

happens is, because we refuse to regulate our consumption or reduce it substantially—because, frankly, we can reduce some through technology and through alternatives, but we just can't restrict consumption because we will restrict economic growth, which we do not want to do.

But what happens, then, is we begin importing from other countries, countries that have lower environmental standards than we do, countries that have less capacity to enforce the meager regulations they have on the books, countries that are more desperate for jobs. Although we want them, there are countries desperate for them. So, inadvertently, we end up increasing pollution, damaging the world environment because we refuse to adopt common-sense principles, which are to extract national resources and develop energy on our own soil, off our own continental shelf, and minimize the degradation internationally.

If anybody wants to come to the Senate floor and debate that with me, I will be more than happy to debate it because I am scrambling for information. Perhaps I have gotten information incorrectly.

I am very concerned because America consumes so much oil and so much gas. I know a lot of that production comes from the Mideast. But now we are asking it of Venezuela and now we are asking countries in Africa. They want to, of course, because if they ship oil to us, their countries make money. They put their people to work. I understand that. We produce a lot of oil and gas.

But I am also well aware, as a producer, of the environmental degradation that can occur if we do not have strong rules and regulations, strong court systems, and a mature political system that can monitor it.

I say to the leaders in our country, when we force production off of our shore, we damage the international environment. It is not right. If some environmental organizations want to challenge that comment, then please do it. I urge them to send mail to me or send e-mails to me and tell me why I am wrong; that we can easily and clearly and without damage drill in other places of the world.

I don't believe it because I know what we went through in the Louisiana Legislature over 20 years ago, led by a group of very great legislators, to try to bring good rules and regulations to the industry. Now the industry is doing much better. But 30 and 40 years ago, people were not too interested in environmental rules and regulations. So I know what can occur when the rules and regulations are not there.

I wonder how the people of California or Florida might feel about the fact that, because they refuse to produce, somebody is producing somewhere for them, in places that do not have rules and regulations like they do, in places they cannot be enforced.

What about the children who live in those areas? What about the families

who are struggling with meager incomes? What environmental legacies are we leaving in Third World countries around the globe?

For all the reasons—for independence, for national security, for jobs, for the economy, and for making this world a more beautiful place than we found it when we got here—I urge this Senate to take seriously the bill that is being put forward by both Senators from New Mexico, the chairman, and the ranking member, to pass an Energy bill before we leave for the August break. I will stand with them. The people of Louisiana support this bill.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred in San Jose, CA. On September 14, 2001, a young Muslim university student was forcibly elbowed out of line in a coffee shop. After pushing the young student, the man then told the clerk, "I'm an American, serve me first."

I believe that Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

THE ASSAULT WEAPONS BAN

Mr. LEVIN. Mr. President, in 1994 I supported legislation which President Clinton signed into law a banning of the production of certain semiautomatic assault weapons and high-capacity ammunition magazines. The 1994 law banned a list of 19 specific weapons as well as a number of other weapons incorporating certain design characteristics such as pistol grips, folding stocks, bayonet mounts, and flash suppressors. The 1994 assault weapons ban prohibited the manufacture of semiautomatic weapons that incorporate at least two of these military features and accept a detachable magazine. Pre-existing military-style semiautomatic weapons were not banned. This law is

scheduled to sunset on September 13, 2004.

Earlier this year, Senator FEINSTEIN introduced the Assault Weapons Ban Reauthorization Act, which would reauthorize this important piece of gun safety legislation. I am a cosponsor of this bill because I believe it is critical that we keep these weapons off the streets and out of our communities. Senator FEINSTEIN's bill also includes a provision that would ban the importation of large capacity ammunition feeding devices. This provision passed the Senate 59 to 39, as an amendment to the 1999 Juvenile Justice bill, and passed the House by unanimous consent. However, the 106th Congress never passed the Juvenile Justice bill because it got stuck in conference, and thus the import ban never became law.

Studies have shown that the assault weapons ban legislation works. According to National Institute of Justice statistics reported by the Brady Campaign to Prevent Gun Violence, gun trace requests for assault weapons declined 20 percent in the first calendar year after the ban took effect, dropping from 4,077 in 1994 to 3,268 in 1995. This indicates that fewer of these weapons were making it onto the streets.

