

After September 11, President Bush promised not only to fight al-Qaida in Afghanistan but here in Washington to work to restore peace and democracy in that war-torn country. The President promised promoting women's rights in Afghanistan would be an important part of that mission.

Although the Taliban has been routed and al-Qaida is on the run, Afghanistan is far from peaceful today. Some say the country is on the verge of a civil war as rival warlords battle for control of the countryside.

Vice President Haji Abdul Qadir was assassinated 2 weeks ago. The international group, Human Rights Watch, reported local warlords are forcing young men to serve in their militias against their will. The United Nations has halted its return of refugees to parts of Afghanistan because of the increased violence.

On top of threats to their safety, families suffer from sabotage and from shortages of food, water, and health care because warlords are disrupting humanitarian aid deliveries. These humanitarian aid deliveries are essential. If they cannot be made, then the country cannot proceed.

Unfortunately, the gains Afghan women appeared to be making after the fall of the Taliban in many instances are simply an illusion. Afghan women continue to feel unsafe and most are afraid to remove their burqas. Many of the women who participated in the Loya Jirga a matter of weeks ago have been threatened and intimidated. Violence against women remains pervasive. They have no recourse or protection.

Aid workers, foreigners, and Afghan women and children have been targeted for robberies, assaults, and rapes. I was told by the Minister of Women and Refugee Affairs with whom I met earlier today about some brutal things that have taken place in that country, such as a 14-year-old girl raped. I have it in my mind and it is hard to get it out. Women's rights in Afghanistan will not be secure if there is no law or order.

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

Mr. REID. I ask unanimous consent I be extended an additional 3 minutes and that same time be extended to the Republicans.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. REID. Mr. President, the rights of women in Afghanistan will not be secure if there is no law and order in Afghanistan. Afghanistan's new government does not have the resources, no matter what their will, to combat warlord infighting, banditry, and lawlessness while trying to reestablish institutions of a civil society that were destroyed by the Taliban.

Interim President Karzai has requested international troops to help maintain order across the country. We have countries that are willing to come in and help. They have been told by our

country that they should not come. Afghan women say they feel safer when international peacekeeping troops are present. That is obvious.

United Nations Secretary Kofi Annan has called for more peacekeepers, and there has been a call by both parties for more peacekeepers in Afghanistan. Yet the Bush administration has not yet committed to increasing the number of troops engaged—in fact, they have pushed against it—in peacekeeping, and they also refuse to allow the International Security Assistance Force, ISAF, to operate outside Kabul. We need these troops. We need this presence outside Kabul. Afghan is more than Kabul. It is a country that has great traditions and has a tradition of peace, except for the past 20 years. It can be reestablished.

When President Bush began military operations in Afghanistan, he promised Afghanistan would have a stable, democratically elected government that can govern in peace. We should not be skeptical of his promises. He should follow through on the promises he made. President Bush owes that to the American people, but especially to the people of Afghanistan. We cannot let the people of Afghanistan down again, and we cannot allow either our allies or enemies to believe America does not stand by its promises.

Today I call on the President of the United States to expand the International Security Assistance Force immediately to stop the violence, allow humanitarian aid to reach impoverished areas, and protect Afghan women and children. They need our help, Mr. President.

The ACTING PRESIDENT pro tempore. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I have a Republican member who wishes to speak. I wonder if I can get a Democratic member to speak. If not, I will go ahead. Is there anyone waiting to speak on the Democratic side? If they are, I do not want to lose the time.

Mr. REID. How much time do the Republicans have now?

The ACTING PRESIDENT pro tempore. The Republicans have 10 minutes.

Mr. GRASSLEY. I will proceed, Mr. President.

The ACTING PRESIDENT pro tempore. The Senator from Iowa.

#### PRESCRIPTION DRUGS

Mr. GRASSLEY. Mr. President, I wish to speak once again, before the vote this afternoon at 2:45 p.m., on the Graham prescription drug bill and point out that that bill sunsets in the year 2010. Also, it omits coverage of most drugs. First of all, the fact the bill sunsets on December 31, 2010, ought to be an overriding factor of how people vote on this amendment.

Pages 78 and 79 of the bill say "drug coverage must stop after December 31, 2010." That is section 1860(k), for people who want to look it up and verify what I am saying.

The Graham-Miller-Kennedy bill would not provide, if enacted, a permanent Medicare prescription drug benefit.

