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Senate

The Senate met at 9:30 a.m. and was called to order by the President pro tempore (Mr. STEVENS).

The PRESIDENT pro tempore. Today's prayer will be offered by our guest Chaplain, Rabbi Milton Balkany of the Congregation Bais Yaakov of Brooklyn, NY.

PRAYER

The guest Chaplain offered the following prayer:

Our Father in heaven!

I sing You a song for the blessed United States of America. I sing a hopeful song for the peace and tranquility that we seek. Every patriotic soul joins me and our voices blend in heartfelt harmony. Let our notes wend their way from the hot Mojave sands to the cool waters of the Great Lakes. Let our song echo in the footsteps of Lewis and Clark as they courageously unraveled the mysteries of this free land. Let our lyrical prayer soar up the peaks of Mount Hood and Mount McKinley until they reach the summit of Your glory and Your mercy.

Though our voices are many, though our accents and inflections are as different as the day is long, our song is one and our one song is plain and true and unchanging. We sing: peace. Peace. True Peace. Bring us back to the times of fearless skies and unbridled New York nerve, of tranquil school yards and cool back porch nights. Return these times to us, O G-D. And we will return to You—with a new song, a mighty, rapturous chorus of jubilation!

Amen!

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE ACTING MAJORITY LEADER

The PRESIDENT pro tempore. The acting majority leader is recognized.

SCHEDULE

Mr. MCCONNELL. Mr. President, we will shortly resume consideration of S. 1, the prescription drug benefits bill. We have been in discussion with the distinguished assistant Democratic leader about votes later this morning. We hope to be able to have an announcement shortly about when the votes will commence. Obviously we will stay on this bill all day today. We will be finishing it this week, hopefully Thursday night. We are going to press forward and encourage Members to continue to offer their amendments. We will try to get votes as rapidly as we can.

Mr. REID. Mr. President, the amendment I understand that has been the focus of so much the last few days is prepared and the two leaders are looking this over. We hope to be able to have a vote on that soon. In the meantime, I have a lot of amendments lined up that we can move on and I will work with my distinguished friend, the majority whip, in determining when we can do that. We hope in the next hour we will start a bunch of votes. We will work on that and the majority will make an announcement soon.

Mr. MCCONNELL. I yield the floor.

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

The PRESIDENT pro tempore. Under the previous order, the hour of 9:30 having arrived, the Senate will proceed to consideration of S. 1, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

Pending:

Graham (FL) amendment No. 956, to provide that an eligible beneficiary is not responsible for paying the applicable percent of the monthly national average premium while the beneficiary is in the coverage gap and to sunset the bill.

Kerry amendment No. 958, to increase the availability of discounted prescription drugs.

Lincoln modified amendment No. 934, to ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin.

Lincoln amendment No. 935, to clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs.

Lincoln amendment No. 959, to establish a demonstration project for direct access to physical therapy services under the Medicare program.

Baucus (for Jeffords) amendment No. 964, to include coverage for tobacco cessation products.

Baucus (for Jeffords) amendment No. 965, to establish a Council for Technology and Innovation.

Nelson (FL) amendment No. 938, to provide for a study and report on the propagation of concierge care.

Nelson (FL) amendment No. 936, to provide for an extension of the demonstration for ESRD managed care.

Baucus (for Harkin) amendment No. 967, to provide improved payment for certain mammography services.

Baucus (for Harkin) amendment No. 968, to restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents.

Baucus (for Cantwell) amendment No. 942, to prohibit an eligible entity offering a Medicare Prescription Drug plan, a MedicareAdvantage Organization offering a MedicareAdvantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements.

Rockefeller amendment No. 975, to make all Medicare beneficiaries eligible for Medicare prescription drug coverage.

Akaka amendment No. 980, to expand assistance with coverage for legal immigrants under the Medicaid program and SCHIP to include citizens of the Freely Associated States.

Akaka amendment No. 979, to ensure that current prescription drug benefits to Medicare-eligible enrollees in the Federal Employees Health Benefits Program will not be diminished.

Bingaman amendment No. 972, to provide reimbursement for Federally qualified health centers participating in medicare managed care.

Bingaman amendment No. 973, to amend title XVIII of the Social Security Act to provide for the authorization of reimbursement for all Medicare part B services furnished by certain Indian hospitals and clinics.

Baucus (for Edwards) modified amendment No. 985, to strengthen protections for consumers against misleading direct-to-consumer drug advertising.

Baucus (for Lautenberg) amendment No. 986, to make prescription drug coverage available beginning on July 1, 2004.

Murray amendment No. 990, to make improvements in the MedicareAdvantage benchmark determinations.

Harkin amendment No. 991, to establish a demonstration project under the Medicaid program to encourage the provision of community-based services to individuals with disabilities.

Dayton amendment No. 960, to require a streamlining of the Medicare regulations.

Dayton amendment No. 977, to require that benefits be made available under part D on January 1, 2004.

Baucus (for Stabenow) amendment No. 992, to clarify that the Medicaid statute does not prohibit a State from entering into drug rebate agreements in order to make outpatient prescription drugs accessible and affordable for residents of the State who are not otherwise eligible for medical assistance under the Medicaid program.

Baucus (for Dorgan) amendment No. 993, to amend title XVIII of the Social Security Act to provide for coverage of cardiovascular screening tests under the Medicare program.

Grassley amendment No. 974, to enhance competition for prescription drugs by increasing the ability of the Department of Justice and Federal Trade Commission to enforce existing antitrust laws regarding brand name drugs and generic drugs.

Durbin amendment No. 994, to deliver a meaningful benefit and lower prescription drug prices.

Smith/Bingaman amendment No. 962, to provide reimbursement for Federally qualified health centers participating in Medicare managed care.

Hutchison amendment No. 1004, to amend title XVIII of the Social Security Act to freeze the indirect medical education adjustment percentage under the Medicare program at 6.5 percent.

Sessions amendment No. 1011, to express the sense of the Senate that the Committee on Finance should hold hearings regarding permitting States to provide health benefits to legal immigrants under Medicaid and SCHIP as part of the reauthorization of the temporary assistance for needy families program.

Sununu amendment No. 1010, to improve outpatient Vision services under part B of the Medicare program.

Conrad amendment No. 1019, to provide for coverage of self-injected biologicals under part B of the Medicare program until Medicare Prescription Drug plans are available.

Conrad amendment No. 1020, to permanently and fully equalize the standardized payment rate beginning in fiscal year 2004.

Conrad amendment No. 1021, to address Medicare payment inequities.

Clinton amendment No. 1000, to study the comparative effectiveness and safety of important Medicare covered drugs to ensure that consumers can make meaningful comparisons about the quality and efficacy.

Clinton amendment No. 999, to provide for the development of quality indicators for the priority areas of the Institute of Medicine, for the standardization of quality indicators for Federal agencies, and for the establishment of a demonstration program for the reporting of health care quality data at the community level.

Clinton amendment No. 953, to provide training to long-term care ombudsman.

Clinton amendment No. 954, to require the Secretary of Health and Human Services to develop literacy standards for informational materials, particularly drug information.

Reid (for Boxer) amendment No. 1036, to eliminate the coverage gap for individuals with cancer.

Reid (for Corzine) amendment No. 1037, to permit Medicare beneficiaries to use Federally qualified health centers to fill their prescriptions.

Reid (for Jeffords) amendment No. 1038, to improve the critical access hospital program.

Reid (for Inouye) amendment No. 1039, to amend title XIX of the Social Security Act to provide 100 percent reimbursement for medical assistance provided to a Native Hawaiian through a Federally-qualified health center or a Native Hawaiian health care system.

AMENDMENT NO. 988

Mr. THOMAS. I ask unanimous consent to lay aside the pending amendments.

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

Mr. THOMAS. I send an amendment to the desk.

The PRESIDENT pro tempore. The clerk will report.

The Senator from Wyoming [Mr. THOMAS], for himself and Mrs. LINCOLN, proposes an amendment numbered 988.

Mr. THOMAS. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To provide for the coverage of marriage and family therapist services and mental health counselor services under part B of the medicare program, and for other purposes)

At the end of subtitle B of title IV, add the following:

SEC. ___. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM.

(a) COVERAGE OF SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

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

(B) in subparagraph (V)(iii), by inserting ''and'' after the semicolon at the end; and

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

''(W) marriage and family therapist services (as defined in subsection (ww)(1)) and mental health counselor services (as defined in subsection (ww)(3));''.

(2) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Marriage and Family Therapist Services; Marriage and Family Therapist; Mental Health Counselor Services; Mental Health Counselor

''(ww)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

''(C) in the case of an individual performing services in a State that provides for licensure or certification of marriage and family therapists, is licensed or certified as a marriage and family therapist in such State.

''(3) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(4) The term 'mental health counselor' means an individual who—

''(A) possesses a master's or doctor's degree in mental health counseling or a related field;

''(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

''(C) in the case of an individual performing services in a State that provides for licensure or certification of mental health counselors or professional counselors, is licensed or certified as a mental health counselor or professional counselor in such State.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

''(v) marriage and family therapist services and mental health counselor services;''.

(4) AMOUNT OF PAYMENT.—Section 1833(a)(1) (42 U.S.C. 1395*l*(a)(1)) is amended—

(A) by striking ''and (U)'' and inserting ''(U)''; and

(B) by inserting before the semicolon at the end the following: '', and (V) with respect to marriage and family therapist services and mental health counselor services under section 1861(s)(2)(W), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under subparagraph (L)''.

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING

FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended in section 301(a), is amended by inserting ''marriage and family therapist services (as defined in subsection (ww)(1)), mental health counselor services (as defined in section 1861(ww)(3)),'' after ''qualified psychologist services,''.

(6) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clauses:

''(vii) A marriage and family therapist (as defined in section 1861(ww)(2)).

''(viii) A mental health counselor (as defined in section 1861(ww)(4)).''.

(b) COVERAGE OF CERTAIN MENTAL HEALTH SERVICES PROVIDED IN CERTAIN SETTINGS.—

(1) RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''or by a clinical social worker (as defined in subsection (hh)(1)),'' and inserting '', by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (ww)(2)), or by a mental health counselor (as defined in subsection (ww)(4)),''.

(2) HOSPICE PROGRAMS.—Section 1861(dd)(2)(B)(i)(III) (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by inserting ''or a marriage and family therapist (as defined in subsection (ww)(2))'' after ''social worker''.

(c) AUTHORIZATION OF MARRIAGE AND FAMILY THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-HOSPITAL SERVICES.—Section 1861(ee)(2)(G) (42 U.S.C. 1395x(ee)(2)(G)) is amended by inserting ''marriage and family therapist (as defined in subsection (ww)(2)),'' after ''social worker,''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2004.

Mr. THOMAS. This extends the opportunity to directly pay medical health consultants. I will discuss it later. In the meantime, I will set it aside for later discussion.

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

The Senator from California.

Mrs. BOXER. Mr. President, I take a couple of minutes to explain an amendment we will be voting on later that was introduced on my behalf by Senator REID and to let my colleagues know I think it is a stunning situation when suddenly, after fighting back all the amendments that we had to try to improve the benefits, that we are giving our seniors—miraculously there is $12 billion found and it will start a whole new experiment, which may be very interesting and may be just fine. It will push some people out of Medicare and see if it works better in the private sector. I hate to say we have tried it and it hasn't worked but that is fine.

At the same time, we are going to allow Medicare to do more prevention and do more pharmaceutical benefit. We will see what that looks like when it comes to us.

The point I am making, yesterday the Senator from Pennsylvania was railing against some Members who wanted to make this plan better because there was no money. It was so expensive. But they found money to do some experiment.

Today I have an amendment to give people a chance to decide if they want to help people with cancer, if they want to help people who are diagnosed with cancer.

I don't know if you have ever had the experience of having cancer in your family, but surely we all know people who have had that experience. Life in that family comes to a halt. People are reeling from the diagnosis of cancer, whether it is breast cancer, lung cancer, prostate cancer, colon cancer, stomach cancer, blood cancer which is leukemia, lymphoma; millions of Americans are touched. And we have a drug benefit that stops at $4,500 and then $1,300 later you start getting help for your medication.

Yesterday, I gave the Senate a chance to close that benefit shutdown, close that coverage gap, and the Senate refused to do it, mostly on a party-line vote.

Today I offer an amendment to let people redeem themselves. What I say is, if you are diagnosed with cancer, you should never have your drug benefit shut down. You are reeling from this diagnosis. You are sick with this disease. And you should not have to worry about whether you can afford your medicine.

Later in the day we are going to have a chance to see if people are willing to have enough compassion in their heart to stop the benefit shutdown for families where there is a cancer diagnosis. Why do I choose cancer? I could have chosen a number of other diseases. I chose that one because it touches so many families. If it passes, I am going to offer one where there is an Alzheimer's diagnosis. If that passes, I will offer one where there is a Parkinson's diagnosis.

There are a couple of good things in this bill. It starts a prescription drug benefit. That is a plus. We are going to have to fix it. It is a mess. It is the only plan in the country I have found that has such a benefit shutdown. The premiums can go up at any time. HMOs and PPOs can drop out of the business and then you do not know what you are going to do. The fact there is a benefit is important. And it is generous to those who are very poor.

But I want it to be fair to those in the middle class and I want it to be fair to those who need their pharmaceutical products the most. So I am going to give my colleagues a chance to end the benefit shutdown for people who have cancer. If you want to vote no, vote no. If you want to tell people you had a chance to make sure they have those pharmaceutical products through a period of their lives when they are frightened, when they are fighting a disease, go ahead. Do it. Do it.

But I ask you to look inside your soul. You are about to vote on a new program of $12 billion. Don't walk away from the people with cancer just to give money to HMOs, because that vote will come back to haunt you. That is how I feel.

I was very disappointed yesterday that we had a straight party-line vote, pretty much, on my amendment to end the benefit shutdown. But around here you have to be held accountable for what you do. So I am going to give people a chance to come back and say, OK, in the case of cancer, people are not going to have their benefits shut down. Just imagine what it is like, going through chemotherapy, taking all kinds of risks so you can live, because chemotherapy, as you know, basically kills a lot of healthy cells, too.

And, if that is not enough, you are going to have to deal with the accountants with their eyeshades in the HMOs, who will say, What have you done? You really didn't get to $4,500. Why are you shutting down my benefit? You will be begging them not to shut you out because your doctor says if you miss this medicine you could reverse the progress you are making on this disease.

I am going to stop discussing this amendment. I think it is pretty clear. Senators will have a chance to help people with cancer. If you do not want to do it, then you have to live with that vote.

Mr. President, I yield the floor and I look forward to this vote on my amendment.

The PRESIDENT pro tempore. The Democratic leader.

Mr. DASCHLE. Mr. President, under the unanimous consent agreement we reached last night, there was scheduled an amendment to be voted upon, the so-called Grassley benchmark amendment, at 10 o'clock. We have not yet had the opportunity to review the amendment. As I understand it, it is still being negotiated. So we are not in a position, obviously, to agree to the amendment at 10 o'clock. We look forward to consulting with both managers of the bill. Certainly I will be talking to the majority leader as we continue to work to bring the amendment to the floor.

Given the fact we are not yet at a position to vote, it would not be my expectation that there would be a vote at 10 o'clock.

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

The PRESIDING OFFICER (Mr. GRAHAM of South Carolina). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

AMENDMENT NO. 972

Mr. BINGAMAN. Mr. President, I ask unanimous consent to call up amendment No. 972 on Medicare community health center payments.

The PRESIDING OFFICER. That amendment is pending before the Senate.

Mr. BINGAMAN. I ask unanimous consent to revise the list of sponsors of the amendment to read: Senators SNOWE, BINGAMAN, SMITH, HOLLINGS, and HATCH.

