The Secretary shall implement a program to provide incentives of the type provided for in subchapter B of this chapter for the development of chemoprevention drugs for precancerous conditions of the lung, drugs for targeted therapeutic treatments and vaccines for lung cancer, and new agents to curtail or prevent nicotine addiction. The Secretary shall model the program implemented under this section on the program provided for under subchapter B of this chapter with respect to certain drugs.

''(b) APPLICATION OF PROVISIONS.—The Secretary shall apply the provisions of subchapter B of this chapter to drugs, biological products, and devices for the prevention or treatment of lung cancer, including drugs, biological products, and devices for chemoprevention of precancerous conditions of the lungs, vaccination against the development of lung cancer, and therapeutic treatment for lung cancer.

''(c) BOARD.—The Board established under section 6 of the Lung Cancer Mortality Reduction Act of 2009 shall monitor the program implemented under this section.''.

(c) ACCESS TO UNAPPROVED THERAPIES.—Section 561(e) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb(e)) is amended by inserting before the period the following: ''and shall include providing compassionate access to drugs, biological products, and devices under the program under section 581, with substantial consideration being given to whether the totality of information available to the Secretary regarding the safety and effectiveness of an investigational drug, as compared to the risk of morbidity and death from the disease, indicates that a patient may obtain more benefit than risk if treated with the drug, biological product, or device.''.

(d) CDC.—Title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) is amended by adding at the end the following:

''SEC. 1511. LUNG CANCER MORTALITY REDUCTION PROGRAM.

''(a) IN GENERAL.—The Secretary shall establish and implement an early disease research and management program targeted at the high incidence and mortality rates among minority and low-income populations.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary to carry out this section.''.

SEC. 5. DEPARTMENT OF DEFENSE AND THE DEPARTMENT OF VETERANS AFFAIRS.

The Secretary of Defense and the Secretary of Veterans Affairs shall coordinate with the Secretary of Health and Human Services—

(1) in the development of the Lung Cancer Mortality Reduction Program under section 417E of part C of title IV of the Public Health Service Act, as amended by section 4;

(2) in the implementation within the Department of Defense and the Department of Veterans Affairs of an early detection and disease management research program for military personnel and veterans whose smoking history and exposure to carcinogens during active duty service has increased their risk for lung cancer; and

(3) in the implementation of coordinated care programs for military personnel and veterans diagnosed with lung cancer.

SEC. 6. LUNG CANCER ADVISORY BOARD.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a Lung Cancer Advisory Board (referred to in this section as the ''Board'') to monitor the programs established under this Act (and the amendments made by this Act), and provide annual reports to Congress concerning benchmarks, expenditures, lung cancer statistics, and the public health impact of such programs.

(b) COMPOSITION.—The Board shall be composed of—

(1) the Secretary of Health and Human Services;

(2) the Secretary of Defense;

(3) the Secretary of Veterans Affairs; and

(4) two representatives each from the fields of—

(A) clinical medicine focused on lung cancer;

(B) lung cancer research;

(C) imaging;

(D) drug development; and

(E) lung cancer advocacy,

to be appointed by the Secretary of Health and Human Services.

SEC. 7. AUTHORIZATION OF APPROPRIATIONS.

For the purpose of carrying out the programs under this Act (and the amendments made by this Act), there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.

By Mr. LUGAR:

S. 334. A bill to authorize the extension of nondiscriminatory treatment (normal trade relations treatment) to the products of Moldova; to the Committee on Finance.

Mr. LUGAR. Mr. President, I rise today to introduce legislation designed to extend permanent normal trade relations to Moldova. Moldova is still subject to the provisions of the Jackson-Vanik amendment to the Trade Act of 1974, which sanctions nations for failure to comply with freedom of emigration requirements. This bill would repeal permanently the application of Jackson-Vanik to Moldova.