In the tripartisan bill, we are talking about a plan that is permanent. There is no sunset because we know that senior citizens on December 31, 2010, are not going to sunset themselves. They are going to need prescription drugs on January 1, 2001, just as much as they did on December 31, 2010.

We have a bipartisan program that is permanent and continues drug coverage in the future. Why? Because prescription drugs ought to be a part of Medicare as much in the year 2002 as hospitalization was a very important part of Medicare in 1965.

Medicare beneficiaries should understand that there is no guarantee that a prescription drug plan being offered by Senators GRAHAM, MILLER, and KENNEDY, will continue to cover their drug expenses after 2010.

Some refer to this as a sunset, but I wish to make clear, as this chart points out very well, that this is just one very obvious big black hole in this program that will sunset in the year 2010. Sunsetting a Medicare Program seems to be a very strange thing to do. Medicare is an entitlement program. Dependability has been one of its central features. So why should a new drug benefit be any different than any other program that we have—hospitalization, doctor care, or other provisions in Medicare that we have had since 1965.

There is no need to speculate as to why the sponsors sunset their program in 2010. It is a device to make the costs of the bill appear lower than it otherwise would be. In other words, it is a mere gimmick.

I point out another very crucial flaw with the Graham amendment and restrictive formularies that might keep beneficiaries from getting help with their medications that they and their doctor prefer. If we look at the tripartisan plan, any drug that is available, generic or patent that is available, what the doctor and what the patient decide is best for them is going to be available. There is a lower copay for generic drugs. We want to promote generic drugs over patented drugs if that is possible, but for sure we should not in any way limit the availability of drugs as is being done under the Democrat plan.

We have a poster that shows that 100-percent brand name drugs, albeit approved by the FDA, are going to be available under the program we have in the tripartisan bill, but only 10 percent of the brand name drugs are covered by the Graham-Daschle-Kennedy plan, a Government-run process certain to be time consuming and bureaucratic. If a beneficiary wants to appeal the fact that the drug they want and their doctor wants for them is not available under the Kennedy plan, it is possible to go through a Government appeal process to get the preferred drug covered.

Why should we put people to that test of bureaucratic decisionmaking when we have other programs that are available to make the drug that the doctor wants and thinks best for that patient? We do have that in the tripartisan plan. Controls on the pharmacy that can participate in the program, surely this is the biggest gap in coverage.

In any case, the important point is it is going to take another act of Congress to continue the program once it sunsets in the year 2010. Once a program like this sunsets, it could be difficult to pass legislation which would be required to extend it. I do not think that is a particularly good deal for our seniors. Having a drug benefit that disappears into a black hole is a terrible idea, as sunseting is equivalent to disappearing into a black hole.

I would like to have Senators who are still in doubt about how they are going to vote this afternoon look at the tripartisan 21st century Medicare amendment as a reasonable alternative because it is bipartisan, because it is middle ground between the least expensive and the most expensive plans. It is not a big cost to Medicare, and it is something that brings permanency and that is predictable well into the future for Medicare. That is what we should have, and that is what we have in the tripartisan drug plan.

Any Senators on my side of the aisle who want to speak should get here soon.

I reserve the remainder of my time.

Mr. FEINGOLD. Mr. President, I rise today in strong support of a comprehensive and affordable prescription drug benefit for America's seniors. At the same time, we must modernize the entire Medicare benefits package by promoting regional equity in Medicare spending to ensure access to Medicare's basic services.

The absence of affordable prescription drug coverage for most seniors is devastating, and we must address this issue with the same vigor that our predecessors in Congress brought to their effort to enact the original Medicare program.

The addition of a prescription drug benefit will be the largest expansion of the Medicare program since it was initiated in 1965. But we should not simply add a benefit, we must get it right.

Congress must pass an attractive benefit with an affordable premium and a provision on catastrophic costs that is an insurance policy for all Medicare beneficiaries. While I recognize that the cost of any new benefit will be shared with Medicare beneficiaries, any deductibles or co-payments must be low enough to ensure significant participation in the program.

I am very encouraged that my colleagues from Florida and Georgia have recognized the importance of a comprehensive benefit through the Medicare program. It is affordable, comprehensive, and reliable. I am particu-

larly supportive of their effort to fund a defined benefit with no deductible.

While I am certainly open to working with my colleagues on the benefit structure, I am very concerned about proposals to enact this benefit outside the Medicare program that would amount to a privatized benefit. Past efforts to offer privatized benefits outside the Medicare benefit structure have simply not worked in Wisconsin.