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

Mr. BINGAMAN. Mr. President, I thank the chairman and ranking member for agreeing to this very important amendment related to our Nation's community health centers. I also thank Senator SNOWE, with whom all who are now cosponsoring this amendment introduced S. 654, the Medicare Safety Net Access Act of 2003. Her leadership on the Nation's community health centers has been unwavering and has made it possible to get to the point where we can adopt this amendment.

I also thank Senator SMITH, Senator HOLLINGS, Senator HATCH, and Senator CONRAD for their longstanding advocacy support for community health centers. Senator SMITH and Senator HOLLINGS need to be thanked for their constant advocacy and push to see this amendment pass.

In addition, it should be noted that Senators HATCH and CONRAD spearheaded a very similar effort to protect community health centers in the Medicaid Program back in 1997.

As we proceed with the passage of S. 1, we need to be careful not to create potential unintended consequences as a result of our actions. This amendment corrects an important unintended consequence that this legislation could have had on our Nation's community health centers. Community health centers have broad bipartisan support. The President and the Congress have committed to doubling the funding for community health centers over a 5-year period. The health centers provide care for over 13 million people annually. Nearly one million of those are low-income Medicare beneficiaries. They receive section 330 Federal Public Health Service Act grant funds to support care for the uninsured and for low-income patients. To ensure those grant funds are used entirely for that purpose, Congress has specifically taken action to ensure that both Medicare and Medicaid are fully reimbursing health centers for the costs associated with the care provided for Medicare and Medicaid beneficiaries.

Simply put, the funding intended for low-income and uninsured people should not be diverted and instead used to subsidize Medicare underpayments. Therefore, health centers are reimbursed by Medicare under a cost-base system. This amendment would simply extend the same requirement to the new Medicare Advantage programs by ensuring that community health centers are provided with a wraparound or supplemental payment equal to the difference between the payments they now receive under Medicare generally and the payment they would receive from Medicare Advantage plans. This is not a new concept.

In 1997, Congress allowed States to dramatically increase the number of patients who were enrolled in Medicaid managed care. We recognized the potential adverse impact on community health centers, and to deal with that we required the Medicaid Program to provide a wraparound or supplemental payment for the difference between the managed care organizations payment and a health centers reasonable cost. Again, Senators HATCH and CONRAD were instrumental in that effort.

With this important amendment we are proposing today we would do the same in the Medicare Program. According to testimony Tom Scully gave at the Center for Medicare and Medicaid Services and testimony that the Congressional Budget Office gave on the 13th of June, their estimates for how many Medicare beneficiaries actually were enrolled in the private health plans ranged all over the board. It went from 9 percent in one estimate, the CBO estimate, to 43 percent, the estimate that Tom Scully's actuaries developed. It was a fivefold difference in those estimates.

In the words of Dr. Holtz-Eakin, the head of the CBO, these are honest differences in trying to read a very uncertain future.

We do have clearly ahead of us a very uncertain future as to how many people will choose to leave traditional Medicare and move into the private plans. Mr. Scully is correct that health centers will lose their guarantee of cost-base reimbursement to 43 percent of their Medicare patients. Potentially, this could result in centers having to dip into their Federal grant fund money intended to provide care to the uninsured, and they would have to dip into those Federal grant funds in order to make up for losses they were incurring trying to provide services to Medicare patients.

Our Nation's safety net is already fragile. We need to take this action to ensure we are not jeopardizing it through the passage of this legislation.

Again, both the President and Congress have committed to double the capacity of our Nation's health centers to deal with the growing number of uninsured in this country. In light of this, the amendment we are offering today would protect the vital role that health centers play. It would ensure that health centers are not forced to decide either between subsidizing the Medicare Program with their grant dollars or refusing to provide services to some of the 1 million low-income Medicare beneficiaries that currently depend upon them for services.

I thank the chairman and ranking member for agreeing to accept this amendment. I thank all the chief sponsors, Senator SNOWE, and all cosponsors for their hard work. I believe it is a very important amendment. I urge my colleagues to support it.

Ms. SNOWE. Mr. President, I rise today to speak on behalf of the amendment that I am offering today with Senator BINGAMAN, a longtime champion of community health centers and the original cosponsor of the legislation that we introduced, S. 654, the Medicare Safety Net Access Act, from which this provision has been taken. I also would like to thank my colleagues, Senators HATCH and SMITH for their help in moving this important policy change forward. Chairman GRASSLEY and Senator BAUCUS also should be recognized for their work on behalf of Community Health Centers. Their willingness to work with me has made adoption of this policy possible.

This amendment will help ensure that Community Health Centers remain a viable and integral part of the health care delivery system for Medicare beneficiaries and rural communities at large. Community Health Centers, also known as Federally qualified health centers, provide care to millions of medically underserved Medicare beneficiaries. In many cases, Community Health Centers are the only source of primary and preventive services to which these beneficiaries have access. This is especially true for people living in America's rural and inner-city medically underserved areas.

As many of you know, under the traditional fee-for-service program Community Health Centers currently are reimbursed by Medicare bases on the cost to deliver care. However, because managed care plans, such as those expected to be used under the new MedicareAdvantage program, use capitated rates, which are negotiated rates based on patient volume and often are lower than the fee-for-service cost-reimbursement rate, Community Health Centers would likely experience substantial reductions in payments.

If, as CMS predicts, over 40 percent of seniors enter the new MedicareAdvantage program, Community Health Centers would experience a substantial loss of revenue because their payment for almost half of their clients would be based on a capitated rate. If this happens, Community Health Centers would be unable to meet the growing demand of serving the Medicare population.

This amendment ensures that doesn't happen. Starting in 2006, if the capitated rate that a Community Health Center receives from a participating MedicareAdvantage plan is less than the fee-for-service cost reimbursement rate, the Medicare program will pay the difference in the amount. This is done presently under the Medicaid program and it should be no different under the Medicare program.

Community Health Centers are an invaluable component in the health care delivery system in rural communities and I am pleased that this amendment has been accepted into S. 1.

Mr. HATCH. Mr. President, I rise in strong support of the Bingaman-Snowe-Hatch amendment. This amendment addresses an important issue for both Medicare beneficiaries and community health centers by ensuring that

Medicare beneficiaries, regardless of their Medicare health coverage choice, would receive seamless coverage if they choose to receive services from a community health center. And, it provides the Community Health Centers the ability to give the Medicare beneficiaries that they serve seamless health coverage as well.

I have been a strong supporter of community health centers for many years. These health centers provide care to over 13 million people annually; nearly one million are low-income Medicare beneficiaries. These health centers receive funding under the Public Health Service Act in order to provide quality care to their uninsured and low-income patients. To ensure those dollars are used only to provide health care to health center patients, Congress has taken action to ensure that both the Medicare and Medicaid programs are reimbursing health centers for the costs associated with care to Medicare and Medicaid beneficiaries. Therefore, community health centers are reimbursed by Medicare and Medicaid under a cost-based system.

In 1997, Congress allowed States to increase greatly the number of patients enrolled in Medicaid managed care by requiring the Medicaid program to provide a ''wrap-around' payments for the difference between the managed care organization's payment and a health center's reasonable costs.

This amendment ensures that we do the same thing for Medicare beneficiaries in the MedicareAdvantage program. More specifically, the amendment ensures that community health centers are provided with a ''wrap-around'' or supplemental payment equal to the difference between the payments they now receive under Medicare through the cost-based system and the payment they would receive from MedicareAdvantage plans.

Officials at the Centers for Medicare and Medicaid Services and the Congressional Budget Office estimate that nine to 43 percent of Medicare beneficiaries will enroll in private health plans offered through the MedicareAdvantage program. If these estimates are accurate, then health centers will lose their guarantee of cost-based reimbursement for up to 43 percent of their Medicare patients. This could result in centers having to dip into their Federal funding received through the Public Health Service Act. This funding is intended to provide care to the uninsured—not to fill in the gaps for certain Medicare health center patients.

The Bingaman-Snowe-Hatch amendment would not only protect the vital role of health centers but would also ensure that these health centers would continue to provide seamless health coverage to one million low-income Medicare beneficiaries. I urge my colleagues to support this amendment.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. GRASSLEY. Mr. President, I ask unanimous consent that at 11 o'clock today, the Senate proceed to a vote in relation to amendment No. 972 and that the amendment now be considered as being proposed by Senators SNOWE, BINGAMAN, and HATCH; further, that following that vote, there be 2 minutes equally divided for further debate prior to a vote in relation to the Edwards amendment, No. 985, to be followed by 2 minutes equally divided and a vote in relation to the Graham amendment, No. 956, with no second-degree amendments in order prior to the vote.

Finally, I ask unanimous consent that the time until the votes be equally divided between the two managers or their designees, and I further modify the request to allow 4 minutes equally divided prior to the Edwards vote.

The PRESIDING OFFICER. Is there objection?

AMENDMENT NO. 985, AS MODIFIED FURTHER

Mr. EDWARDS. Mr. President, reserving the right to object, I have a modification at the desk with additional modifications. I ask unanimous consent, first, that the modification be accepted.

The PRESIDING OFFICER. The amendment is further modified.

The amendment (No. 985), as modified further, is as follows:

At the end, add the following:

TITLE ____—DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. ___01. HEAD-TO-HEAD TESTING AND DIRECT-TO-CONSUMER ADVERTISING.

(a) NEW DRUG APPLICATION.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subparagraph (A) of the second sentence of subsection (b)(1), by inserting before the semicolon at the end the following ''(including, if the Secretary so requires, whether the drug is safe and effective for use in comparison with other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug)''; and

(2) in subsection (d)(5)—

(A) by inserting ''(A)'' after ''will''; and

(B) by inserting after ''thereof'' the following: '' or (B) if the Secretary has required information related to comparative safety or effectiveness, offer a benefit with respect to safety or effectiveness (including effectiveness with respect to a subpopulation or condition) that is greater than the benefit offered by other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug''.

(b) MISBRANDING.—Section 502(n)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)(3)) is amended by inserting after ''effectiveness'' the following: ''(including effectiveness in comparison to similar drugs for substantially the same condition or conditions)''.

(c) REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) CONTENTS.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to effectiveness of the drug (including effectiveness in comparison to other drugs for substantially the same condition or conditions);

(ii) information relating to side effects and contraindications; and

(B) any advertisement present a fair balance, comparable in depth, between—

(i) aural and visual presentations relating to effectiveness of the drug; and

(ii) aural and visual presentations relating to side effects and contraindications, *provided that*, nothing in this section shall require explicit images or sounds depicting side effects and contraindication.

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. ___02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

''(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

''(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

''(A) the Secretary provides the person written notice of the violation; and

''(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

''(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

''(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

''(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

''(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).''.

SEC. ___03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n)

of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. ___04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisements except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, for the information of Senators, we are going to have this block of votes. Then there is going to be a period of time where the two leaders have agreed there would be no amendments voted on. At about 2:30 or quarter to 3, we are going to try to line up a batch of votes to take up time this afternoon.

So for the information of Senators, at 2:30 or quarter to 3, the two managers and leaders are going to try to line up a bunch of votes.

AMENDMENT NO. 985, AS MODIFIED FURTHER

Mr. EDWARDS. Mr. President, I rise today, together with my friend, Senator TOM HARKIN from Iowa, to introduce an amendment to bring down the cost of prescription drugs. As everyone knows, the cost of prescription drugs has been skyrocketing. We have to bring these costs under control, not only to lower the drug costs for seniors but also to lower drug costs for all Americans, including those who will not get a prescription drug benefit under the Medicare Program.

There are lots of reasons drug costs are rising, and I have offered several proposals to address that in the past. This amendment addresses two particular concerns. The first is what is called the ''me too'' drugs that provide minimal benefits for people but large profits for drug companies. The second is the massive growth in the direct-to-consumer advertising that does not genuinely educate consumers.

This amendment, from TOM HARKIN and me, would address these problems with two steps. First, we call on the Secretary of HHS to require drug manufacturers to prove that ''me too'' drugs actually provide benefits before they are approved. Second, we would impose new requirements for fairness and balance in drug advertising.

Drug companies provide a very important service to America and to the sick. They deserve to make a profit for that, all of us agree on that. But they should also fulfill their mission as businesses, to generate innovative drugs that reduce pain, alleviate suffering, and cure disease.

Unfortunately, many drug companies seem to be giving that mission short shrift. We know they spend far more on marketing, advertising, and administration than they spend on research and development. We also know that instead of focusing on truly innovative breakthroughs, drug companies are focusing on ''me-too'' drugs to compete against blockbuster treatments for chronic conditions like allergies and high cholesterol. I want to talk about that for a minute.

Me-too drugs can be good things. They can help a specific population, or they can be safer and more effective. Of course those are good things. But here is the problem. Companies should not be able to profit off of a me-too drug just by misleading consumers about the benefits compared to existing drugs. Consumers should know how exactly the new drug stacks up against the existing drug.

Senator CLINTON spoke of the same need last night, when she introduced her very sound amendment. Consumers need to be given the ability to make an informed choice about the best drug for them.

This amendment would give the Secretary of HHS the authority to require drug companies to test drugs against their competitors. And if the drug company is going to advertise its ''me-too'' drug, it should tell the consumer how that drug compares to what they may already be taking for that condition.

Now, I want to talk about the larger point, which is drug advertising.

Some drug advertising is a good thing. Drug ads can let people know about drugs about which they don't otherwise hear. The drug industry's major trade group, PhRMA, says the purpose of direct-to-consumer advertising is:

> . . . to educate consumers about diseases, about the symptoms that may help them identify diseases, and the available therapies developed to treat them.

Those are good. Those are good goals. Here is the problem. Does anyone think drug advertising today is genuinely about educating consumers, as PhRMA says, rather than marketing? Does anyone believe that?

Are drug companies educating consumers about allergy medicines by showing this picture of a woman running through a field? I think all of us know, when this kind of advertisement, as in this picture, is shown on television, it is clearly about selling and about marketing. This is not for the purpose of educating consumers, and the American people know that. They know that without anyone telling them that.

Are they educating consumers about arthritis with images of a couple dancing in their kitchen? If this were about education, would an announcement read: ''Health warnings: Headache, nausea,'' and so on, while the picture on the screen still shows happy pictures of a mom and her kids? Absolutely not. These ads are not about education; they are about marketing.

There is nothing wrong with marketing and persuasion in most contexts. If they are selling paper towels or shaving cream, companies should go ahead and market as aggressively as they can. But prescription drugs are different. There is nothing more important in our lives than our health, and there is nothing more important than drugs for our health. These are matters of life and death for families, for seniors, and for kids. Advertisements for these products should be held to a much higher standard. They should educate, not just market.

That is not what these ads do. You don't have to take my word for it; that is what Consumer Reports says, that is what doctors say, and, most importantly, it is what common sense says. These ads make promises they cannot keep. They overstate benefits and they understate risks. Let me give just a couple of examples from recent research.

This is from a study from the magazine Consumer Reports. They studied drug ads and they found:

> . . . a broad and disconcerting range of misleading messages: ads that minimize the product's risk, exaggerated its efficacy, made false claims of superiority over competing products; promoted unapproved uses for an approved drug; or promoted use of a drug still in the experimental stage.

In a recent FDA survey of 500 general practitioners, family doctors, 7 out of 10 said advertisements about drugs confused patients about the risks and benefits of medicines. In another study, 75 percent of doctors said their patients came away with the impression that the drugs they saw in advertisements work better than they actually do.

The Kaiser Family Foundation did a survey of nearly 2000 adults who saw drug advertisements; 7 out of 10 said they learned little or nothing about what the treated condition; 6 out of 10 said they learned little or nothing about the drug. Here are comments from Arnold Relman and Marcia Angell, two former editors-in-chief of the New England Journal of Medicine. They said:

> DTC ads mainly benefit the bottom line of the drug industry, not the public. They mislead consumers more than they inform them, and they pressure physicians to prescribe new, expensive, and often marginally helpful drugs, although a more conservative option might be better for the patient.