Moldova is a small country located in Europe between Ukraine and Romania. Throughout the Cold War it was a part of the Soviet Union. It gained its independence from the Soviet Union on August 27, 1991. The United States has supported Moldova in its journey toward democracy and sovereignty.

The United States enjoys good relations with Moldova and has encouraged Moldovan efforts to integrate with Euro-Atlantic institutions. Moldova has been selected to participate in the Eastern Partnership, an initiative proposed by the European Union in 2008, which will facilitate the creation of free trade agreements, energy security plans, and closer economic ties between the EU and Moldova.

Since declaring independence from the Soviet Union in 1992, Moldova has enacted a series of democratic and free market reforms. In 2001, Moldova became a member of the World Trade Organization. Furthermore, Moldovan

President Vladimir Voronin has recently expressed his desire to sign an accord to strengthen relations between Moldova and the European Union this year. Until the United States terminates application of Jackson-Vanik on Moldova, the U.S. will not benefit from Moldova's market access commitments nor can it resort to WTO dispute resolution mechanisms. While all other WTO members currently enjoy these benefits, the U.S. does not.

The Republic of Moldova has been evaluated every year and granted normal trade relations with the United States through annual presidential waivers from the effects of Jackson-Vanik. The Moldovan constitution guarantees its citizens the right to emigrate and this right is respected in practice. Most emigration restrictions were eliminated in 1991 and virtually no problems with emigration have been reported in the 16 years since independence. More specifically, Moldova does not impose emigration restrictions on members of the Jewish community. Synagogues function openly and without harassment. As a result, the administration finds that Moldova is in full compliance with Jackson-Vanik's provisions.

Since declaring independence from the Soviet Union in 1992, Moldova has enacted a series of democratic and free market reforms. Parliamentary elections in 2005 and local elections in 2007 generally complied with international standards for democratic elections.

Moldova has also contributed constructively towards a resolution of the long-standing separatist conflict in the country's Transniestria region, most recently by proposing a series of confidence-building measures and working groups. In addition, trade increased between the two parties by 30 percent in 2007.

The United States and Moldova have established a strong record of achievement in security cooperation. In 1997 the Nunn-Lugar Cooperative Threat Reduction Program responded to a Moldovan request for assistance. The U.S. purchased and secured 14 nuclear-capable MiG–29Cs from Moldova. These fighter aircraft were built by the former Soviet Union to launch nuclear weapons. Moldova expressed concern that these aircraft were unsecure due to the lack of funds and equipment necessary to ensure they were not stolen or smuggled out of the country. Specifically, emissaries from Iran had shown great interest and had attempted to acquire the aircraft. These planes were not destroyed. They were disassembled and shipped to Wright Patterson Air Force Base because they can be used by American experts for research purposes.

Moldova has made small, but important, troop contributions in Iraq. These contributions include significant demining capabilities and contingents of combat troops. I am pleased that the United States remains prepared to assist in weapons and ammunition disposal and force relocation assistance to help deal with the costs of military realignments in Moldova and to assist with military downsizing and reforms.

One of the areas where we can deepen U.S.-Moldovan relations is bilateral trade. In light of its adherence to freedom of emigration requirements, compliance with threat reduction and cooperation in the global war on terrorism, the products of Moldova should not be subject to the sanctions of Jackson-Vanik. The U.S. must remain committed and engaged in assisting Moldova in pursuing economic and development reforms. The government in Chisinau still has important work to do in these critical areas. The support and encouragement of the U.S. and the international community will be key to encouraging the Government of Moldova to take the necessary steps to initiate reform. The permanent waiver of Jackson-Vanik and establishment of permanent normal trade relations will be the foundation on which further progress in a burgeoning economic and energy partnership can be made.