The Medicare+Choice program has offered very few choices to most Wisconsin seniors. While the structures of some of the private Medicare prescription drug benefits are plainly different from the Medicare+Choice program, I remain concerned that states like Wisconsin will end up with few choices. As with Medicare HMOs in the Medicare+Choice program, Wisconsin seniors will likely be faced with little choice with Medicare prescription drug HMOs.

We must also harness the purchasing power of the Medicare program to ensure that the Federal Government gets a fair price for the prescription drug program. That's the reason why I support the Hatch-Waxman reforms in the underlying bill.

By closing a series of loopholes in the original Hatch-Waxman law, these reforms will increase competition by preventing brand-name pharmaceutical firms from blocking generic drugs from entering the market. While I strongly support the original Hatch-Waxman law because it promoted competition and consumer choices, the reforms in the underlying bill will modernize the law and strengthen competition in the marketplace.

If we simply allow pharmaceutical companies to dictate the price of prescription drugs to consumers, the cost of the prescription drug benefit will skyrocket out of control. I am not advocating price controls. But we must ensure that taxpayers and Medicare beneficiaries get a fair price.

And I have further concerns on behalf of American taxpayers, as each of the proposals we are likely to consider actually digs our deficit hole deeper at a time when our budget deficit already is getting worse every day.

In its recently released mid-session review of the budget, the Office of Management and Budget estimates that the budget deficit for the current fiscal year, the one ending on September 30, will be a whopping \$165 billion, and that includes the Social Security Trust Fund balances.

If you look at the real budget deficit—the one that does not use the Social Security Trust Funds to help mask our fiscal problems—the figure is \$322 billion.

The projected \$322 billion deficit for this year is just shy of the \$340 billion deficit that we faced when I was first elected to the U.S. Senate in 1992.

We spent the balance of the last decade climbing out of that deficit hole, and in the end, thanks to the virtuous cycle of fiscally responsible budget

policies and a growing economy, we were able to balance our books and actually began to pay down some of the massive Federal debt that was racked up during the 1980s and early 1990s.

But in the course of a little over a year, thanks in large part to the fiscally reckless tax cut enacted last year, the administration and Congress have squandered what was achieved during the previous eight years.

Even OMB's estimate of the real deficit over the next five years is over \$1 trillion! And that estimate may be based on overly optimistic assumptions.

It is against that backdrop that we are now considering Medicare prescription drug proposals.

There is no doubt that we need to modernize Medicare by adding a prescription drug benefit. I strongly favor such a reform. But we should find off-sets to fund a drug benefit.

It would be far better if we pay for this new program. Unless we pay for this needed reform, it will always be at risk of being severely cut back or even eliminated. Medicare beneficiaries can not rely on any drug benefit enacted under such circumstances, and we will do a disservice to them if we do so.

We must enact a real prescription drug benefit, one that provides meaningful help to seniors, and one which beneficiaries will know will be there for them when they really need it, not placed on the budget chopping block the instant it is enacted.

Congress could achieve some of these cost savings by modernizing other aspects of the Medicare program. For example, I am hopeful that the Senate will consider proposals to modernize the underlying Medicare program to promote regional fairness among Medicare beneficiaries.

We must address Medicare's discrimination against Wisconsin's seniors and health care providers. The Medicare program should encourage the kind of high-quality, cost-effective Medicare services that we have in Wisconsin. By encouraging this high-quality, low-cost care, we may well achieve cost savings to the program and offset part of the cost of a prescription drug benefit.

To give an idea of how inequitable the distribution of Medicare dollars is, imagine identical twins over the age of 65. Both twins worked at the same company all their lives, at the same salary, and paid the same amount to the Federal Government in payroll taxes, the tax that goes into the Medicare Trust Fund. But if one twin retired to New Orleans, LA, and the other retired in Madison, WI, they would have vastly different health care options under the Medicare system. The twin in Louisiana would get much more.

For example, in most parts of Louisiana, the first twin would have a wide array of options under Medicare. The high Medicare payments in those areas allow Medicare beneficiaries to choose between an HMO or traditional fee-for-

service plan, and, because area health care providers are reimbursed at such a high rate, those providers can afford to offer seniors a broad range of health care services. The twin in Madison would not have the same access to care. Because of low Medicare payments in Madison, there is no option to choose an HMO, and there are fewer health care agencies that can afford to provide care under the traditional fee-for-service plan.