If the law is not reauthorized, the production of assault weapons can legally resume. Restarting production of these weapons will increase their number and availability and inevitably lead to a rise in gun crimes committed with assault weapons. The Congress should act this year to reauthorize the ban.

PRESCRIPTION DRUG AND MEDICAL CARE IMPROVEMENT ACT OF 2003

Mrs. LINCOLN. Mr. President, I rise today to reflect on the recently passed Prescription Drug and Medicare Improvement Act of 2003, S.1. I am pleased to support this bipartisan effort both in the Senate Finance Committee and here on the floor. I believe this bill represents a positive compromise and a good start for America's senior citizens and individuals with disabilities who have relied on the Medicare Program for generations. I hope that the conferees act deliberately and fairly in the coming weeks to embrace what is good about this bill and to retain its bipartisan spirit. This process has been a long road for many of us who have worked on this issue for years but it has been an even longer road for America's seniors, who have watched drug prices escalate while Washington failed to act. Like all legislative products, this bill is not perfect. I have worked to improve this bill for Arkansas seniors in many ways, and I am committed to correcting any problems with it as it is implemented.

Despite its shortcomings, which I will detail later, S. 1 is much better for Arkansans than the plan President Bush proposed earlier this year. First and foremost, S. 1 gives all Medicare beneficiaries access to a prescription drug benefit. Under President Bush's

proposal, Arkansas seniors who wanted a drug benefit would have been forced to drop out of traditional Medicare and enroll in a private HMO instead, even though such a plan may not have been available in their area. Under the President's plan, seniors who remained in traditional Medicare would have received nominal discounts on prescriptions and a limited catastrophic benefit if they had extremely high drug expenses. I have said all along that it is simply unfair to deny a prescription drug benefit to beneficiaries in traditional Medicare. All 442,000 Medicare beneficiaries in Arkansas are currently enrolled in traditional Medicare with no access to Medicare + Choice because private insurance companies found the profit margin of health care insurance in rural areas to be too small. That is why Medicare needs to be there as a safety net. That is why prescription drug coverage must be a part of traditional Medicare. That is why the guarantee in S. 1 that traditional Medicare will pick up the slack where private insurers decline to operate needs to remain in the final version of this new policy.

Second, I helped ensure that S. 1 provides special assistance to our State's most vulnerable seniors—those with low incomes. Over 40 percent of Medicare beneficiaries in Arkansas have incomes below 160 percent of the Federal Poverty Level—in 2003, \$14,368 for a single and \$19,392 for a couple—and simply cannot afford to fill their prescriptions. These are the seniors who struggle to pay for food, heat, and other necessities in order to afford their lifesaving drugs, and I hear from them often. I fought in the Senate Finance Committee to ensure that seniors under 160 percent of poverty would get special assistance with their premiums, deductibles, and cost-sharing. Those with very low incomes who also qualify for an assets test would receive more generous help. I helped improve the low-income provisions even more on the Senate floor by working with Senators BINGAMAN and DOMENICI to increase the asset test levels from \$4,000 to \$10,000, adjust these levels yearly for inflation, and reduce the paperwork burden for eligible seniors. Because this amendment passed, many more seniors in Arkansas will receive help with the cost-sharing imposed under this bill. Today, lower income seniors only fill about 20 prescriptions per year, compared to an average of 32 for those with prescription drug insurance. These provisions will help ensure that lower-income beneficiaries will be able to afford to fill their prescriptions, keeping them healthier and helping them live longer.

I succeeded in including in S. 1 a number of other provisions that will improve the Medicare Program for Arkansas for many years to come. Two such provisions are based on legislation I introduced earlier this year, the Geriatric Care Act, S. 387. My first provision would provide for a 3-year dem-

onstration project in Arkansas and five other sites on complex, chronic care management. Once this demonstration project is completed, S. 1 allows the Secretary of Health and Human Services, HHS, to use its findings to add this service as a part of traditional Medicare from 2009 to 2013 as long as it costs no more than \$6 billion.