So this amendment is simple. It says that drug ads should be balanced. They should include information about other drugs that may address conditions better. And they should have a real balance between the images selling the drug and the images questioning the drug.

Now, the Bush administration sees it differently. They think see it as drug companies should be able to use whatever marketing gimmicks they want to sell their drugs.

The FDA is supposed to stop ads that are misleading. But last year the Bush administration's FDA instituted a new policy that slows down the FDA's efforts. As a result, the FDA issued two-thirds fewer warning letters last year

than the year before. The GAO looked into this and found that warning letters are often ''not issued until after the advertising campaign has run its course.''

This is a gift to the drug companies. Without the threat of a warning letter, they can basically air whatever kind of ad they want and just ask for forgiveness afterwards.

Take the case of an ad for the prescription drug Tamiflu that ran on the radio last year. It featured Eric Bergoust, the Olympic gold-medal skier, who said ''I felt better so soon that I didn't miss a single day of training.'' The FDA told the drug maker Hoffmann-La Roche to stop running the ad because Bergoust's words ''misleadingly overstated the drug's efficacy.'' But the FDA's request came nearly three months after the company had submitted the ad for review, a month after the flu season had ended, and well after the company stopped running the ad.

Our amendment would make sure this kind of thing cannot happen. The FDA should speed up the review process and use their authority to have misleading ads pulled before millions of consumers have already seen them. And drug companies need to be held accountable when they repeatedly violate FDA regulations. In this amendment, Senator HARKIN and I call for stiff civil penalties for such offenders.

So, in short, this amendment would not bar all direct-to-consumer advertising. It would simply require the advertising to educate, rather than simply market. I urge my colleagues to support this amendment.

This amendment is for the purpose of doing something to control drug advertising, to make sure that it is, in fact, about education, and to make sure these ''me too'' drugs actually have a benefit before they are approved by the FDA.

Thank you, Mr. President.

VOTE ON AMENDMENT NO. 972

The PRESIDING OFFICER. The hour of 11 a.m. having arrived, the question is on agreeing to amendment No. 972, proposed by Senators Snowe, Bingaman, and Hatch.

Mr. EDWARDS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) and the Senator from Arizona (Mr. MCCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. MCCAIN) would vote ''yea.''

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 94, nays 1, as follows:

[Rollcall Vote No. 242 Leg.]

YEAS—94

Akaka	Dodd	Lugar
Alexander	Dole	McConnell
Allard	Domenici	Mikulski
Allen	Dorgan	Miller
Baucus	Durbin	Murkowski
Bayh	Edwards	Murray
Bennett	Ensign	Nelson (FL)
Biden	Enzi	Nelson (NE)
Bingaman	Feingold	Nickles
Bond	Feinstein	Pryor
Boxer	Fitzgerald	Reed
Breaux	Frist	Reid
Brownback	Graham (SC)	Roberts
Bunning	Grassley	Rockefeller
Burns	Hagel	Santorum
Byrd	Harkin	Sarbanes
Cantwell	Hatch	Schumer
Carper	Hollings	Sessions
Chafee	Hutchison	Shelby
Chambliss	Inhofe	Smith
Clinton	Inouye	Snowe
Cochran	Jeffords	Specter
Coleman	Johnson	Stabenow
Collins	Kennedy	Stevens
Conrad	Kohl	Sununu
Cornyn	Kyl	Talent
Corzine	Landrieu	Thomas
Craig	Lautenberg	Voinovich
Crapo	Leahy	Warner
Daschle	Levin	Wyden
Dayton	Lincoln	
DeWine	Lott	

NAYS—1

Gregg

NOT VOTING—5

Campbell	Kerry	McCain
Graham (FL)	Lieberman	

The amendment (No. 972) was agreed to.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote.

Mr. BROWNBACK. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the time for the next two votes be limited to 10 minutes.

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

AMENDMENT NO. 985, AS MODIFIED FURTHER

The PRESIDING OFFICER. There are 4 minutes equally divided on the Edwards amendment prior to a vote.

Who yields time?

The Senator from North Carolina.

Mr. EDWARDS. Mr. President, the purpose of this amendment is to do something about the skyrocketing costs of prescription drugs in this country. Whatever we do to provide a real prescription drug benefit for seniors under Medicare, both for the purpose of keeping the cost of that plan down and for the purpose of doing something for all Americans who have no prescription drug coverage, we have to bring the cost of prescription drugs under control.

There are two abuses at which this amendment is aimed: First, stopping the proliferation of ''me too'' drugs that have no meaningful benefit; second, stopping the abuses in advertising.

Everyone has seen the ads: Couples dancing in the kitchen; people running through fields. These are not for the purpose of education. They are for the purpose of marketing. We are trying to bring this under control by putting fairness, honesty, and accuracy in that advertising.

The purpose of the amendment is to help control both those activities and, in the process, bring down the cost of prescription drugs.

Mr. President, I ask my colleague, the coauthor of this amendment, Senator HARKIN from Iowa, what he believes we need to do to bring down the cost of prescription drugs. I yield to Senator HARKIN.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Mr. President, parliamentary inquiry: What type of time agreement are we under now?

The PRESIDING OFFICER. Four minutes equally divided. The Senator has 31 seconds.

Mr. HARKIN. Mr. President, I thank my colleague from North Carolina for offering his amendment of which I am a cosponsor. Every time I go back to Iowa, I hear from consumers and others: Why do I get inundated with all these ads, and I cannot buy them unless I go to the doctor?

Right now, the drug companies are spending more on advertising every year than they are on research, and we wonder why the price of drugs keeps going up.

This all changed a few years ago. If my colleagues will remember, before 1997, we did not see all these ads. Now it is time to cut out this massive advertising of drugs that we cannot even buy in the marketplace.

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

Mr. GRASSLEY. Mr. President, I yield the 2 minutes on this side to the Senator from Wyoming.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I ask the body to vote no on the Edwards amendment to increase drug costs. This is a new drug approval. The amendment masquerades as a direct-to-consumer advertising amendment while sweeping away carefully calibrated FDA drug approval standards.

While the Edwards amendment masquerades as an amendment to ''strengthen protections against misleading direct-to-consumer advertising,'' the amendment drastically changes the requirements for drug approval in the United States.

We have a great system that is working. Under the current law, pharmaceuticals must demonstrate they are safe and effective to be approved by the Food and Drug Administration. Under the Edwards amendment, the Secretary of Health and Human Services would be authorized to vary this standard on a

drug-by-drug basis to create new hurdles to drug approvals.

These new hurdles include lengthy, costly comparative trials and a showing that the drug is safer or more effective for a subpopulation or condition than a previously approved drug.

These changes to fundamental, longstanding law could hurt patients by delaying, and possibly denying, the approval of new drugs that patients need; by dramatically adding to drug development costs, discouraging companies from developing additional drugs to treat the same conditions; and increasing drug spending by reducing brand-to-brand competition.

We know far more about pharmaceuticals than many other medical interventions since, unlike most other interventions, they must obtain approval under FDA's safe and effective standard before they can be used. We should reject this amendment as it would add another regulatory hurdle to the already long and costly drug development and approval process.

The PRESIDING OFFICER. All time has expired. The question is on agreeing to amendment No. 985, as modified further.

Mr. EDWARDS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second. The clerk will call the roll.

The bill clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) and the Senator from Arizona (Mr. MCCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. MCCAIN) would vote ''yea.''

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 26, nays 69, as follows:

[Rollcall Vote No. 243 Leg.]

YEAS—26

Akaka	Feingold	Miller
Boxer	Feinstein	Nelson (FL)
Byrd	Harkin	Pryor
Cantwell	Inouye	Reed
Clinton	Johnson	Reid
Daschle	Kohl	Rockefeller
Dayton	Leahy	Schumer
Durbin	Levin	Stabenow
Edwards	Lincoln	

NAYS—69

Alexander	Bond	Cochran
Allard	Breaux	Coleman
Allen	Brownback	Collins
Baucus	Bunning	Conrad
Bayh	Burns	Cornyn
Bennett	Carper	Corzine
Biden	Chafee	Craig
Bingaman	Chambliss	Crapo
DeWine	Hutchison	Roberts
Dodd	Inhofe	Santorum
Dole	Jeffords	Sarbanes
Domenici	Kennedy	Sessions
Dorgan	Kyl	Shelby
Ensign	Landrieu	Smith
Enzi	Lautenberg	Snowe
Fitzgerald	Lott	Specter
Frist	Lugar	Stevens
Graham (SC)	McConnell	Sununu
Grassley	Mikulski	Talent
Gregg	Murkowski	Thomas
Hagel	Murray	Voinovich
Hatch	Nelson (NE)	Warner
Hollings	Nickles	Wyden

NOT VOTING—5

Campbell	Kerry	McCain
Graham (FL)	Lieberman	

The amendment (No. 985), as modified further, was rejected.

Mr. REID. I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 956

The PRESIDING OFFICER (Ms. MURKOWSKI). The order of business is amendment numbered 956, the Graham of Florida amendment.

Mr. REID. Madam President, it is my understanding the next matter is the Graham amendment.

The PRESIDING OFFICER. That is correct.

Mr. REID. Madam President, on behalf of Senators GRAHAM, FEINSTEIN, MURKOWSKI, JOHNSON, and this Senator, this is a tremendous piece of work Senator GRAHAM has done. It is good legislation. At least 12 percent of our seniors would be subject to a gap in coverage under this bill. Standard coverage would require seniors to pay 100 percent of the cost of prescriptions between $4,500 and $5,812 in total spending. At the same time, they are paying 100 percent of each prescription, and they are still required to pay a monthly premium.

Collecting a premium while a senior is in the gap is equivalent to levying a tax on the sick. This amendment suspends the payment of premium once the beneficiary hits the gap in coverage. This amendment is endorsed by the National Committee to Preserve Social Security, the Alliance of Retired Americans, and the National Council on Aging.

The amendment is offset by clarification of the Medicare secondary payer provision. This noncontroversial offset, which yields $8.9 billion over 10 years, is fully supported by the Department of Justice and is in the House Republican drug bill.

Mr. GRASSLEY. Madam President, I have to ask my colleagues to vote against this amendment because it costs $200 billion. We are working within a $400 billion package. I wish we could eliminate the gap, as well. What we are trying to do is help the most people who have the most need with the money we have. Most seniors will not be affected by the gap in coverage. Most seniors will not have drug spending in a year that exceeds the benefit limit.

According to the CBO, about 88 percent of the seniors will not even have prescription drug spending that exceeds the $4,500 limit.

The Senator from Florida calls the benefit limit a ''sick tax'' because he believes that seniors should not pay a premium for coverage for catastrophic costs. This is as if to say you should not pay for fire insurance if your house is not going to be on fire. Of course, that is not how insurance works. People purchase insurance to protect them against an unfortunate accident.

The PRESIDING OFFICER. All time is expired.

Mr. REID. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the amendment.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) and the Senator from Arizona (Mr. MCCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. MCCAIN) would vote ''yea.''

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 39, nays 56, as follows:

[Rollcall Vote No. 244 Leg.]

YEAS—39

Akaka	Dodd	Levin
Bayh	Dorgan	Lincoln
Biden	Durbin	Mikulski
Bingaman	Edwards	Murray
Boxer	Feingold	Nelson (FL)
Byrd	Feinstein	Pryor
Cantwell	Harkin	Reed
Carper	Hollings	Reid
Clinton	Inouye	Rockefeller
Conrad	Johnson	Sarbanes
Corzine	Kohl	Schumer
Daschle	Lautenberg	Stabenow
Dayton	Leahy	Wyden

NAYS—56

Alexander	Dole	McConnell
Allard	Domenici	Miller
Allen	Ensign	Murkowski
Baucus	Enzi	Nelson (NE)
Bennett	Fitzgerald	Nickles
Bond	Frist	Roberts
Breaux	Graham (SC)	Santorum
Brownback	Grassley	Sessions
Bunning	Gregg	Shelby
Burns	Hagel	Smith
Chafee	Hatch	Snowe
Chambliss	Hutchison	Specter
Cochran	Inhofe	Stevens
Coleman	Jeffords	Sununu
Collins	Kennedy	Talent
Cornyn	Kyl	Thomas
Craig	Landrieu	Voinovich
Crapo	Lott	Warner
DeWine	Lugar	

NOT VOTING—5

Campbell	Kerry	McCain
Graham (FL)	Lieberman	

The amendment (No. 956) was rejected.

Mr. REID. I move to reconsider the vote.

Mr. ENSIGN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Madam President, I ask unanimous consent that Senator EDWARDS be recognized to offer an amendment—and he will speak, if necessary, at a later time—and, following the offering of his amendment, Senator ENZI be recognized to offer two amendments; and following that, Senator DURBIN—we hope at 12:30 or 12:35—be recognized to offer his amendment; that following the offering and the speech by Senator DURBIN, we ask that Senator ENSIGN be recognized to offer an amendment—sometime around 1 o'clock this afternoon.

For the information of Senators, the two managers are working to get a list of at least four amendments to vote on starting at 3 o'clock this afternoon. I ask unanimous consent for what I asked previously except for the voting at 3 o'clock.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from North Carolina.

Mr. EDWARDS. Madam President, I ask unanimous consent to lay aside the pending amendments.

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

AMENDMENT NO. 1052

Mr. EDWARDS. Madam President, I have an amendment I send to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from North Carolina [Mr. EDWARDS], for himself and Mr. HARKIN, proposes an amendment numbered 1052.

Mr. EDWARDS. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To strengthen protections for consumers against misleading direct-to-consumer drug advertising)

At the end, add the following:

TITLE ___—DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. ___01. DIRECT-TO-CONSUMER ADVERTISING.

Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended by inserting at the end of the following:

REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) CONTENTS.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to effectiveness of the drug (including, if available, effectiveness in comparison to other drugs for substantially the same condition or conditions); and

(ii) information relating to side effects and contraindications;

(B) any advertisement present a fair balance, comparable in depth, between—

(i) aural and visual presentations relating to effectiveness of the drug; and

(ii) aural and visual presentations relating to side effects and contraindications, *provided,* that nothing in this section shall require explicit images or sounds depicting side effects and contraindications;

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. ___ 02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

''(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

''(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

''(A) the Secretary provides the person written notice of the violation; and

''(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

''(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

''(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

''(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

''(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).''.

SEC. ___03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. ___04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisement except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

Mr. EDWARDS. Madam President, I ask unanimous consent that the amendment be laid aside.

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

Mr. EDWARDS. I suggest the absence of a quorum.

The PRESIDING OFFICER. Will the Senator withhold?

Mr. EDWARDS. Yes.

The PRESIDING OFFICER. The Senator from Wyoming.

AMENDMENT NO. 1051

Mr. ENZI. Madam President, I ask unanimous consent to set the pending amendments aside and call up amendment No. 1051.

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

The clerk will report.

The bill clerk read as follows:

The Senator from Wyoming [Mr. ENZI], for himself and Mrs. LINCOLN, proposes an amendment numbered 1051.

Mr. ENZI. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To ensure convenient access to pharmacies and prohibit the tying of contracts)

On page 37, between lines 20 and 21, insert the following:

(C) CONVENIENT ACCESS TO PHARMACIES.—In this section, the term 'convenient access' means access that is no less favorable to enrollees than the rules for convenient access to pharmacies of the Secretary of Defense established as of June 1, 2003, for purposes of the TriCare retail pharmacy program. Such rules shall include adequate emergency access for enrolled beneficiaries.

On page 48, between lines 4 and 5, insert the following:

(4) TYING OF CONTRACTS.—No eligible entity with a contract under this part, or its agent, may require a pharmacy to participate in a medicare prescription drug plan as a condition of participating in nonmedicare programs or networks, or require a pharmacy to participate in a nonmedicare program or network as a condition of participating in a medicare prescription drug plan.