How can two people with identical backgrounds, who paid the same amount in payroll taxes, have such different options under Medicare? They can because the distribution of Medicare dollars among the 50 States is grossly unfair to Wisconsin, and much of the Upper Midwest. Wisconsinites pay payroll taxes just like every American taxpayer, but the Medicare funds we get in return are much less than what other states receive.

The low payment rates received in Wisconsin are in large part a result of our historic high-quality, cost-effective practice of health care. In the early 1980s, Wisconsin's lower-than-average costs were used to justify lower payment rates. Since that time, Medicare's payment policies have only widened the gap between low- and high-cost states.

I have introduced a package of legislation that will take us a step in the right direction by reducing the inequities in Medicare payments to Wisconsin's hospitals, physicians, and skilled nursing facilities. At the same time, my proposals would establish pilot programs to encourage high-quality, cost-effective Medicare practices. My proposal would reward providers who deliver higher quality at lower cost. It would also require that the pilot states create plans to increase the amount of providers providing high-quality, cost-effective care to Medicare beneficiaries.

Congress must modernize Medicare and add a prescription drug benefit. It should do so in a fiscally-responsible manner. And it must also restore basic equity to the Medicare program and stop penalizing higher quality providers of Medicare services.

The issue before us is an important one. And it is important enough to do it right.

Mr. THOMPSON. Mr. President, I rise today to discuss the important issue of adding a prescription drug benefit to the Medicare program. As a part of the debate on this drug pricing bill, we are considering amendments to provide Medicare beneficiaries with coverage for their prescription drug costs. This would be the largest expansion of any Federal entitlement program since Congress enacted Medicare in 1965. And as I listen to the debate, I am concerned that this body is ignoring some very serious issues, namely the cost of what we are doing and whether we can afford to take this action given the current budget situation.

I think each of us here today would agree that the Medicare program is

outdated. If we were creating this program from scratch right now, there is no question that we would include coverage for prescription drugs. Medicines have become integral to the treatment of disease, in many cases replacing costly surgical procedures. However, in our desire to address one serious flaw in Medicare, I am concerned that we are missing the broader questions of the impact of our actions on future generations of taxpayers and on the sustainability of the Medicare program. We cannot legislate in a vacuum.

I want to begin my remarks by reminding my colleagues of the demographic time bomb we are facing in this country. The first wave of the 76 million baby boomers will begin retiring in 2008. Between now and 2035, the number of Americans over the age of 65 will double. We will go from having 3.4 workers to support Medicare and Social Security beneficiaries today to 2.3 workers by 2026. Not only is the over-65 population growing rapidly, but they are living longer. Increased life expectancy is a good thing, but it also has serious implications for the Federal budget and entitlement spending.

According to the Medicare Trustees' most recent report to Congress, the Medicare Part A Trust Fund is scheduled to be in a cash deficit beginning in 2016 and will go bankrupt in 2030. Spending on Medicare Part B, which covers outpatient services, is growing at a faster rate than our economy. Over the next 10 years, the Medicare trustees estimate that Part B spending will increase on average by 6.1 percent each year, compared to a growth rate in the economy of 5.1 percent per year. The Congressional Budget Office projects that Federal expenditures on Medicare, Social Security and Medicaid combined will grow from the current 7.8 percent of GDP to 14.7 percent of GDP in 2030. I think it's important to remember that the Federal Government has generally taken no more than 20 percent out of the economy in taxes to fund the government. Entitlement spending is moving dangerously close to that limit.

David Walker of the General Accounting Office testified before the Senate Budget Committee earlier this year, and he warned us that by 2030, absent any changes to Social Security and Medicare, there will be virtually no money left for discretionary spending such as national defense, education or law enforcement. This estimate does not take into consideration any new spending Congress may authorize, such as adding a Medicare prescription drug benefit or increasing Medicare payments to health care providers. As inadequate as the current Medicare program may be, it is not sustainable even in its current form.

In addition, I feel compelled to offer additional context to this debate. We all know that our world and budget situation have changed dramatically over the past 10 months. The latest projections from the Office of Management

and Budget are that our deficit this year could reach \$165 billion. In addition, the requirements of protecting our Nation and combating terrorism have placed urgent new claims on Federal resources.