More than 80 percent of Medicare dollars are spent on Medicare beneficiaries with three or more chronic conditions like Alzheimer's disease, cancer, or diabetes. Better care management for these seniors should improve patients' overall quality of life and reduce the need for expensive hospitalizations for chronic conditions. It is my hope that this further, more extensive study of chronic care management provided by geriatricians and their health care teams will prove this. We in Arkansas are blessed to have the Donald W. Reynolds Department of Geriatrics and the Center on Aging at the University of Arkansas for Medical Sciences, whose geriatric specialists have vastly improved the care for seniors across our State. These provisions will make it easier for our medical school and others across the country to better care for patients with chronic conditions while also training more physicians in geriatrics. The other provision included in S. 1 provides the Secretary of HHS with the authority to clarify that geriatric training programs are eligible for 2 years of fellowship support under Medicare. This change would help maintain incentives for fellows to continue into second-year training, a critical pathway to careers in academics and geriatric research.

S. 1 also allows the Secretary of HHS to cover preventive benefits that aren't currently covered under traditional Medicare between the years 2009 to 2013. I have long fought to add new preventive services to Medicare, such as cholesterol screening, medical nutrition therapy services for beneficiaries with cardiovascular disease, counseling for cessation of tobacco use, and diabetes screening. These benefits are especially important for women, who are the majority of Medicare recipients and who make up 71 percent of the Medicare population over 85 years of age. By encouraging women to get screened for diseases like heart disease, osteoporosis, and breast cancer, we can save and improve lives.

I also succeeded in including my legislation, S. 1114, to provide Medicare coverage for kidney disease education services. Each year, some 80,000 people are diagnosed with chronic kidney failure—also known as end-stage renal disease (ESRD). Patients with ESRD require regular kidney dialysis treatments or a transplant to survive, and most are entitled to have this care paid for by the Medicare Program. Unfortunately, many of these renal patients are never informed that, prior to kidney failure, there are a number of steps they can take to improve their chances

of having better outcomes with dialysis. Medicare currently requires that ESRD patients receive education on treatment options—but not until after the patient is already under the care of a dialysis clinic. Unfortunately, by then it is essentially too late to take advantage of much of the information. My provision makes counseling available to patients before dialysis is initiated to help patients understand all the therapies available for the treatment of ESRD. My amendment will save money and improve patient care.

I also succeeded in including an important amendment to ensure Medicare coverage for insulin syringes. Before my amendment, S. 1 provided no coverage for insulin syringes although it did provide coverage for insulin. Roughly 40 percent of the senior population with diabetes, or 1.8 million seniors, use syringes to inject insulin into their bodies to control their diabetes every day. Without coverage, syringe purchases—which can be especially expensive for seniors on fixed incomes—would not count towards cost-sharing and yearly maximum out-of-pocket expenses. My amendment changed that. Now, the bill ensures coverage for syringes and other necessary medical supplies associated with administering insulin as determined by HHS. Providing coverage for insulin syringes will help diabetic seniors who take insulin keep their disease under control. Syringe coverage will help seniors manage or prevent long-term complications of diabetes like kidney failure, blindness, and amputations by helping to keep blood glucose levels in a normal range.

I was also able to include a 3-year, 5-site demonstration project to determine the merits of allowing Medicare beneficiaries direct access to physical therapists' services within the Medicare Program, as authorized by State law. Currently, some 37 States, including Arkansas, allow direct access to physical therapist services. While non-Medicare patients can directly access such services in these States, Medicare beneficiaries are restricted from such access by the requirement that they obtain a referral from another practitioner. Requiring a referral is unnecessary and limits access to timely and medically necessary physical therapist services. This demonstration, which is designed to be budget neutral, will determine if direct access does in fact improve patient care and save Medicare money.

I also worked with Senator CRAIG THOMAS to include a bill we sponsored together, S. 310, to provide Medicare coverage of licensed professional counselors and marriage and family therapist services. Although the rate of suicide among seniors is higher than for any other age group, fewer than 3 percent of seniors report seeing mental health professionals for treatment. Lack of access to mental health providers is one of the primary reasons why older Americans don't get the

mental health treatment they need. Not surprisingly, this problem is exacerbated in rural areas. Licensed professional counselors are often the only mental health specialists available in rural communities. This is true in Arkansas, where 91 percent of Arkansans reside in a mental health professional shortage area. This provision will significantly increase the number of Medicare-eligible mental health providers in Arkansas, providing better access for patients.