Mr. ENZI. Madam President, I rise to offer an amendment that would build upon the protections for seniors and pharmacists that the Senate approved last week. I am pleased to be joined by my distinguished colleague from Arkansas, Senator LINCOLN, in offering this amendment.

This amendment would ensure that seniors have convenient access to local pharmacies. The amendment would accomplish this in two ways.

First, there is language in the Finance Committee's bill that requires

the Government to develop a standard for ensuring that seniors have convenient access to local pharmacies. This amendment would further define what we mean by ''convenient access.''

The amendment would ensure that access to retail pharmacies under Medicare is ''no less favorable to enrollees'' than the access standards under the TRICARE retail pharmacy program.

TRICARE is the health care program for active-duty and retired members of the uniformed services, their families, and survivors. TRICARE is a regionally managed program that offers eligible beneficiaries three choices for their health care.

First, there is TRICARE Prime, where military facilities such as Department of Defense hospitals are the principal source of health care services. There is also TRICARE Extra, a preferred provider option. Finally, there is a TRICARE Standard, the fee-for-service option that used to be known as CHAMPUS.

For all three options, TRICARE offers pharmacy benefits that include access to a retail pharmacy network. To win an award to manage TRICARE benefits for the military, a contractor must maintain a retail pharmacy network that ''minimizes the number of eligible beneficiaries who will have to change pharmacies'' to use the contractor's network.

There are three minimum beneficiary access standards for the TRICARE retail pharmacy network.

In urban areas, the contractor must have a network pharmacy within 2 miles of 90 percent of eligible beneficiaries. In suburban areas, the standard is a pharmacy within 5 miles of 90 percent of the beneficiaries. In rural areas, the standard is a pharmacy within 15 miles of 70 percent of the beneficiaries.

The Enzi-Lincoln amendment would not require Medicare drug plans to meet these exact standards. It would only require that a Medicare drug plan's network be ''no less favorable'' to seniors than the TRICARE program is for active-duty military and retirees, including those who participate in the new TRICARE Senior Pharmacy Program, provided by the 2001 National Defense Authorization Act. If the Administrator of the new Center for Medicare Choices or a Medicare drug plan had a better way of meeting or exceeding the TRICARE standard, they would not be restrained from doing so.

As I mentioned earlier, there is another way this amendment would ensure that seniors have convenient access to their local pharmacies. The amendment includes a provision that prohibits a Medicare drug plan operator from requiring pharmacies to accept non-Medicare business and reimbursement rates as a condition of participating in the plan's Medicare business, or vice versa.

I expect that health plans and pharmacy benefits managers that operate in the commercial insurance market will be the same companies that will compete to provide Medicare drug plans and Medicare Advantage preferred provider options to seniors. If a plan wins a bid to provide a Medicare drug benefit, they may offer reimbursement rates to retail pharmacies that are better or worse than the rates they offer in their private sector commercial business. That is fine with me.

What concerns me is the possibility of these large plans ''tying'' their Medicare and non-Medicare business together. A Medicare drug plan should not be able to require a community pharmacist to accept an unprofitable reimbursement rate for its private sector business as a condition of participating in its Medicare network. Likewise, a community pharmacist should not have to take a money-losing Medicare reimbursement rate in order to keep its non-Medicare business from the same large plan.

We should allow community pharmacists to refuse unprofitable private sector business from a health insurer or a pharmacy benefits manager yet participate in a Medicare drug plan run by the same entities. By doing so, we will further ensure that seniors have convenient access to local pharmacies based on fair reimbursement rates that should take into account the added costs pharmacies incur in providing counseling and advice to Medicare beneficiaries, especially since pharmacists are rarely reimbursed directly for the time and effort it takes to provide that counseling and advice.

I urge my colleagues to join with Senator LINCOLN and me in continuing to improve this Medicare bill by ensuring that seniors have convenient access to their local pharmacists.

I yield the floor to my colleague on this amendment.

The PRESIDING OFFICER. The Senator from Arkansas.

Mrs. LINCOLN. Madam President, I thank my colleague from Wyoming. I am extremely pleased to offer this amendment with him to help our seniors by ensuring that local pharmacists can continue providing their services under the new prescription drug program created under this bill. I compliment him on his leadership—as well as the hard work of his staff—in crafting a very plausible solution to many of our problems.

I was proud to have supported another amendment offered by my friend Senator ENZI and Senator REED of Rhode Island which sought to ensure that PBMs can't force seniors into mail order programs. For those of us, such as the Presiding Officer and others, who represent large tracts of rural areas in our States, it is important to know that all seniors across this great Nation are going to get a fair shake when it comes to a prescription drug package. We want to make sure that the package we design and the law we produce are going to ensure that every senior has the same quality of care, the same quality of product, and the same quality of access through this prescription drug package.

Many Arkansas pharmacists, including Gene Boeckmann, owner of Wynne Apothecary, have explained to me the many problems with mail order pharmacy operations. For one, it weakens the personal contact between customer and pharmacist, a vital connection when it comes to one's health and particularly when you live in a rural area where medical professionals may not be there full time. I know many of our communities—the one just mentioned—have medical facilities that are satellites of hospitals from larger communities. Consequently, many of their medical professionals are not full-time residents. Oftentimes the only medical professional they have happens to be the pharmacist, someone they can call on a weekend or late at night if they run into problems.

Mail order pharmacies that are owned by PBMs also take money out of local communities. In many small towns across Arkansas, pharmacists such as Mr. Boeckmann are the ones paying the taxes. They support the local community baseball and softball teams. They donate money so the school band can go to competitions. They are serving their communities. They have the right and responsibility to do that and, through this bill, we want them to continue. Our communities need leaders such as Mr. Boeckmann. It is for this reason I am proud to support the Enzi-Reed amendment.

As we began drafting the amendment, we attempted to include a provision to prevent conflicts of interest. I hope we will be able to address this issue in conference. Our original amendment would have prohibited a PBM from favoring a mail order contractor it owns. Regrettably, we could not work out language agreeable to everyone, but I do hope we can continue to address the conflict of interest issue in conference. I will be working diligently with others to see that we can.

The amendment seeks to build on that effort by ensuring that seniors have access to their community pharmacists. Over the many years of this debate, I have heard from countless seniors who have told me how important their community pharmacist is to their health care.

I have told them time and time again, they are preaching to the choir with me. I can look back in my own life to when my grandmother was diagnosed with cancer. She lived with us the last 2 years of her life in the back of the house in the room next to mine. I can remember when she would suffer from discomfort, she didn't want to talk to the doctor. She knew what her ailment was. She wanted to talk to the pharmacist.

She would call him. He would say: Mrs. Adne, you need to stop taking your blue pill and keep your yellow pill, but remember it is going to upset

your stomach if you don't take it with a glass of milk or a biscuit.

She found great relief in the knowledge that the pharmacist could provide her. There was nothing more the doctors could do for her. Yet the pharmacist could provide her that information.

I look back on the journey my family had with my own father when we traveled down almost 10 years of a road through the disease of Alzheimer's, recognizing very little could be done by the physicians. Yet the pharmacist was the one we could call in our small community who actually could tell us how we could provide relief, ways we could enhance the quality of life for my father as he lived out those last few years and then those last few days in his own home, in the very woods he grew up in as a little boy.

These are the qualities of life we are talking about for our families, for our loved ones in rural areas, to make it possible essentially for them to be able to do that. What we are talking about is really putting common sense into the bill and recognizing how important it is to maintain that contact in rural areas. Seniors like my late grandmother or my father don't need a mail order service with a 1–800 number and a recording. They need their local pharmacist to talk to.

This amendment seeks to guarantee seniors convenient access to pharmacists. ''Convenient access'' would be defined as access standards that are at least as favorable as the Department of Defense's TRICARE program, to which Senator ENZI referred. That should be the minimum level of access. The TRICARE program requires that at least 90 percent of beneficiaries in urban areas have access to a network pharmacy within 2 miles, 90 percent of beneficiaries in suburban areas have access to a network pharmacy within 5 miles, and 70 percent of beneficiaries in rural areas have access to a network pharmacy within 15 miles.

Second, our amendment seeks to prevent PBMs from tying one contract with a pharmacist to another contract. The practice of committing pharmacists with one contract to another simply ties their hands from being able to provide the kind of service they should be able to provide.

As several of my colleagues have mentioned, PBMs play a major role in the negotiating process between pharmacists and drug companies. Some PBMs have the market power to require a pharmacy provider to accept one contract rate as a condition of participating in a totally unrelated program. This ''tying,'' as it is termed, of one contract to another is an abuse of market power, and it should be prohibited in the Medicare Program. Our amendment would prohibit tying.

I encourage my colleagues to join us by supporting this important amendment that will make Medicare a better program for our seniors and for our pharmacists. Let's make this easier for the seniors and keep the pharmacists in the business.

As I urge my colleagues to support the amendment Senator ENZI and I have offered, I also encourage them to think back to a circumstance, perhaps, in which they found themselves or a story they have heard from one of their rural constituents who can best describe to them in their own words how vital it is to have these important health care providers remain in our communities.

I thank my colleague from Wyoming for his great leadership and the hard work of his staff. I am proud to join him in offering the amendment. I do encourage all of our colleagues to support it and to support rural America so that all seniors across the Nation will have a benefit that will be equal in terms of access and for the information they need in order to find quality of life through the prescription drug package we believe they can.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I thank the Senator from Arkansas for her diligent effort. I ask my colleagues to vote for it.

Ms. LINCOLN. I thank the Senator.

AMENDMENT NO. 1030

Mr. ENZI. Madam President, I ask unanimous consent to set aside the pending amendment and call up amendment No. 1030.

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

The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Wyoming [Mr. ENZI] proposes an amendment numbered 1030.

Mr. ENZI. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To encourage the availability of MedicareAdvantage benefits in medically underserved areas)

On page 356, strike lines 8 through 11, and insert the following:

(C) CONSTRUCTION.—Subparagraph (B) shall not be construed as restricting—

(i) the persons from whom enrollees under such plan may obtain covered benefits; or

(ii) the categories of licensed health professionals or providers from whom enrollees under such a plan may obtain covered benefits if the covered services are provided to enrollees in a State where 25 percent or more of the population resides in health professional shortage areas designated pursuant to section 332 of the Public Health Service Act.

Mr. ENZI. Madam President, this amendment would make the Medicare Advantage preferred provider organization option more attractive to people in areas of the country that have shortages of doctors and other health care providers.

The proposed amendment would ensure that Medicare Advantage plans pay for covered services provided by any properly licensed health professionals to seniors in ''medically underserved States.''

In other words, if a MedicareAdvantage plan covers a service, then the plan must pay for the service if it is provided by a licensed provider in a medically underserved State, regardless of other plan limitations on the types of health professionals that may provide the service.

I assure my colleagues that this is nothing new. The law that governs the Federal Employees Health Benefits Program provides special consideration for enrollees of preferred-provider plans who live in States with critical shortages of physicians and other health professionals. Such States are designated as ''medically underserved areas'' for purposes of the Federal employees program, and the law requires preferred provider organizations to pay for services provided by any qualified providers in these States.

As a result, in medically underserved areas, Federal employees' health plans must treat any licensed health professional as a ''covered provider'' for any covered services performed within the scope of that State's licensure laws.

This amendment simply would require the same treatment by MedicareAdvantage plans of seniors who live in medically underserved States. If the plan says that a physician must provide a service, but a nurse practitioner is permitted under State law to provide the service, a senior in a medically underserved State could get that service from his or her local nurse practitioner.

The amendment would define a ''medically underserved State'' in the same way it is defined for the Federal Employees Health Benefits Program. The Federal employees program law defines a ''medically underserved State'' as one in which 25 percent or more of the population lives in health professional shortage areas, as defined by the Secretary of Health and Human Services. This amendment would transfer that language to MedicareAdvantage.

In 2003, the following States were considered ''medically underserved'' for purposes of the Federal employees health plan: Alabama, Idaho, Kentucky, Louisiana, Maine, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, West Virginia and Wyoming.

By the way, Louisiana, Maine, and West Virginia were added to the list in 2003, which demonstrates that the list if flexible enough to recognize States that may not have shortages of health professionals right now, but may have a shortage in the future.

Here's an example of how this provision works in the Federal employees program. The Rural Letter Carrier Benefit Plan allows physical and occupational therapy services to be provided by qualified and licensed physical therapists, occupational therapists, and physicians. However, the Govern-

ment Employees Hospital Association Benefit Plan, or the G–E–H–A plan, does not generally allow qualified physicians to provide physical or occupational therapy services. As a result, physicians who may have special expertise in rehabilitation medicine, for example, cannot provide such services to members of the G–E–H–A plan.

However, in medically underserved States, the G–E–H–A plan must allow Federal employees to receive physical or occupational therapy services from any physician who is qualified to do so and whose State license permits him or her to do so.

As a result, Federal employees in medically underserved States who live 50 miles from the nearest physical or occupational therapist don't have to drive 50 miles to receive a service they could get from the local physician.

Here's another example. The Rural Letter Carriers plan allows chiropractors to perform manipulation of the spine and extremities, as well as related procedures such as ultrasound and cold-pack application. The G–E–H–A plan allows chiropractors to perform manipulation of the spine and certain X-rays to detect and determine nerve interferences, but it doesn't allow for chiropractors to perform ultrasound or other related procedures like the Rural Letter Carriers plan does. Both plans also reserve certain procedures for other types of health professionals.

However, in medically underserved States, both plans must permit chiropractors to perform any service that the plans cover—provided that the services are within the scope of the chiropractor's State license.

Now that I have explained what this amendment would accomplish, let me be clear about what this amendment would not do.

First, the amendment would not require MedicareAdvantage plans to pay for services that they would not ordinarily cover. It would only require that plans pay for covered services in medically underserved States without limiting the types of professionals who may provide the service. Again, this provision only applies to services that the plan has already decided to cover.

Second, this amendment is not an ''any willing provider'' amendment. A number of States have ''any willing provider'' laws that require health plans to permit all providers to participate in the network if they agree to accept the plan's contract terms, especially their payment rates.

This amendment, however, would not require MedicareAdvantage plans to allow any health care provider to participate in the plan's network just because he or she is willing to do so. Nor would this amendment provide that a MedicareAdvantage plan could not pay a non-network provider any less than whit it pays a network provider.

This amendment simply directs plans to pay either their in-network or out-of-network for covered services that are provided by any type of health professional who is licensed to provide the service in a medically underserved State.

Finally, this amendment is not intended to favor physicians versus physical therapists, nurse practitioners, or other health professionals, or for that matter, to favor those other health professionals versus physicians.

This amendment simply would recognize the reality of healthcare in rural and frontier America—there simply aren't enough healthcare providers to go around. In States like Wyoming, the problem is getting worse, not better. Many of our doctors and other health professionals are growing older and retiring, while others are leaving our State to move to places with better medical liability laws.

In States with dire shortages of doctors and other healthcare providers, seniors shouldn't have to get into the car in the heat of summer or the cold of winter to drive to the nearest city to get healthcare services that they could get in their own town, or the town next door.

Even going to the town next door can be a challenge in Wyoming, because the town next door may be many miles away!

I want seniors in Wyoming and other sparsely populated States to be able to choose a MedicareAdvantage plan if they want comprehensive health coverage. These plans will be competing to offer seniors an integrated medical and drug benefit, innovative services like disease management, and more complete preventive services to keep seniors healthier.

For seniors in rural States to choose MedicareAdvantage, they need to know that a plan's network provides real access. There's a big difference between a network of health care providers being available, and a network of health care providers being accessible.