In fiscal year 2002, we will spend at least \$29.2 billion on homeland security. The supplemental appropriations bill would spend an additional \$5.8 billion, bringing the total to nearly \$38 billion. The President's budget request for fiscal year 2003 proposes spending of \$37.7 billion for homeland security. This amount is double what we were spending on homeland security items prior to the September 11 attacks. The Brookings Institute recently recommended funding of \$45 billion for fiscal year 2003 on homeland security.

We are also in the process of considering the President's proposal to create a new Department of Homeland Security. The cost of creating this new department could be another billion dollars. The truth is that we just don't have a good notion of how much homeland security spending will cost in the coming years, but we know that the costs will be tremendous, and we know that we must spend whatever it takes.

On top of these security-related claims on our Federal resources, we need to remember that a majority of Congress just voted to increase spending on farmers by \$90 billion above the current level over the next 10 years. I opposed that legislation, because I believe much of that money would be better spent on other priorities, including a prescription drug benefit. And let us not forget that we voted in May to create a new, \$20 billion federal health care entitlement for workers displaced by trade. These things add up. We're spending money we no longer have.

I do believe that Congress should address the needs of the one-third of seniors who have no prescription drug coverage now. But when I look at the cost of adding a prescription drug benefit, it is clear to me that there is just no inexpensive way to provide seniors with a meaningful drug benefit. CBO projects that seniors' spending on prescription drugs over the next 10 years will be \$1.8 trillion. That is 21 percent higher than CBO's 10-year estimate from last year. Although two-thirds of that increase is due to the changing budget window, dropping the low-cost year, 2002, and adding the higher cost year, 2012, this projection still concerns me.

The various Medicare prescription drug proposals we are debating have 10-year cost estimates ranging from a low of \$150 billion for the Hagel/Ensign, bill to \$370 billion for the tripartisan bill, to as much as \$600 billion for the Graham/Kennedy bill. Can we really rely on the accuracy of these numbers?

Last year's budget resolution set aside \$300 billion over 10 years for Medicare modernization and a prescription drug benefit. My colleagues on the

other side of the aisle strongly supported that \$300 billion number as sufficient to pay for a Medicare drug benefit. If we were to trend that \$300 billion forward one year, we would be looking at a \$350 billion drug package. This year, the budget resolution that was reported by the Senate Budget Committee, but never passed by the full Senate, contains \$500 billion over 10 years for a Medicare prescription drug benefit and for increased Medicare provider payments and for providing health coverage to the uninsured. How is it that we are even considering a \$600 billion bill that would only provide prescription drug coverage?

I am firmly in the camp of those who believe that we should not add a prescription drug benefit to Medicare without also making much-needed changes to strengthen the program. The Medicare and Social Security Trustees advise us that we can make relatively small changes now to put the Medicare and Social Security programs on sound financial footing for the future. But, the longer we wait, the harder it will be. This debate over a Medicare prescription drug benefit provides us with an excellent opportunity to begin taking steps that will make Medicare sustainable over the long term.

I want to commend the members of the tri-partisan group for their efforts to put us on the path toward a strengthened Medicare program. They have worked hard for more than a year to craft their bill to provide a reasonable and permanent drug benefit, unlike the proposal of my colleague from Florida. And, they have drafted the only proposal that makes any meaningful improvements to the Medicare program. I believe that the tri-partisan proposal would provide greater security for today's seniors and for tomorrow's seniors. The new fee-for-service plan, Medicare Part E, would make the transition to Medicare more seamless for those Americans who are beginning to age into the Medicare program by providing them with a benefit that more closely resembles the private health plan they are used to. The tri-partisan bill would also provide seniors with protection from unusually high health care costs for the first time.

I am deeply disappointed that the Finance Committee has not been given the opportunity to mark up either the tri-partisan bill or any other Medicare prescription drug bill. It is a shame that the Majority Leader has decided once again to by-pass the committee process, which might have yielded a product that could garner the 60 votes needed to pass a Medicare prescription drug benefit. Even more important is that we would not be in the current parliamentary situation of needing 60 votes to waive a budget point of order on these bills if the Senate had passed a budget this year.

In the likely event that neither of two comprehensive prescription drug proposals garners 60 votes, then I would

hope we could at least pass the Hagel/Ensign proposal. The Hagel/Ensign amendment would provide the neediest seniors with assistance with their prescription drug costs. It would allow all seniors to benefit from group discounts. And, it would provide all seniors with protection from unusually high drug costs. These benefits could be implemented immediately, and the proposal would buy us time to find bipartisan consensus on an affordable, comprehensive Medicare prescription drug benefit.