I was successful in working with Senator CANTWELL on an amendment that will restrict pharmacy benefit managers (PBMs), and require the Department of Justice and the Health and Human Services Inspector General to review PBM financial practices for any potential collusion between PBMs and drug manufacturers on drug pricing and availability. I also supported an amendment with Senator ENZI to ensure that pharmacists have the option of offering 90-day prescriptions when they are also offered by mail order.

I sponsored an amendment with Senator JOHN ENSIGN to repeal the \$1,590 cap on outpatient physical therapy, occupational therapy, and speech-language pathology. The current therapy cap discriminates against the most vulnerable of Medicare beneficiaries. While the majority of enrollees will not exceed an annual \$1,590 limitation on rehabilitation services, approximately 13 percent of seniors and individuals with disabilities covered by Medicare will be forced to pay for medically necessary services out of pocket. This is a particularly burdensome situation for beneficiaries living in rural communities. Most likely to be harmed are beneficiaries who have experienced a stroke or hip fracture or who have Parkinson's disease or other conditions that require extensive rehabilitation following injury or illness. Before Senator ENSIGN and I withdrew our amendment to repeal this cap, we discussed the amendment on the floor with the chairman of the Finance Committee, Senator GRASSLEY, who promised to work in the conference committee to enact a moratorium on the therapy cap.

I also succeeded in including a number of my amendments during debate of the bill in the Senate Finance Committee. The committee adopted my amendment to waive temporarily the late enrollment penalty for military retirees and their spouses who sign up for Medicare Part B and to permit year-round enrollment so that retirees can access the new benefits immediately. Currently, military retirees and their spouses who do not join Medicare Part B when initially eligible can only do so during the annual open enrollment season. This amendment was needed because many retired beneficiaries previously saw no value in enrolling in Medicare Part B because they believed they were promised lifetime health care in military treatment facilities, many of which were subse-

quently closed due to base realignment and closure.

The committee also adopted my amendment to establish an adult day services demonstration project for home health beneficiaries. A bill I introduced earlier this year, S. 1238, would give Medicare beneficiaries the option to receive their Medicare home health services in an adult day setting. This would be a substitution, not an expansion, of services and is designed to be budget neutral. The option of Medicare home health services in an adult day location has a number of important advantages for beneficiaries and their families, including: increased social interaction, therapeutic activities, nutrition, health monitoring, medication management, and enabling family caregivers to continue working, since care would be provided all day. More than 22 million families nationwide, or nearly one in four families, serve as caregivers for aging seniors, providing close to 80 percent of the care to individuals requiring long-term care. Nearly 75 percent of people providing care for aging family members are women who also maintain other responsibilities, such as working outside of the home and raising young children. The average loss of income to these caregivers has been shown to be over \$650,000 in wages, pension, and Social Security benefits. The loss of productivity in U.S. businesses ranges from \$11 to \$29 billion a year. The services offered in adult day care facilities provide continuity of care and an important sense of community for both the senior and the caregiver. This important demonstration project will benefit women of all ages.

The bill also includes my amendment to ensure that Medicare Quality Improvement Organizations (QIOs), can assist providers, practitioners, benefit administrators and plans to improve the quality of care under the new Medicare drug benefit system. This will be consistent with the role that QIOs already play in ensuring quality health care.

These initiatives, among others, will dramatically improve the Medicare Program. I am also pleased that S. 1 includes a number of provisions that I have cosponsored over several years that will significantly help rural health care providers in Arkansas keep their doors open to Medicare beneficiaries. By correcting a disparity in the way the Medicare physician fee schedule values physician work, practice expenses, and professional liability insurance, Medicare will pay rural physicians more fairly for treating Medicare patients. Also, the bill contains several provisions contained in my bill with Senators CONRAD and THOMAS, S. 816, to correct the disparities in Medicare payments to rural hospitals. Rural physicians and hospitals in Arkansas will receive millions of dollars of extra Medicare reimbursements under this bill.

And now that I have discussed some of the positive aspects of this bill, I

would like to focus on some of my concerns regarding other provisions.