This amendment would provide protection and peace-of-mind to seniors who might consider joining a MedicareAdvantage plan. It's the same safeguard enjoyed by other Federal employees, including the Members of this Body. I ask my colleagues to join me in passing this amendment to ensure that seniors in rural and frontier States receive the same protection and piece-of-mind that we have in our own Federal health plan.

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Illinois is recognized.

Mr. DURBIN. I see my colleague from Nebraska. There as a unanimous consent that I was to be recognized. I know the Senator has come to the floor. I hope we can work out a time that the Senator from Nebraska might be able to speak.

Mr. HAGEL. Senator ENSIGN and I are teaming up on a couple of amendments. We will follow the distinguished Senator from Illinois.

Mr. DURBIN. I will finish at no later than 1 o'clock.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Madam President, understand what this debate is about. It is the first time Congress has seriously considered offering help to senior citizens to pay for prescription drugs. I have said to Senators GRASSLEY and BAUCUS, who bring S. 1, the bill that is before us, to the floor, that I congratulate them for their good efforts. It is not an easy achievement.

For the first time in American history, we will offer this kind of assistance to seniors. But I have to say, having conceded their valiant effort, this prescription drug plan they have brought to the floor still has major deficiencies and major problems. I think it is going to run into a firestorm of criticism, primarily from senior citizens and their families, once they understand the specifics of S. 1.

For example, a lot has been said about a $35 monthly premium. This bill, S. 1, doesn't guarantee a $35 monthly premium for prescription drug coverage. It is a suggestion. It is not even worth the paper it is printed on. What is guaranteed is a $275 deductible, which means you really don't get any drug coverage until you have spent at least $275. For some people, that is not a major outlay from their own personal budget. For others, it could be.

There also is no assurance in terms of the amount of money that will be paid for your prescription drugs by the Government. The goal is 50/50—that you would split it with the Government. There is no assurance that will happen.

There is also going to be a gap in coverage. In other words, if you sign up for this voluntary program, if you pay your monthly premium of $35 plus, and if you start receiving checks from the Government, you may find a time, perhaps during the end of the year, when the Government checks stop coming because there is a gap in coverage.

My friend, Senator BOXER of California, will offer an amendment later to say what are we going to do about cancer victims—people who take expensive drugs that are necessary to save their lives. Under the bill before us, there will come a point in time each year when the Government stops helping cancer victims pay for the prescription drugs they need to stay alive. That gap in coverage is troubling, and it should be.

Also, there is no allocation for money spent by employers on behalf of retirees, that that be counted for the employee's benefit to qualify for this plan, which means that some employers might be tempted not to provide coverage at all to their retirees, and others won't see the benefit of that coverage because it doesn't translate into help under S. 1.

Those who push this plan believe in competition, so long as the competition is limited to two HMOs that can offer private insurance coverage for prescription drugs. That is the only

competition they are interested in. The interesting thing is, when you go to the seniors of America and say what are you looking for in a prescription drug plan, it is an amazing response.

Over 600 seniors were asked in a survey of a week or so ago: Which should be a higher priority of Congress, passing prescription drug coverage for seniors under Medicare or passing a bill to control excessive prices for prescription drugs? The choice: S. 1, prescription drug coverage for seniors under Medicare or passing a bill to control the excessive, runaway, skyrocketing prices.

Look at what they said. Of all seniors—people over 55—25 percent want Medicare drug coverage; 53 percent said control drug prices. Then look as you go down here. That portion here, 55 to 64 years of age, said 25 percent want Medicare drug coverage; 57 percent said control drug prices. For seniors, 65 and older, 26 percent want Medicare drug coverage and 50 percent said control drug prices.

In each instance, by a margin of more than 2-to-1, seniors—people over the age of 55—have said to Congress: Don't miss the ball here. The object has to be controlling the excessive cost of drugs. You can offer a helping hand to us, and that is good—25 percent believe that is good—but it won't mean anything if you don't do something about the cost of prescription drugs.

I am sorry to report to you that S. 1—I always have to look to see how many pages this is—with 654 pages doesn't dedicate a paragraph or a page to bringing down the excessive cost of prescription drugs. So the No. 1 issue, by a margin of 2-to-1, for people over 55 in America is controlling excessive drug prices, and it is ignored by S. 1. So here we are with this historic opportunity, and we are completely missing what most seniors in America believe to be the highest priority.

I went to my staff and said: Let's start from the beginning. What kind of a prescription drug program would we create if we had a blank slate? I said to them: Here is what I would like to see us come up with. Let me give a comparison between what we are proposing as my substitute amendment and the underlying bill.

The Grassley-Baucus bill has a $275 deductible. I said: Let's eliminate that deductible, and we did. Under the MediSAVE amendment, there is no deductible.

The premium under Grassley-Baucus is estimated to be $35, which means it could be much higher. I said: Let's require that the premium for this volunteer prescription drug plan be $35 defined in statute.

Cost sharing, under the best of circumstances, is 50/50 under the Grassley-Baucus plan, and under the MediSAVE plan, which we propose, it is 70/30, a substantially greater benefit for every senior covered by this plan.

The coverage gap I mentioned earlier in Grassley-Baucus says if you reach a point where you had $4,500 in prescription drugs in a given year—not an outrageous possibility; that is a little more than $350, $400 a month; a lot of seniors face that—that at some point during the course of the year your benefits will stop. I said: Eliminate that gap. I want full coverage all the way up to the catastrophic level of $5,000 in prescription drugs, which then kicks in at 90-percent reimbursement. And we did.

Then we got to this issue: Will we have lower prescription drug prices? Under Grassley-Baucus, no. That is why the pharmaceutical companies love this bill. We have not heard a word from them. They think this is great. Uncle Sam is going to provide some assistance to seniors to pay for prescription drugs, and the drug companies can continue to hike the prices of the drugs every single year without any restraint in S. 1. But we know there is a better way, and the better way is not socialism, as some of my critics might say.

The better way is the Veterans' Administration of the United States of America. They look at their hospitals across America and the millions of veterans they serve and they go to the drug companies and say: If you want your drug used in our Veterans' Administration hospitals, you have to give us a discount, and they do. The drug companies give a 40- to 50-percent discount, and that should be part of this Medicare plan as well.

Probably the most important single element in this MediSAVE plan I am offering is we are going to have Health and Human Services negotiating group purchasing. Drug companies are not going to like this. Pharmaceutical companies do not like to see their profit margins come down. But these are the most profitable corporations in America. I do not believe it is the responsibility of the Senate to find ways to reward the special interest groups, the pharmaceutical companies, and the HMOs at the expense of senior citizens. That is exactly what this bill does.

As I mentioned earlier, more benefits would count toward out-of-pocket spending. Medicare would have a deliberate benefit available. That is what I think is equally important. We say: Fine, competition in choice. Private insurance companies can offer prescription drug benefits but allow Medicare, the Government agency, to have a prescription drug program available to every senior across the United States.

Why is that important? Medicare, as an agency, has no profit motive. Medicare, as an agency, has a lower administrative cost than health insurance companies across America, and Medicare, an agency speaking for tens of millions of seniors, can negotiate lower prices. They can do what the Veterans' Administration has done, and that is why many of the most conservative Members of this Chamber live in dread for fear that Medicare would be able to compete with private insurance companies. Put that competition in place. Give the seniors a choice. MediSAVE does it. Grassley-Baucus does not.

We have an option for private coverage. Of course, it is in both bills.

We have a fallback which says if a senior citizen wants to go to the Medicare plan, they can always go to it, whether there is a private insurance plan in their region.

The benefit begins, incidentally, under the Grassley-Baucus bill, conveniently after the next Presidential election. So the White House can go around crowing about S. 1, prescription drug coverage is on the way, we delivered for seniors of America, and it is going to show up a few days after the election. What is wrong with this picture?

Seniors need help right now. A discount card is nice, but let's put a prescription drug policy in place that helps seniors right now. So we call on the establishment of this program as soon as practicable.

How did we do this? How did we put together all these benefits, which are much more generous than Grassley-Baucus, and still have CBO score it at $400 billion? I learned a little trick from the Republican side of the aisle when it came to tax cuts. When they could not get enough money for tax cuts, they decided they would sunset them at some point and reauthorize them. We did the same thing.

Grassley-Baucus costs $400 billion scored through 2013. Our MediSAVE substitute costs $400 billion scored to sunset at 2010. At that point, Congress can take a look at it. If we reach the point where we want to reauthorize the program or change it, it is up to us. In the meantime, we offer seniors in America a quality program, something they want, something they can use, and something that will truly help them.

If we do not address the cost of prescription drugs as part of a prescription drug program, we are going to fail. There is nothing we can do offering a percentage helping hand to seniors that will keep up with the dramatic increase in the cost of prescription drugs, which happens every single year. This substitute I am offering will provide that kind of competition.

Before I yield to my friend from Minnesota, who is a cosponsor of this amendment, let me give a couple other items that I believe might be of interest to my colleagues.

The Durbin MediSAVE amendment is cosponsored by Senator DAYTON of Minnesota, who is here, Senator BOXER, Senator BYRD, Senator CORZINE, Senator HARKIN, Senator LANDRIEU, Senator STABENOW, and Senator JOHNSON. It also has been endorsed by the AFL–CIO, United Auto Workers, AFSME, Alliance for Retired Americans, the American Federation of Teachers, and the National Committee to Preserve and Protect Social Security.

At this point, I wish to yield, for the purpose of debate, to my colleague

from Minnesota, Senator DAYTON, without yielding the floor.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Minnesota.

Mr. DAYTON. I thank the Chair.

Madam President, I thank Senator DURBIN. I commend my distinguished colleague from Illinois, Senator DURBIN, who has spearheaded the development of this amendment, and for the leadership he has shown in this and so many other areas. I stand proudly with the Senator today.

The Durbin amendment is the essential test for this body. It is going to be the measure of our commitment to seniors and to other Medicare beneficiaries all over America. It is going to be a test of our sincerity of what we said we intend to do for those people who are either disabled, through no choice of their own and are required to be on Medicare at an early age, or senior citizens who have worked throughout this country who have served this country so well and now are in their retirement years, the largest users by age of prescription drug medicines. So they are the ones most dependent on the quality of coverage we provide for them.

I heard again today from colleagues on the other side of the aisle, as I have heard others say throughout this Chamber, and as I have said many times in Minnesota, that our senior citizens deserve prescription drug coverage that is as good as Members of Congress receive; that is as good as the Federal employees receive through the plan of which we are all part. Yes, we pay into that plan, but it is also very well covered—''subsidized'' would be the right word—by our employer, the Federal Government; the same in the case of Senator DURBIN's amendment, at a level of parity to our plan.

If we want to provide senior citizens and other Medicare beneficiaries with the same level of coverage that we get in Congress, then Senator DURBIN's amendment is the way to do that.

S. 1, by contrast, provides half of those benefits overall—one-half of what we get in Congress. That is not right, that is not fair, and that is contrary to what I have heard most of my colleagues rhetorically say over the last month, and even the last couple of years, about the intent.

We cannot have it both ways. It is either going to be only half as good under S. 1 for senior citizens as it is for Members of Congress or it is going to be as good as Members of Congress receive under the Durbin amendment.

Do we have the resources? Yes, we have the resources. We surely had plenty of resources when I came to the Senate 2½ years ago, surpluses for a decade, as far as the eye could see. Now that we have been shifted into deficit mode, suddenly we are talking about a bill that is inadequate.

It is not lack of money. It is a lack of priorities. It is a lack of the right priorities for people in this country, and Senator DURBIN's amendment would say we are going to go back to the drawing board and do what is right for seniors and Medicare, and then we are going to turn around and do what we must to balance that equation.

As the Senator from Illinois also pointed out so well, if we want to do anything to address the ravaging of budgets of people of all ages by these prescription drug prices, it has to be through the kind of structured program which the Senator has proposed; otherwise, it is just a continued license to steal for the pharmaceutical industry.

S. 1 does nothing except say taxpayers are going to pay the costs of these rapidly escalating drug prices. Seniors will have to pay for a part of it as well. And then all of the taxpayers who are not senior citizens who are paying for part of this program for seniors are going to have to go to the drugstores for their families and themselves and keep paying prices that go higher and higher.

I had a deck of cards made that I am handing out in Minnesota. They compare the prices of these drugs now in Canada and the United States. Aside from the exchange rates, they show a fair comparison of prices for the same medicine, same manufacturer, same packaging, everything exactly the same in Canada as the United States. The prices in Canada are sometimes as low as 10 percent of what they are in the United States, 20 percent quite common, a third—one can get the same medicine in Canada for one-third the price in the United States.

Why? Because the Canadian Government stands up for its citizens. The Canadian Government says: We are not going to allow you to charge these exorbitant prices and make these excessive profits out of the pockets of our people. Tragically, our Government does nothing of the sort. This bill would continue that policy: Hands off; pharmaceutical industry, take whatever you can get.

So I commend the Senator from Illinois. I am grateful to him for putting this amendment together. I am proud to cosponsor it. I commend it to my colleagues, and I ask the people of America to keep an eye on this vote because it is going to determine whether we mean what we say.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Madam President, I thank the Senator from Minnesota, and I think it really does come down to whether we are going to pass a prescription drug plan in name only or something that seniors truly want and can use and is fair for them.

The Senator from Minnesota led us yesterday in an amazing rollcall vote, 93 to 3. We, as Members of the Senate, said we would live by the prescription drug plan that is created by this bill. Well, stay tuned. See if that amendment survives the conference committee or ever comes back to us.

If it does not, if it is taken out, the Senator from Minnesota has made a point. As Members of Congress, we will have a benefit twice as generous as what we are now offering to seniors across America, and what we are offering is not that generous to the seniors.

Look at what it is. We estimate over the next 10 years the cost of prescription drugs for seniors in America will be $1.8 trillion. In that period of time, we are going to spend $400 billion in this prescription drug benefit. So that is less than one-fourth of the total cost of prescription drugs.

How can that one-fourth, $400 billion, go further? If the overall costs are reduced down from $1.8 trillion.

Let me give an idea of how that works. The Veterans' Administration has cut drug prices for veterans by as much as 50 percent by negotiating with drug companies. There is no provision in S. 1 that requires the Federal Government or Medicare or anyone to negotiate with the drug companies on behalf of senior citizens—none. At best, we hope some private insurance companies will work out a formulary that gives them an opportunity for a profit by reducing the cost of drugs. That is as good as it gets. That is as close as this Senate will come to saying to the drug companies that they have to do better.

When it came to our veterans, we stood up as a government and said: We are going to stand behind them. When it comes to this situation for prescription drugs for seniors, we do not.

Health and Human Services has a similar formulary of drugs available across America for community health centers and the like. They bargain down prices. But when it comes to seniors, the largest unprotected group of prescription drug users across America, this bill is silent; it does nothing. The alternative which I am proposing will do something.

Medicare has 25 times the number of people as the Veterans' Administration. It has bargaining power. It can reduce the cost of drugs. At this point, we know the inspector general of HHS compared a list of 24 drugs covered by both Medicare and VA and found that VA spent 52 percent less for the same drugs. The inspector general estimated that Medicare would have saved $760 million in 1 year on those 24 drugs alone.

Let me say parenthetically, when we went to the Congressional Budget Office to score this, incredibly, they refused to even concede that we could get a discount on drugs. Now, I like the Congressional Budget Office. I am sure they are the greatest people in the world. But to whom are they listening? They are ignoring the reality of the Veterans' Administration. There is real cost savings that we can anticipate.

Let me tell my colleagues what the savings are for seniors when we move from the 50/50 split that is proposed by this bill to a 70/30 split, 70 percent paid by the Government for prescription

drugs, assuming a $35 monthly premium.

Take a look at it. If a senior in 1 year spent $1,000 for prescription drugs, they would end up spending out of pocket $720 under our proposal—that is under MediSAVE—but under the Grassley-Baucus bill, they would actually spend over $1,000.