I hope we can carry forward the spirit of the tri-partisan group and work together to address the needs of our seniors who lack prescription drug coverage, bring Medicare into the 21st century and set it on sound financial footing, and do so while recognizing the new budget world in which we live.

I suggest the absence of a quorum. The PRESIDING OFFICER (Mrs. CARNAHAN). The clerk will call the roll. The bill clerk proceeded to call the roll.

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

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

Mr. GRASSLEY. Madam President, I yield back our 3 minutes.

The PRESIDING OFFICER. All time is yielded back.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

EXECUTIVE SESSION

NOMINATION OF RICHARD H. CARMONA, OF ARIZONA, TO BE MEDICAL DIRECTOR IN THE REGULAR CORPS OF THE PUBLIC HEALTH SERVICE, AND SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE

CLOTURE MOTION

The PRESIDING OFFICER. Under the previous order, the Senate will now go into executive session and proceed to the cloture vote on Executive Calendar No. 921, which the clerk will report.

The bill clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on Executive Calendar No. 921, the nomination of Richard H. Carmona, of Arizona, to be the Surgeon General of the Public Health Service:

Edward M. Kennedy, Debbie Stabenow, Tom Daschle, Harry Reid, Jack Reed, Richard J. Durbin, Barbara Mikulski, Patrick Leahy, Jean Carnahan, Tom Carper, Byron L. Dorgan, Paul Wellstone, Jon Corzine, Jeff Bingaman, Daniel Inouye, Kent Conrad.

The PRESIDING OFFICER. By unanimous consent, the mandatory quorum call has been waived.

The question is, Is it the sense of the Senate that debate on Executive Calendar No. 921, the nomination of Richard H. Carmona, of Arizona, to be Medical Director in the Regular Corps of the Public Health Service, and to be Surgeon General of the Public Health Service, shall be brought to a close?

The yeas and nays are required under the rule.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. NICKLES. I announce that the Senator from North Carolina (Mr. HELMS) and the Senator from Pennsylvania (Mr. SPECTER) are necessarily absent.

The yeas and nays resulted—yeas 98, nays 0, as follows:

[Rollcall Vote No. 185 Exe.]

YEAS—98

Akaka	Dorgan	Lugar
Allard	Durbin	McCain
Allen	Edwards	McConnell
Baucus	Ensign	Mikulski
Bayh	Enzi	Miller
Bennett	Feingold	Murkowski
Biden	Feinstein	Murray
Bingaman	Fitzgerald	Nelson (FL)
Bond	Frist	Nelson (NE)
Boxer	Graham	Nickles
Breaux	Gramm	Reed
Brownback	Grassley	Reid
Bunning	Gregg	Roberts
Burns	Hagel	Rockefeller
Byrd	Harkin	Santorum
Campbell	Hatch	Sarbanes
Cantwell	Hollings	Schumer
Carnahan	Hutchinson	Sessions
Carper	Hutchison	Shelby
Chafee	Inhofe	Smith (NH)
Cleland	Inouye	Smith (OR)
Clinton	Jeffords	Snowe
Cochran	Johnson	Stabenow
Collins	Kennedy	Stevens
Conrad	Kerry	Thomas
Corzine	Kohl	Thompson
Craig	Kyl	Thurmond
Crapo	Landrieu	Torricelli
Daschle	Leahy	Voinovich
Dayton	Levin	Warner
DeWine	Lieberman	Wellstone
Dodd	Lincoln	Wyden
Domenici	Lott	

NOT VOTING—2

Helms Specter

The PRESIDING OFFICER. On this vote, the yeas are 98, the nays are 0. Three-fifths of the Senators duly chosen and sworn having voted in the affirmative, the motion is agreed to.

The Senator from Arizona.

Mr. MCCAIN. Thank you, Madam President. It is my understanding we are now in postcloture debate time; is that correct?

The PRESIDING OFFICER. The Senator is correct.

THE ANDEAN TRADE PREFERENCE ACT

Mr. MCCAIN. Madam President, I want to take a few minutes to talk about the failure of the Congress to enact the Andean Trade Preference Act, the importance of this issue in our hemisphere, and the absolute criticality of us acting before we go out for the August recess on the Andean Trade Preference Act.

Madam President, America is facing a crisis in its relations with our Latin