I am hopeful that my colleagues will join me in supporting this important legislation. It is essential that we act promptly to bolster this important relationship and promote stability in this region.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 22—RECOGNIZING THE GOALS OF CATHOLIC SCHOOLS WEEK AND HONORING THE VALUABLE CONTRIBUTIONS OF CATHOLIC SCHOOLS IN THE UNITED STATES

Mr. VITTER (for himself and Ms. LANDRIEU) submitted the following resolution; which was considered and agreed to:

S. RES. 22

Whereas Catholic schools in the United States have received international acclaim for academic excellence while providing students with lessons that extend far beyond the classroom;

Whereas Catholic schools present a broad curriculum that emphasizes the lifelong development of moral, intellectual, physical, and social values in the young people of the United States;

Whereas Catholic schools in the United States today educate 2,270,913 students and maintain a student-to-teacher ratio of 14 to 1;

Whereas the faculty members of Catholic schools teach a highly diverse body of students;

Whereas the graduation rate for all Catholic school students is 95 percent;

Whereas 83 percent of Catholic high school graduates go on to college;

Whereas Catholic schools produce students strongly dedicated to their faith, values, families, and communities by providing an intellectually stimulating environment rich in spiritual character and moral development; and

Whereas in the 1972 pastoral message concerning Catholic education, the National Conference of Catholic Bishops stated, ''Education is one of the most important ways by which the Church fulfills its commitment to the dignity of the person and building of community. Community is central to education ministry, both as a necessary condition and an ardently desired goal. The educational efforts of the Church, therefore, must be directed to forming persons-in-community; for the education of the individual Christian is important not only to his solitary destiny, but also the destinies of the many communities in which he lives.'': Now, therefore, be it

Resolved, That the Senate—

(1) recognizes the goals of Catholic Schools Week, an event cosponsored by the National Catholic Educational Association and the United States Conference of Catholic Bishops that recognizes the vital contributions of thousands of Catholic elementary and secondary schools in the United States; and

(2) commends Catholic schools, students, parents, and teachers across the United States for their ongoing contributions to education, and for the vital role they play in promoting and ensuring a brighter, stronger future for the United States.

SENATE RESOLUTION 23—HONORING THE LIFE OF ANDREW WYETH

Mr. CASEY (for himself, Mr. SPECTER, Ms. SNOWE, and Ms. COLLINS) submitted the following resolution; which was considered and agreed to:

S. RES. 23

Whereas Andrew Wyeth was one of the most popular American artists of the twentieth century, whose paintings presented to the world his impressions of rural American landscapes and lives;

Whereas Andrew Wyeth was born in Chadds Ford, Pennsylvania on July 12, 1917, where he spent much of his life and where today stands the Brandywine River Museum, a museum dedicated to the works of the Wyeth family;

Whereas Andrew Wyeth died the morning of January 16, 2009, at the age of 91, in his home in Chadds Ford, Pennsylvania;

Whereas it is the intent of the Senate to recognize and pay tribute to the life of Andrew Wyeth, his passion for painting, his contribution to the world of art, and his deep understanding of the human condition;

Whereas Andrew Wyeth was born the son of famed illustrator N.C. Wyeth and grew up surrounded by artists in an environment that encouraged imagination and free-thinking;

Whereas Andrew Wyeth became an icon who focused his work on family and friends in Chadds Ford and in coastal Maine, where he spent his summers and where he met Christina Olson, the subject of his famed painting 'Christina's World';

Whereas Andrew Wyeth's paintings were immensely popular among the public but sometimes disparaged by critics for their lack of color and bleak landscapes portraying isolation and alienation;

Whereas Andrew Wyeth's works could be controversial, as they sparked dialogue and disagreement in the art world concerning the natures of realism and modernism;

Whereas Andrew Wyeth was immensely patriotic and an independent thinker who broke with many of his peers on the issues of the day;

Whereas Andrew Wyeth was a beloved figure in Chadds Ford and had his own seat at the corner table of the Chadds Ford Inn, where reproductions of his art line the walls;

Whereas Andrew Wyeth received the Presidential Medal of Freedom in 1963 and the Congressional Gold Medal of Honor in 1988;