How is that possible? A thousand dollars of prescription drugs and it costs more than $1,000? Do not forget the monthly premium. The monthly premium has to be added in. That has to be paid. So if a senior signs up for this voluntary prescription drug benefit under this plan, for the first $1,000 in drugs they have spent, they are not going to get anything back; they are still going to be out of pocket.

Now let's look at what happens with $2,300, which is the average that seniors pay for prescription drugs. Under our MediSAVE plan, it says a senior will spend out of pocket $1,110—that counts your monthly premium. Under the Grassley-Baucus bill, it is $1,708. We are going to save them about $600 if they are the average senior with the average annual cost for prescription drugs of $2,300. Our bill will save seniors $600 over the Grassley-Baucus plan.

As we go up to $4,000, $1,620 is what a senior would pay out of the $4,000 prescription drug bill under our plan, $2,558 under the Grassley-Baucus plan. For the $5,000 plan, the situation is a senior would pay $1,920 under MediSAVE, $3,307 under the Grassley-Baucus bill. And then for $10,000, here is a situation where a senior would have out of pocket $2,420 for a $10,000 bill—and prescription drugs can reach that cost; ask people on cancer therapies—$4,539 if they took the Grassley-Baucus plan.

So by every single measure at every single stop along the road, the plan I am proposing is going to offer much better and real savings for seniors.

Some I have talked to on the Republican side of the aisle say: DURBIN, there you go again; this would be a price control. Well, the Veterans' Administration bargains with drug companies. We do not call it price control. When Canada stands up for its citizens to the same American drug companies, I think they are standing up for a national value and a family value. It is not a matter of corrupting the marketplace. The marketplace now is being driven by a handful of prescription drug companies that have little or no competition.

So unless and until some force such as the Government or the Veterans' Administration or the Department of Health and Human Services steps in, the average family, the average senior, does not have a fighting chance.

Incidentally, we brought this other chart out so people can see that even under this administration, we have had efforts by the Secretary of Health and Human Services to bargain down the cost of drugs.

Remember the anthrax scare? They said perhaps everybody should be prepared to buy Cipro. They took a look at Cipro market prices, and it was $4.67 per tablet. People said: If we have an anthrax problem across America, how will we afford this?

The Secretary of Health and Human Services, Tommy Thompson, went in and bargained it down to 95 cents and ultimately to 75 cents a pill from $4.67, and they made a profit at 75 cents. Do you want to know what the markup is on your prescription drugs? Look at what he achieved.

I will quote Secretary Thompson, who achieved this, and I commend him for it:

> Everyone said I wouldn't be able to reduce the price of Cipro. I'm a tough negotiator.

He obviously was, but when it comes to tough negotiations, this bill is silent. S. 1, the bill before us, is silent when it comes to these negotiations. We need to have someone who will stand up for seniors, families, and against the excessive prices charged by drug companies. The reason the drug companies want this bill is that no one is standing against them.

The bill I am offering, the MediSAVE substitute, will have exactly the opposite impact. We will bring down the excessive costs of prescription drugs. We will guarantee a $35 monthly premium, no deductible. We will make certain there is no gap in coverage so the private insurance companies cannot yank the chains of seniors across America. We will always give you a Medicare option so, as a senior, you can turn back to that agency and you can have a not-for-private low administrative overhead cost formulary that is discounted always available to you.

That is what seniors want. That is what they need. That is why so many organizations endorsed this bill. This is the bill we should be passing. We should send this to the House and say: What you are offering is a pale alternative to the real thing; MediSAVE is the real thing.

I commend it to my colleagues. I hope they join in voting for passage of this amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. HAGEL. Madam President, I ask unanimous consent the pending unanimous consent be modified so I be allowed to offer an amendment in the slot allocated to the Senator from Nevada, since we are cosponsor, and I ask unanimous consent I be allowed to offer two amendments.

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

AMENDMENT NO. 1012

(Purpose: To provide medicare beneficiaries with an additional choice of Medicare Prescription Drug plans under part D that consists of a drug discount card and protection against high out-of-pocket drug costs)

Mr. HAGEL. Madam President, I ask unanimous consent that the pending amendment be laid aside and the Senate proceed to the consideration of amendment No. 1012.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

> The Senator from Nebraska [Mr. HAGEL], for himself and Mr. ENSIGN, proposes an amendment numbered 1012.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

AMENDMENT NO. 1026

(Purpose: To provide medicare beneficiaries with a discount card that ensures access to privately-negotiated discounts on drugs and protection against high out-of-pocket drug costs)

Mr. HAGEL. Madam President, I ask unanimous consent that the pending amendment be laid aside and the Senate proceed to the consideration of amendment 1026.

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

The clerk will report.

The assistant legislative clerk read as follows:

> The Senator from Nebraska [Mr. HAGEL], for himself, Mr. ENSIGN, Mr. LOTT, and Mr. INHOFE, proposes amendment numbered 1026.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. HAGEL. Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

AMENDMENT NO. 1012

Mr. ENSIGN. Madam President, I will speak on the pending amendment that Senator HAGEL and I have offered. This amendment is similar to the bill we offered in last year's Medicare prescription drug debate. We offered it as a complete substitute last year. I will describe this legislation.

What we are proposing to do is substitute our piece of legislation for the prescription drug portion of the pending legislation. It is very important to have a prescription drug benefit for those seniors, especially those who are low or middle income, who have serious diseases and sometimes have to choose between prescription drugs and rent or prescription drugs and maybe even the type of food they eat.

I have heard story after story around my State of seniors who literally sometimes do not take their medications or maybe take half a dose because they cannot afford the prescriptions their doctor has recommended.

The Hagel-Ensign amendment has several advantages over the current portion of the committee bill. First, it takes effect one full year earlier than the committee bill. Second, we do not have monthly premiums for our prescription drug benefit. Under the committee's mark, seniors pay $35 a month; under ours, it is a one-time annual fee of $25, that is all. They pay that once a year, unless they are low-income, and then we waive that annual fee. Under the committee's mark, it is $35 a month.

We have several other differences in the bill. In the committee's mark, low-

income seniors have a very generous benefit for those above Medicaid income but who are below 160 percent of poverty. We recognize it is very generous. As a matter of fact, I submit it is overly generous and we will see an overutilization by those senior citizens because they do not have anything at stake. One to two dollar co-pays when you are paying 97.5 percent of their out-of-pocket expenses is not enough to discourage overutilization. We are going to see an explosion of utilization of drugs, especially in the low-income market.

Let me explain the amendment. We offer a prescription drug benefit with the seniors paying up to a certain percent depending on income, up to a certain dollar figure, and after that the Government will pick up 90 percent of the cost. For people who are below 200 percent of poverty, which is around $18,000 a year for an individual or $24,000 for a couple, they would be capped at an out-of-pocket expense of $1,500, and after that the Government picks up 90 percent. Between 200 and 400 percent of poverty, incomes for an individual up to nearly $36,000, and for a couple a little over $45,000, they would be capped at an out-of-pocket expense once again of $3,500 a year, and the Government pays 90 percent above that. Between 400 and 600 percent they are capped at $5,500 out-of-pocket a year. For people above that, the wealthier seniors, 20 percent of their income is their deductible under this plan.

All of these people get a prescription drug discount card. That prescription drug discount card can provide a discount of 25 to 40 percent on the drugs they purchase. Before these ever kick in they have already saved money for every senior. This is a completely voluntary plan. If seniors like the coverage they have today, they can stay in the coverage they have today. If they want to try something guaranteed to cap their out-of-pocket expenses, this is the plan for them.

We have several real-life examples to compare with the committee mark. First, James Johnson is 68 years old with an income of around $16,000. He is above 160 percent of poverty. He is being treated for diabetes. These are typical medications of someone being treated for diabetes: glucophage, glyburide, neurontin, lescol, zoloft. This totals $5,736 a year that this person pays for prescription drugs.

Let's compare under the committee mark versus the Hagel-Ensign approach. Under the committee mark, this person would have a total out-of-pocket expense of $4,000. Under the Hagel-Ensign, this person would have about $1,900. This person would do a little over $2,000 better under Hagel-Ensign than under the committee mark. For those low-to-middle income seniors who have a serious disease, they do better under our approach.

Everyone wants to help the most those who need it the most. Under our approach that is exactly what happens. Those people who are sick, who need the most help, get the most help under our plan.

Here is another real life example. Doris Jones is 75 years old with an income of around $17,000 per year and is being treated for diabetes, hypertension, and high cholesterol. She takes lipitor, glucophage, insulin, coumadin, with total drug costs around $3,600. To compare the committee mark, the bill before us compared to Hagel-Ensign would spend around $2,380 a year under the committee bill; under the Hagel-Ensign approach she spends about $1,700. Although she did not have as much out-of-pocket drug costs for the year, she saves almost $700 a year under the Hagel-Ensign approach.

And the last real-life example, Betty Smith is 66 years old. She has an income of around a little over $15,000 per year and is being treated for breast cancer. She is still receiving low-dose radiation therapy with nolvadex. Her medication profile is as follows: morphine, paxil, dexamethasone, aciphex, and nolvadex, with total costs for drugs around $8,000 a year. To compare Betty's costs between the Hagel-Ensign approach and the committee mark: her total out-of-pocket expenses will be $4,340 with the committee mark; under our bill, she will spend around $2,100, which would be a savings to her of almost $2,200 a year.

Once again, comparing the two approaches, those middle- to low-income seniors who have serious diseases are going to get much more help under the Hagel-Ensign plan.

Our bill actually costs less money than the committee approach and because of that we are going to be offering an amendment, which subsidizes the costs for people with incomes 160 percent of poverty and under; I will talk about that in just a minute. But the reason our bill comes in at less money is because the seniors are paying the first dollars out of pocket. After that, the Government kicks in to subsidize their costs. So, by them paying the first dollars out of pocket, we encourage people to be accountable in the system. The person who is receiving the drugs is responsible for paying those first dollars. Guess what: that causes them to go out and shop. They call the various pharmacies and find out what the best price is. They ask their doctor, Is there a generic drug available that is just as effective? If it is something maybe not life-threatening and they want to take the generic version of the drug, the doctor can say, Yes, I have had good experience with patients with this. They can take the generic drug, saving themselves money and saving the whole system money.

That is why our bill overall would cost less money. What Senator HAGEL and I have decided to do is, because there is $400 billion available to spend under the budget, we have taken around $60 billion, spread over 10 years, to put toward those people who are truly poor, below 160 percent of poverty. Our plan would give them, in a pharmaceutical benefit account, $700 to spend on prescription drugs. If they do not use it, it rolls over to the next year. By the way, if it rolls over 2 years in a row, and the third year they get another $700, at the end of the year they get to keep anything above $1,500. So there is an incentive; they have something at stake, so they will still shop around for the best price for their drugs. So it keeps market forces at play within our Medicare prescription drug system. That is one of the strong points, we feel, about our plan.

There are several other advantages that we think are in our bill that are not included in the committee mark. I asked this question yesterday; I asked the administration, I asked Secretary Thompson, and I asked the director who oversees Medicare, What will happen under the committee's mark to the State plans? My State of Nevada and many other States, New York, Massachusetts, West Virginia—have State plans that help senior citizens with prescription drugs. What will happen to those state low-income plans—above Medicaid level but below around 160 percent of poverty—if the committee mark is enacted?

The simple answer is: all of those plans will go away because, for those seniors under this plan, there is no reason for the States to pick them up anymore. The committee mark will pick them up completely.

Our plan works with the States, instead of substituting for the States. Those plans in the States that are already working, and working well, will continue. As a matter of fact, each State can learn from the other. If they want to be a little more generous, a little less generous, they can do that. But it doesn't supplant the States, like the committee mark does.

The other big problem I have heard articulated with the committee's prescription drug benefit is that private companies that currently have plans are going to start dropping their plans left and right. Under our bill, because we offer a higher deductible than most of the plans offer, there is not going to be the incentive for them to drop their plans. So it is not going to be a transfer from the private sector onto the public sector. And when I say public sector, I mean the taxpayer—younger people paying the taxes for older citizens.

There are many benefits to our plan, we think, over the committee mark. Let me just quickly repeat those.

First, we help those seniors, especially in the middle- to low-income, much more than the committee mark does, those who have serious diseases.

Second, we have no monthly premiums. The committee mark has a $35-a-month monthly premium.

Third, our plan does not replace State plans, it works with State plans.

Fourth, our plan also does not encourage the replacement of private

plans that companies have set up for their retirees.

Fifth, I believe our bill will control drug costs into the future. I applaud the committee. They have gotten together in a bipartisan way, trying to come up with a fix to a serious problem. But the problem I see is that it is right now scored by the Congressional Budget Office at around $400 billion. I think there is going to be so much overutilization in that, that it is going to end up being more like $800 billion or a $1 trillion plan. Young people are going to have to pay that.

That is just how much it is going to cost in the next 8 to 10 years. When you start extending that out into the 10 years beyond that, you start doubling and tripling those costs as we get the new, more expensive drugs into the marketplace.

So I think we should do the responsible thing. That is why we are encouraging our colleagues to take a look at this. We had the same bill voted on last year. We got a bipartisan vote. We had 51 Senators vote for this plan. If we got that for this amendment, this amendment would be adopted as part of the bill.

I know there have been deals made: Let's just defeat all amendments. I encourage people to say, If we can improve this bill, let's improve this bill. Let's make it responsible to the next generation. But let's also do what we say we all want to do, and that is to help those seniors who truly need the help. Let's help those who are the sickest and those who are in the lower-income categories, who end up having to make those decisions I talked about: choosing between prescription drugs and rent, between prescription drugs and food, or maybe only taking one of their prescriptions or a half dose of their prescription because they cannot afford the full dose.

In conclusion, I plead with my colleagues to study this issue. I know this bill is being rushed through, so people have not had a chance to take a look at all the options. This is so serious. This is the biggest entitlement program that any Senator who is currently serving will ever vote on. This has incredible implications for generations to come. We'd better do it right the first time because coming back for a fix a couple of years from now—we have seen how difficult it was to get to this point—is going to be virtually impossible.

So we'd better do it right the first time—at least get as close to right as we can. That is why we are encouraging our colleagues to take a serious look at the Hagel-Ensign amendment and do something right for the country.

I yield the floor.

The PRESIDING OFFICER (Mr. HAGEL). The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be set aside.

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

AMENDMENT NO. 1060

(Purpose: To provide for an income-related increase in the part B premium for individuals with income in excess of $75,000 and married couples with income in excess of $150,000)

Mr. BAUCUS. Mr. President, on behalf of Senators FEINSTEIN and NICKLES, I send an amendment to the desk regarding an income-related increase in Part B premiums and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mrs. FEINSTEIN, for herself, Mr. NICKLES, Mr. CHAFEE, and Mr. GRAHAM of South Carolina, proposes an amendment numbered 1060.

Mr. BAUCUS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. BAUCUS. Mr. President, I ask unanimous consent that all pending amendments be set aside.

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

AMENDMENT NO. 1061

Mr. BAUCUS. Mr. President, on behalf of Senator AKAKA, I send an amendment to the desk regarding the treatment of Hawaii as a low-DSH State and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. AKAKA, proposes an amendment numbered 1061.

Mr. BAUCUS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To provide for treatment of Hawaii as a low-DSH State for purposes of determining a medicaid DSH allotment for the State for fiscal years 2004 and 2005)

On page 633, after line 21, add the following:

(3) APPLICATION TO HAWAII.—Section 1923(f) (42 U.S.C. 1396r–4(f)), as amended by paragraph (1), is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

''(7) TREATMENT OF HAWAII AS A LOW-DSH STATE.—The Secretary shall compute a DSH allotment for the State of Hawaii for each of fiscal years 2004 and 2005 in the same manner as DSH allotments are determined with respect to those States to which paragraph (5) applies (but without regard to the requirement under such paragraph that total expenditures under the State plan for disproportionate share hospital adjustments for any fiscal year exceeds 0).''.