I am concerned that private, drug-only plans may not provide the stability or predictability that seniors want and need. The insurance companies have told me they don't want to offer a prescription drug-only plan. The administrator of the Centers for Medicare and Medicaid Services has said such a plan "doesn't exist in nature." And, quite frankly, I believe we have proven through the Medicare, Medicaid, and Veteran's program that the Government can do it in a more cost-effective manner.

That is why I am glad the bill contains a Medicare guaranteed drug plan—or safety net—called the fallback. However, the fallback is that it is available for seniors for only 1 year at a time. That means if private insurers decide to test whether they want to offer the benefit in a community, seniors lose access to the fallback plan, even if the new plan is significantly more expensive for them or more restrictive. I offered an amendment to S. 1 that would have provided more stability for seniors by giving the fallback a 2-year contract instead of one. This would prevent seniors from having to switch plans from year to year with no end in sight. Although my amendment failed on a narrow margin, I will continue to try to improve the stability of the drug benefit by enacting this small, but important change to the fallback before the benefit starts in 2006.

I am also concerned about the fact that drug plans will vary throughout the country, meaning that seniors in Arkansas may have different premiums, cost-sharing, and formularies than seniors in other States. And, even worse, these plans can change their premiums, cost-sharing, and formularies every other year. I voted for many amendments to make the prescription drug benefit less volatile for seniors. For example, to reduce the variance in premiums across the country, I supported an amendment to limit variations in the amount seniors have to pay in premiums to only 10 percent above the national average, no matter where they live. I felt that we should give seniors some assurance that their premiums will not vary or increase unreasonably. Currently, all Medicare beneficiaries pay a \$58.70 premium for physician services no matter where they live. Seniors should have this same stability in the drug benefit. I am concerned that under S.1, seniors in rural areas, who are often older and sicker, will pay higher premiums than seniors in urban areas. Unfortunately, this amendment to stabilize the premium was defeated. However, I succeeded in the Senate Finance Committee in passing an amendment with Senator SNOWE to encourage the Secretary of Health and Human Services to geographically adjust payments to plans to account for differences in drug utilization across service areas so that premiums wouldn't vary as much.

I voted for many other amendments to strengthen the drug benefit in this bill but they failed. I voted to make the drug benefit more attractive to seniors by closing the "coverage gap" that exists in S. 1. This gap may penalize sick seniors. Once a senior's total drug spending reaches \$4,500 for the year, the benefit shuts down until her total drug expenditures reach at least \$5,813, unless the senior qualifies for low-income protections. I voted to allow employer-sponsored retiree health plans contributions to count in this gap. I voted to eliminate the coverage gap altogether. I voted to prevent seniors from paying premiums when they are in the coverage gap. Unfortunately, all these amendments were defeated. I will seek to work with my colleagues to close this coverage gap before the benefit starts.

I also voted for amendments to contain the skyrocketing costs of prescription drugs. One measure that I supported, which passed, seeks to increase access to more affordable and equally effective generic drugs. I also voted for an amendment, which failed, to help consumers better compare the cost-effectiveness of prescription drugs. Finally, I voted for a successful amendment to allow wholesalers and pharmacists to import prescription drugs from Canada, which will provide substantial savings to consumers while ensuring their safety.

Another concern I have about S. 1 is its \$6 billion experiment that starts in 2009 to test whether private insurance plans are more efficient and less costly than Medicare. To me and many others, the evidence we have already speaks to the fact that Medicare is more efficient. The Congressional Budget Office, the General Accounting Office, and outside experts all agree that private, preferred provider organizations and managed care plans cannot achieve the efficiencies Medicare can due to their need to make profits. Given these findings, I wonder how much of the "savings" this demonstration project seeks to achieve will come from privatization and how much will come from shifting more costs to seniors and health care providers? More importantly, I wonder why we couldn't have used the \$6 billion to reduce drug costs to seniors by making the benefit better?

Medicare provides health care for a special population of Americans—millions of seniors, individuals with disabilities, and people with kidney failure—those who are uninsurable in the private market. Congress created Medicare in the first place because private insurance plans were failing to provide affordable health care coverage for this high-risk population. I wonder why we must turn back the clock and commit billions of taxpayer dollars to again test whether the private insurance market wants to insure this population.