Mr. AKAKA. Mr. President, I rise in support of my amendment to restore a Medicaid disproportionate share hospital, DSH, allotment for Hawaii. Medicaid DSH payments are designed to provide additional support to hospitals that treat large numbers of Medicaid and uninsured patients.

The Balanced Budget Act of 1997, BBA, created specific DSH allotments for each State based on each their actual DSH expenditures for fiscal year 1995. In 1994, the State of Hawaii implemented the QUEST demonstration program that was designed to reduce the number of uninsured and improve access to health care. The prior Medicaid DSH program was incorporated into QUEST. As a result of the demonstration program, Hawaii did not have DSH expenditures in 1995 and was not provided a DSH allotment.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 made further changes to the DSH program, which included the establishment of a flood for DSH allotments. However, States without allotments were again left out. Other States that have obtained waivers similar to Hawaii's have retained their DSH allotments. Only two States, Hawaii and Tennessee, do not have DSH allotments.

As currently drafted, S. 1 provides that States without DSH allotments could obtain an allotment if their waiver was terminated or removed. It is my understanding that while this language would permit an allotment for Tennessee, it would prevent Hawaii from obtaining its DSH allotment as long as the QUEST program remains in place.

My amendment would provide a DSH allotment to Hawaii and allow for my home State to participate in the Medicaid DSH program. This amendment is needed because many of our hospitals in Hawaii are struggling to meet the elevated demands placed upon them by the increasing number of uninsured people. DSH payments will help Hawaii hospitals meet the rising health care needs of our communities and reinforce our health care safety net. All 50 States need to have access to Medicaid DSH support.

My amendment is similar to language included in the Senate passed version of S. 2, the Jobs and Growth Tax Act of 2003, that would have provided assistance to low DSH States and would have provided an allotment for Hawaii. Unfortunately, the DSH provisions were not retained in the conference report. A Hawaii specific provision is necessary as we attempt to provide additional support for hospitals in low DSH States in this legislation.

I appreciate all of the work done by my colleague from New Mexico, Senator BINGAMAN, to provide additional support for low DSH States. I urge that my colleagues support this amendment to allow the State of Hawaii to be treated like other extremely low DSH States and finally receive a Medicaid DSH allotment.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

AMENDMENT NO. 1062 TO AMENDMENT NO. 974

Mr. REID. Mr. President, I call for the regular order with respect to Grassley amendment No. 974 and send an amendment to the desk on behalf of Senator BOXER.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mrs. BOXER, proposes an amendment numbered 1062 to amendment No. 974.

Mr. REID. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To eliminate the coverage gap for individuals with cancer)

At the end of the amendment add the following:

SEC. ___. NO COVERAGE GAP FOR ELIGIBLE BENEFICIARIES WITH CANCER.—

''(A) IN GENERAL.—In the case of an eligible beneficiary with cancer, the following rules shall apply:

''(i) Paragraph (2) shall be applied by substituting 'up to the annual out-of-pocket limit under paragraph (4)' for 'up to the initial coverage limit under paragraph (3)'.

''(ii) The Administrator shall not apply paragraph (3), subsection (d)(1)(C), or paragraph (1)(D), (2)(D), or (3)(A)(iv) of section 1860D–19(a).

''(B) PROCEDURES.—The Administrator shall establish procedures to carry out this paragraph. Such procedures shall provide for the adjustment of payments to eligible entities under section 1860D–16 that are necessary because of the rules under subparagraph (A).

Mr. REID. Mr. President, we on this side have been as cooperative as we could be. We have done everything we can to move this legislation along. And I have said publicly that I appreciate how Senator FRIST has handled legislation since he has become the Republican leader. He has not tried to shut off debate. He has rarely filed cloture, and that is commendable. And I have said, on more than one occasion, I appreciate that.

But we are in a situation now where, as part of the regular process of doing business here, we have a difficult amendment. It is a tough vote for a lot of people. It is a Boxer amendment. In effect, it would allow coverage—without exception—for prescription drugs for people who are diagnosed as having cancer.

We have been told by various people on the side of the majority that we are not going to have a vote on this. Well, my response to that is, we are going to do nothing else on the bill. This is now the regular order. And until there is an agreement made that we are going to vote on this, we are going to do nothing else. This is it. We have a lot of tough votes here, and this is one of them.

Now, Mr. President, we could have, if we had been mischievous, done other things. Some said: Why don't we have Alzheimer's? Why don't we have diabetes? Why not have juvenile diabetes? Why not have Parkinson's? The Senator from California, acting in good faith, recognizing the need to move this legislation, said she would limit her amendment to cancer. And that is what has happened.

So, Mr. President, we are now at a point where there is going to have to be a decision made by the majority when we are going to vote. We want a vote. That is all we want. We want a vote. We will do it at any time, but until there is an agreement, there will be an agreement on nothing on this bill.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I would like to speak about the underlying bill.

Mr. President, I think one of the greatest achievements of the Medicare bill that has been reported out by the Senate Finance Committee is the compromise Senator GRASSLEY and I worked out on the issue of private prescription drug plans.

Over the course of this 4-year debate over prescription drugs—and I might add, it has been very frustrating for a lot of Senators. We have been trying to find a way to get prescription drug benefits passed for seniors but have been at loggerheads the last 4 years. Both sides wanted their view and neither was willing to compromise. But I think, finally, it is clear we have reached an agreement.

I commend the chairman of the committee, Senator GRASSLEY, and all those who helped to work to make this possible. Frankly, a lot of people are to be complimented—everybody from Senator BREAUX to Senator KENNEDY. And the list is just endless. Senator SNOWE, for example, has been a great advocate, tirelessly trying to get a compromise agreement over the years.

We finally agreed private entities should administer a Medicare prescription drug program. I know that is something that many, particularly on the Republican side of the aisle, are very interested in.

Both sides of the aisle envision these entities might include pharmacy benefit managers, so-called PBMs. They could include insurance companies, chain store pharmacies, or partnerships among these entities. Any one of those groups would contract with HHS and be the private entity or the contracting company that would contract out the prescription drug benefits to beneficiaries.

The main disagreement was whether these private plans should be required to bear insurance risk for the prescription drug benefit. Without being too arcane, there is a question of performance risk and insurance risk. Performance risk has traditionally been borne by the pharmacy benefits manager. But the performance risk means the administrative risk and the cost of doing a good job just administratively; that is, without addressing the question of insurance risk as to whether people are going to buy these prescription drugs and how much the subsidy is or is not.

Now, some argue if plans are required to bear insurance risk in addition to the performance risk, they will be more efficient and prudent managers of prescription drug costs, the argument clearly being if you are a company or a PBM, and you have to bear the entire cost, the entire risk, including not only performance risk but insurance risk, you are probably going to be more efficient and probably a more prudent manager than you otherwise might be.

Plans will have stronger incentives, if they have that risk, to negotiate better prices and implement cost-containment strategies to minimize unnecessary utilization, the argument goes, if these plans bear at least some level of insurance risk.

Now, there have been critics of this model. Those critics argue if plans are required to bear insurance risk, they would structure their benefit design to discourage high-cost patients from enrolling in their plans; that is, they would cherry pick. We would be in the unfortunate world of adverse selection, where some plans would model their program they would offer to seniors in a way to discourage high-cost patients and encourage lower cost patients, and they therefore would be more profitable, leaving some of the higher cost patients, that is, those who really need drugs, out in the cold.

The health insurance industry has not been exactly rushing to the table to offer these benefits. The insurance industry does not seem willing to offer prescription drug benefits to seniors, even with the subsidies they would get if they are required to bear all of the risk.

Without a strong commitment from the health insurance industry, many fear that the insurance risk structure would lead to an unstable benefit. There would be a lot more instability because we don't know whether companies would be participating by offering plans. After all, this is something that is new. Plans would come in and out at will, forcing seniors to switch plans and possibly their medication.

In writing this bill, one of the greatest challenges Senator GRASSLEY and I faced was how to find the right balance between efficiency and plan stability. There have been several major prescription drug benefit bills and approaches. One we hear a lot about is the tripartisan bill of last year. Another one which explains this phenomenon was the so-called Graham or Kennedy bill of last year. The tripartisan model, in trying to resolve the dilemma between efficiency and stability, tilted more toward efficiency and away from stability. It had many more competitive components in it to

allow companies to be more efficient and cut costs and be more likely to participate. On the other hand, it was more unstable from the point of view of beneficiaries, probably more unstable from the point of view of the company as well, and that was a problem that many on the Democratic side had with that benefit design, particularly that model.

On the other hand, last year a major bill that was considered by the Senate was the so-called Graham-Kennedy bill. That bill tilted much more toward stability at the expense of efficiency. It was more expensive. More than $400 billion had been allocated over 10 years, and seniors would have had more predictability. They would know what they were getting because there was more money for companies. On the other hand, companies would not be able to compete among themselves, and there was much less competition and, therefore, under that model, much less efficiency.

One of the main merits of this bill is that it is in the middle. It is between the so-called tripartisan bill and the Graham bill. In trying to find the right balance between efficiency and stability, we are pretty much in the middle. We have found that balance. We both agreed that we needed to create strong incentives to keep prescription drug prices low. We also agreed that we needed stronger assurances that private plans would be ready and willing to enroll beneficiaries come January 1, 2006, when the benefit begins.

We have found that balance in this bill. This bill was passed out of the Finance Committee by a large bipartisan margin, which is some indication that we found the balance.

There are several important elements of this compromise I would like to highlight. First, our proposal would phase in insurance risk carefully over time through the use of reinsurance payments and risk corridors. Those are pretty big terms. What do they mean? Plans would receive Federal reinsurance payments for 80 percent of their enrollees' costs above the stop-loss level. These payments are intended to ensure that plans have strong incentives to enroll high-cost beneficiaries. That is, Federal reinsurance payments would cover 80 percent of the enrollees' costs above the stop-loss levels contained in the bill.

In addition, our proposal added another component to moderate risk through the use of what we call risk corridors. What in the world is a risk corridor? Simply put, it would limit a plan's loss if the plan sustained substantial financial losses. And by the same token, risk corridors would limit a plan's gains if it earned potential profits. We phase in risk over the first couple of years so that the private plans would have a little cushion, a little better opportunity to know how well their plan is working, and that errs a little bit more on stability at the expense of efficiency. But after a couple years, the tilt is a little more toward efficiency, having gained a couple years of experience, hopefully, of more stability.

During the first couple years the bill would establish a narrow corridor of risk. Over time the risk corridor would be expanded, thereby shifting a greater share of the risk on to the health plan. By phasing in risk over time, this bill addresses one of the biggest concerns plans had in considering whether to participate in the new program. That is, the uncertainty during the first couple years of the benefit.

This uncertainty takes many forms. For example, who will sign up for the benefit? That is a big question. Very few people know. Second, will drug costs increase faster than Congressional Budget Office projections? That is a big question. Moreover, will beneficiaries consume more prescription drugs once the benefit has been implemented?

That is another big question. It is hard to know. That is why we believe it is important to phase in risk rather than just cold turkey, 100 percent insurance risk the first day of the first year.

So during this period of uncertainty, we will ask the plans to bear a minimal level of insurance risk. As plans develop more experience, we will require them to assume more risk.

I am more confident than I was last year that private drug plans will provide a stable delivery system for Medicare beneficiaries under this new plan both in urban and rural areas. I remain concerned that not all seniors will have a choice of two or more prescription drug plans in the region. Plans may simply, given all the provisions we have added to this bill to help give them a little bit of reassurance, not be willing to participate in some parts of the country. After all, it is their choice whether plans want to participate.

This concern is why I insisted that any private plan delivery system must offer all beneficiaries the choice of at least two private plans, and if any part of the country does not have at least two choices, the Secretary would be required to contract with a plan that is a Federal fallback or a backup plan that would offer the standard benefit at the national average premium. Some might argue this delivery model does not provide enough efficiency and cost management. Others might argue that this will prove to be too unstable, too much efficiency, too much instability, despite the changes we have made. Plans may come and go. Worse, they may not even appear and seniors will be confused. That is a concern, and it is a legitimate concern, believe me.

Nevertheless, I believe that given the competing forces of efficiency on the one hand—competition and cost containment—and stability on the other—making sure that seniors have the prescription drugs they want—we have found a balance between these two fairly legitimate concerns.

I am not here to say it is the perfect balance. Clearly, others have better ideas how to address the question of where the balance is. I do believe the provisions of this bill are pretty close to it.

As we implement this benefit, we will have to carefully monitor the new delivery system very closely to ensure that, in fact, it is fair to our seniors and also fair to our taxpayers and to our private sector partners.

There are a lot of concerns here. One surely is making sure the senior citizens get the prescription drug benefit. But then equally important is that the American taxpayers' concerns are respected, and that we get savings, where we can honestly get savings, not at the expense of beneficiaries. That is why I believe an inclusion of private competition is important. It is very important.

Health care in our country is evolving, as you know, very quickly, and into areas we can hardly even imagine. I believe that in the next 10 to 20 years, when we are also faced with the problem of the baby boomers, there are going to be dramatic changes. What are the three areas going to be?

First of all, with the massive computational power that is developing, nanotechnology, married with the biotechnology, we will be able to, in not too many years from now—10, 12, 15 years—predict, with the human genome project, the interaction of systems in our bodies and the effect of DNA and predict what maladies or illnesses people are going to have in the future. We will develop machines that will detect things at a molecular level, with thousands of tests, that will be able to predict what will happen to each individual, or whether some of us are more inclined to get cancer or to have coronary disease—you name it. We are going to be able to predict very precisely in not too many years from now.

In addition, we will then be able to take actions to prevent illnesses with much greater certainty than we can today. We will be able to prevent it, since we know better what will happen to each of us with respect to our health, by deciding whether to take this pill or that pill or that new medicine that addresses a potential coronary disease that may occur with absolute certainty, or near certainty, 30 years later, or a cancer disease that may, with almost near certainty, occur 20 years later. That is where we will be in Medicare. It is changing so much.

Then, basically, health care will change from remedial care to personal wellness care. That is, doctors and people in the health care industry will be working with individuals to determine what illnesses they may or may not get and things they can do right now to prevent those illnesses from occurring. It will be a big shift from remedial care, which is about 90 percent of today's health care, to wellness and preventive care.

What else will happen? Seniors are going to live a lot longer. The quality

of our lives will be a lot better. It will change the demographics of the country and the health care in our country. The main point is that there are going to be a lot of changes in health care in the not-too-distant future.

What we are passing today on prescription drug benefits will also change. It is almost impossible for us to predict what the legislation should be in the years 2009, 2014, as this bill does. Yet we are doing the very best we can.

My point is that, given where we are today, in June 2003, I think this is a very good and aggressive attempt to try to find the right balance given all the different considerations we face. We can be very sure—and the chairman and I will give it utmost vigilance and oversight to make sure—that this delivers what is being promised to all our Medicare beneficiaries, the seniors of our country.

I respectfully urge my colleagues to closely evaluate the provisions and the merits of this compromise proposal. I have mentioned components that I think some Senators haven't had time to look at yet. I am talking about the balance between efficiency and stability. I am talking about phasing in risks, the risk corridors, as a good-faith effort to try to help make competition work—if it does work. If it does not work, we will know after a period of time. If it does not work, the bill provides a safety backup plan so that seniors are protected.

As I said, with all of the health care changes and the changes in the medical care that will happen over the years, we will probably revisit this in the not-too-distant future to address current conditions and the provisions of this bill.