In conclusion, much has been accomplished but more needs to be done. I

look forward to the deliberations of the conference committee and urge my colleagues to engage with me and others in the Senate who are eager to get a good bill signed into law. I hope my friends on the conference committee will retain the Senate low-income assistance provisions, for they are far superior to those in the House bill. This low-income assistance is of special importance to our nation's older women. Of the 19.5 million female Medicare beneficiaries over age 65, 12.4 percent or 2.4 million enrollees live on incomes that are below 100 percent of the Federal Poverty Level. Another 3.2 million, 16 percent, live on incomes between 100 percent and 150 percent of poverty. Of senior men, on the other hand, only 7 percent are below poverty and another 11 percent are between 100 percent and 150 percent of poverty. Medicare seniors are disproportionately women and disproportionately poor, and will be far better served by the Senate's low-income provisions.

Our parents and grandparents are depending on us, and we must not let them down once again. I hope that partisan politics do not stand in the way of a drug benefit that is available to all seniors under traditional Medicare.

STROM THURMOND: POLITICIAN AND PATRIOT

Mr. ALLARD. Mr. President, I rise to pay tribute to our colleague and a friend, Strom Thurmond. We were all deeply moved by the recent passing of this gracious gentleman, and I would like to take a few minutes to reflect on his rich life and to honor his memory.

Strom Thurmond had a long and distinguished career. Over recent weeks we have heard many descriptions of the achievements of this remarkable man. But Senator Thurmond was distinguished for much more than the length of his Senate service or the number of "firsts" he achieved during his life. Rather, Senator Thurmond is distinguished by his love for America. For although Strom Thurmond was perhaps best known as a politician, he was first and foremost a patriot. His military service, his time as a governor, and his tenure in the U.S. Senate were all fueled by his deep and abiding love for America.

Just as deep as his love for America was his love for South Carolina and its residents. Senator Thurmond and his staff were well known for their accessibility and outstanding constituent service. He believed in hard work and service, and never shied away from his convictions.

That same accessibility and attitude of service carried over to his interaction with fellow members as well. I was honored to serve with Senator Thurmond on the Armed Services Committee, and I still remember the helpful guidance he gave me as a new member on the committee. His passion for our military members and his concern for their well-being was evident, and I

hope that I can emulate that same care.

I also remember how generous Senator Thurmond was with his personal time. Obviously as a senior Member of the Senate and the Senate President pro tempore he had a number of responsibilities. However, he still made time to serve this member. Several years ago I was honored when he graciously agreed to speak at the Capitol Conference I hold for Colorado constituents each year. To this day I am deeply appreciative of the time that he spent making remarks, fielding questions, and taking photos with my constituents. Many of the participants later remarked on his wit and vitality, remarkable for any member, but especially for one of his years. Even in their short time with him they were able to see the courtesy and conviction that we witnessed each day.

I feel fortunate to have had the opportunity to get to know Strom Thurmond as the person behind the military hero and political legend. To see the small ways in which he expressed his interest in and appreciation for those around him, such as taking the Senate pages for ice cream. He also expressed personal concern about the health and well being of his staff and Members, which was perhaps necessitated in some part by the candy he was always handing out. I only hope that we can all learn from and retain some part of his charm, confidence, depth of conviction, and commitment.

Although Strom Thurmond may no longer be here with us physically, his legacy will live on. The United States Senate and America are better for his strength, service, and self-sacrifice.

Finally, I would like to take this opportunity to express my sincere condolences to Senator Thurmond's family and friends. He was a proud father, and recently, grandfather. His love for his family was well known, and our thoughts and prayers are with them. My wife Joan and I hope that they are able to find comfort and peace during these difficult days.

I am proud to have called Strom Thurmond my colleague and friend, and today I join the rest of America in honoring this great service and mourning his passing.

Mr. SESSIONS. Mr. President, I rise today as we remember the Honorable Senator from South Carolina, Strom Thurmond. The accomplishments of this man in his 100 years of life were truly amazing. All that he did for his State and our Nation make all Americans proud. He was a vigorous, positive person who unrelentingly worked for a better America.

Senator Thurmond was born on December 5, 1902 in Edgefield, SC. He received his undergraduate degree from then Clemson College, now Clemson University, in 1923. He studied law under his father, Judge William Thurmond and, in 1930, was admitted to the South Carolina Bar. For 8 years, from 1930 to 1938, he served as the Edgefield