As Senators study it more closely, they will realize there is a little more good in this bill than a lot of Senators originally thought. A lot of people have just not had an opportunity to focus on this.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

AMENDMENT NO. 1062 WITHDRAWN

Mr. REID. Mr. President, we have had conversations while the manager has been speaking. We have been assured by the majority that we will have a vote on the Boxer amendment in the next 24 hours. Having said that, I withdraw the Boxer amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. BAUCUS. Mr. President, I address an issue that many of my colleagues have asked me about over the past 2 weeks. It is an issue of great concern to many, particularly on my side of the aisle. That is, if this bill is enacted, how much will premiums vary and what will the actual effect of premium variation be for seniors?

Now, we have had a couple of votes already on this subject. I have not had a chance to address it directly and I would like to do so at this point. The issue again is the extent to which benefits and premiums may vary under this new Medicare drug benefit.

My Democratic colleagues are concerned that if benefits and premiums for participating drug plans are allowed to vary seniors will be confused and they will be unable to make informed choices, that is, the premiums seniors would pay, the monthly amounts they would pay for prescription drug coverage, should they volunteer to participate—that is, if they volunteer to participate, because it is an entirely voluntary program. It is not mandatory like the old catastrophic coverage bill was—in 1989 I think it was. This is voluntary. Seniors have a choice of whether they want to sign up for this new prescription drug benefit plan. If they do sign up, they pay a monthly premium of $35 a month for participating in the prescription drug plan.

Then the question is: How much can premiums vary and how much confusion might that cause among people trying to figure out the various merits of the various plans?

I might say they will not be able to make an apples-to-apples comparison between plans that are available in their own area. That is their concern; they just will not be able to compare fairly. As I said, these concerns are legitimate.

Certainly, those who believe in competition believe choice should be based on price and on quality. It should not be based on a plan's effort to select the healthiest beneficiaries and jettison the sickest. It should also not be based on distortions in the market. That is, we want fairness. We want equity. We do not want so-called cherry picking. We do not want to have certain plans pick the healthiest seniors, adjust premiums to get the healthiest, and leave out other seniors who require more prescription drugs that are not as healthy. That would just not be fair.

At the same time, we want to have some competition, and this bill does provide for private plans to provide a drug delivery benefit. The reason for relying on the competitive delivery system rather than the Government-based program is to allow for innovation and benefit design, to let companies look to try to find a better way of doing things, that is, of containing costs, and be more efficient, without sacrificing quality and stability to our seniors.

I think most of us believe that kind of innovation will lead to efficiency. The attempt is to design it in a way that does not lead to a risk in selection because that would be very unfair. So the question is: How can we ensure that choice is in fact based on the right factors, that is on price and on quality? How can we make sure there is enough flexibility so plans can adapt to changing needs and to a marketplace innovation, without providing so much flexibility that seniors have a difficult time choosing among plans? That is the challenge. That is what we are trying to resolve in this bill.

I think the proposal before us, the legislation reported out of the Finance Committee that has come to the floor, does a pretty good job of constructing that balance, and I will explain why I believe that is true.

First, on benefit variation—that is different benefits seniors may get because of different plans—the Grassley-Baucus bill limits benefits variation at several levels. First, the $275 deductible and the $3,700 out-of-pocket limit are fixed in the statute. Those two figures cannot vary. So plans are permitted to improve the benefit, but they cannot go higher than the deductible outlined in the law, and they cannot raise the stop loss beyond the level specified in the law. So that is one check. It does leave some potential variation on the premium and copay, but at least two components—deductible and stop loss—are fixed in the law.

All plans, whatever the benefit design is, whatever they offer, have to have those two provisions as prescribed in the statute.

Now, a benefit variation is also constrained through various limitations in what the Congressional Budget Office calls actuarial value or expected cost of the benefit. In plain English, that means the value of the benefit must be roughly equal to the standard benefit package outlined in the legislation.

We have all heard about the standard benefit package, the deductible, the stop loss, the premium, and what the copays are, so that the value of the benefit of any plan any company offers must be roughly equal to the standard benefit package outlined in the legislation.

As I understand from actuaries who spend their time thinking about these things, the practical effect of these provisions combined is there will not be significant variation in benefit packages. There just cannot be. All companies are going to know pretty much what they can charge. The actuaries do not predict much variation.

The bill also, however, attempts to minimize premium variation. How? Well, the bill includes various provisions that are intended to control variation in the premiums so beneficiaries will not be faced with widely varying premiums within their own region or across different parts of the country.

For example, if my mother learned her friends in Florida were paying far less in monthly premiums than she was paying in Montana, I believe I would get an earful. I would hear from my

mother. She would wonder whether the system we created is fair. And she would be right; it probably would not be fair.

What do we try to do about this? It is not perfect, but I think it is a major effort, and I think it is a good effort.

First, all Medicare beneficiaries who are enrolled in the new drug program will be combined for purposes of calculating premiums and payments to plans, regardless of whether those beneficiaries are in fee for service, enrolled in a drug-only plan, or whether they are enrolled in a private PPO or HMO. All senior citizens who are enrolled in Medicare will be combined for the purposes of calculating premiums and payments to plans, regardless.

Mr. ALLEN. Mr. President, will my good colleague from the State of Montana please yield for the purpose of an introduction of an esteemed guest? I know this is very important, but I ask if he will yield for a moment.

Mr. BAUCUS. Mr. President, I yield 1 minute to the Senator from Virginia.

The PRESIDING OFFICER. The Senator from Virginia.

VISIT TO THE SENATE BY THE HONORABLE PATRICK COX, PRESIDENT OF THE EUROPEAN PARLIAMENT

Mr. ALLEN. I thank the Senator because I know he is talking about a very important issue to all the people of America.

I do have the honor of presenting to my Senate colleagues the Honorable Patrick Cox, who is the President of the European Parliament. As my colleagues know, the European Parliament is the only directly elected body in the European Union and the only popularly elected international assembly in the entire world.

Every 5 years, Europe's 375 million citizens have the chance to vote for 626 representatives. President Cox's position is the equivalent of the Speaker of the House and the President of the Senate combined. So he is TED STEVENS and DENNY HASTERT together.

I appreciate the indulgence of the Senator from Montana, and I request my colleagues to take a moment to introduce themselves to President Cox because we do have so many transatlantic bonds, not only philosophically but also economically for jobs.

I yield the floor.

Mr. BAUCUS. We are very honored to have our guest. I don't know how long he wants to stay. There are so many transatlantic issues we can address.

I see my very good colleague from Iowa in the Chamber, and we have lots of agricultural issues. We would also like to learn from Europe about European health care systems. I am sure there are provisions in Europe we could look at and adopt. No country has a monopoly on good ideas and no region of the country has a monopoly on good ideas.

I urge our guest to stay as long as he possibly can and hopefully have time to converse over some of these issues so we can get a better idea of how we can resolve some of these huge issues, including agricultural and other trade issues. We all know the more we work together, the better we will be on both sides of the Atlantic.

Mr. ALLEN. Thank you, Mr. President.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—CONTINUED

Mr. BAUCUS. I have been explaining various provisions in the bill that I think largely address concerns that some on the Democrat side have and I suppose on the Republican side of the aisle, too; namely, potential premium variation. Premiums that seniors pay might vary. Much confusion might occur for seniors and anyone else involved in prescription drug benefits that would be distributed under this legislation.

As I mentioned, the actuaries say there should not be much change. Also, the risk pool will include all Medicare beneficiaries, ensuring an adequate number of low-drug-cost beneficiaries will be able to subsidize the few beneficiaries with the high drug costs. Already, there is a huge risk pool. There is kind of a cross subsidization. Those with very low drug costs will help pay for those much higher costs of other seniors. The larger risk pool will prevent premium variation because we use the whole pool.

In addition, the bill will calculate Federal contributions toward plan premiums based on the national average of all plan bids. This contribution is then adjusted geographically for differences in prices. This is a so-called geographic adjustor. We want to make sure one part of the country is not discriminated against compared to another part of the country or vice versa, and we included the geographic adjustment on prices.

We have not included so far, because it is difficult to calculate, geographic adjustment based on utilization. As we know, in some parts of the country there is more utilization. That is a fancy term for saying there is a lot more care given to people than in other parts of the country. More care, the greater utilization, tends to be in parts of the country with more hospitals, more specialty health care providers.

There is an interesting study I urge my colleagues to read by Dr. Wennberg. I have not found anyone who refutes it. Looking at the country as a whole, there are parts of the country where utilization is twice as high and more than twice as high as other parts of the country. People, because of where they live, get twice as much health care in some parts of the country than in other parts of the country. This is adjusted for age, for race, for gender. It is adjusted for all the factors that can possibly be thought of.

The more interesting part of this study, even though some parts of the country get twice as much health care as other parts of the country—and it is because there are twice as many doctors or hospitals in some parts of the country as in others—the interesting part of the study is, the actual care given is no better, and in fact in some cases it is worse. That is, if you get twice as much health care, that is, twice as many visits to the doctor or the hospital, particularly for chronic diseases, you will not be twice as healthy; you will not be any healthier, on average, than you will be in parts of the country where there is less utilization.

The point is that we are trying to adjust, as I mentioned earlier, and have a geographic adjustment based on the costs. We have not yet figured out a way to adjust for different utilization mainly because, when it comes to prescription drug benefits for seniors, there is virtually no data because we have not had prescription drug benefits for seniors yet. Obviously, it is hard to get the data if we have not had the program.

There are other provisions in the bill that enable us to get more data, so fairly quickly we can get better utilization data and therefore have a geographic adjustment based not only on price but also on utilization. That will go a long way to address some of the concerns people have about potential premium variation and complexity. When we get that data, as I said, we will have a lot more information, but there is enough information already to have the effect of minimizing concern about premium variations.

There is another provision in the bill to help address this potential problem. That is, we have included in this bill a provision based on the Federal Employees Health Benefits Program—otherwise known as FEHBP—that prohibits plans from changing premiums that are unreasonably higher than the costs of the benefits provider. In other words, plans are prohibited from price gouging. That standard currently is in the law with respect to the FEHBP plan. That is in the law. There is a provision in current law that prohibits the FEHBP plans from charging premiums that are unreasonably higher than the cost that has been provided. I believe that same provision as applied to prescription drug pricing is an additional guarantee against gouging and certainly against unconscionable premium variation.

Finally, this bill allows the Secretary to refuse to contract with the plan. That is in the bill. Maybe a plan leans toward enrolling healthier beneficiaries. Maybe the Secretary determines that this plan is not a good actor; this plan is price gouging; this plan is engaging in cherrypicking; it is engaging in adverse selection at the expense of an American; or maybe it seems less committed to staying in the program; maybe there is a shady operation; who knows, maybe it seems more likely to drop out fairly quickly

and it is not solvent or financially healthy; maybe the premiums seem inconsistent with others in the region.

For any of these reasons and reasons not contemplated at this time, the Secretary can decide, at his discretion, not to contract with a drug plan that has submitted a bid to participate in Medicare. That option is still there as a protection for our senior citizens. It is my hope that this discretion will help assure better plan choices for seniors and the benefits and premiums will, in fact, be fair and reasonable.

In short, in developing this compromise bill, Senator GRASSLEY and I have tried to allow a level of variation in premiums and benefits so as to foster innovation and to foster efficiency but not so much variation that seniors will be confused or plans will game the system.

I think we have done a pretty good job of ending confusion and a pretty good job of preventing plans from gaming the system. I hope my colleagues will agree this proposal strikes at that.

Madam President, I yield the floor.

AMENDMENT NO. 1040

(Purpose: To provide for equitable reimbursement rates in 2004 and 2005 for Medicare+Choice organizations making the transition to MedicareAdvantage organizations)

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Madam President, the Senator from New York, Mr. SCHUMER, and I are in the Chamber now to offer a amendment. Unfortunately, I have to withdraw that amendment because of budgetary constraints with which we are going to be dealing.

This is an amendment that we believe is critically important as a bridge from where we are right now on the Medicare Program to where this bill takes us. The bridge is in the area of Medicare+Choice, which is the Medicare option that is available in certain counties in this country for a health maintenance organization, the only place in Medicare that provides prescription drug coverage today.

About 10 to 12 percent of beneficiaries under Medicare participate in Medicare+Choice or Medicare HMO programs. Their satisfaction rate is as high or higher than in the traditional Medicare Program. The problem with Medicare+Choice or the Medicare HMOs is they are funded at a level which does not increase at the same rate that the Medicare Program increases. They are held at an artificially low level, which makes it very difficult for them to survive.

The concern of Senator SCHUMER, who has been a great leader on this issue, and my concern is what happens between now and 2006 when the new MedicareAdvantage Program comes into effect under this bill. That program will include Medicare+Choice or Medicare HMOs, and a new option that will be available through this bill of a PPO, which is a more lightly managed insurance. Medicare HMOs are heavily managed with gatekeepers and a restricted number of providers, both doctors and hospitals to which you have access, but you get more benefits. PPOs have less restrictions, less management, and more choices. The fee-for-service has no restrictions, maximum choices, but higher costs.

What we wanted to do is put in an amendment that gave us a bridge of funding so these existing HMO plans can survive until we get to 2006, because there is a big concern. We have seen HMO plan after HMO plan go out of business because of inadequate funding. Through the work of Senator SCHUMER and several others in this Chamber, we have been pushing this issue in the Senate. We ran into a roadblock because of the unavailability of funds in the Senate bill. But there is money in the House bill, and the amendment Senator SCHUMER is going to offer here, as soon as I drop the mike, will mirror what the House bill does.

I will turn it over to my colleague from New York. This is a vitally important amendment. It is really important for us to come out of the conference with money for Medicare+Choice or Medicare HMO plans for the years 2004 and 2005, so when 2006 rolls around we will have a viable program, a robust program that this new MedicareAdvantage Program can intersect.

If we, on our side of the aisle, are concerned about competition and choices and if we want choices, then we have to fund those choices to get to 2006, when, candidly, there will be a lot more money for these programs to survive. I would like to see them survive in the interim.

The Senator from New York, as I said before, is leading the charge on this issue. The House, thankfully, has included it in their underlying bill. We hope we will be able to keep that in conference.

I yield the floor.

The PRESIDING OFFICER. The Senator from New York.

Mr. SCHUMER. Madam President, I ask unanimous consent to set aside pending amendments and call up amendment No. 1040.

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

The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from New York [Mr. SCHUMER], for himself, Mr. SANTORUM, Mr. CORZINE, Mrs. CLINTON, Mr. LAUTENBERG, and Mr. KERRY, proposes an amendment numbered 1040.

Mr. SCHUMER. I ask unanimous consent the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To provide for equitable reimbursement rates in 2004 and 2005 for Medicare+Choice organizations making the transition to MedicareAdvantage organizations)

On page 294, line 6, strike ''or (C)'' and insert ''(C), or (D)''.

On page 294, line 21, insert ''(other than in 2004 and 2005)'' after ''multiplied''.

On page 297, strike lines 5 through 9, and insert the following:

''(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(v) For 2004 and 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(D) ANNUAL FEE-FOR-SERVICE COSTS IN 2004 AND 2005.—For 2004 and 2005, the adjusted average per capita cost for the year, as determined under section 1876(a)(4) for the Medicare+Choice payment area for items and services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B and not enrolled in a Medicare+Choice plan under this part for the year, except that such amount shall be adjusted—

''(i) to exclude costs attributable to payment adjustments described in subsection (a)(5)(B)(ii), and

''(ii) to include an amount equal to the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

On page 298, line 10, strike ''subparagraph (B)'' and insert ''subparagraphs (B) and (E)''.

On page 301, between lines 8 and 9, insert the following:

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for 2004 and 2005, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

On page 302, line 23, insert ''(or, in the case of calculations for payments for months beginning on or after January 1, 2004, and before December 31, 2005, the average number of medicare beneficiaries enrolled in a Medicare+Choice plan that are)'' after ''medicare beneficiaries''.

On page 303, line 9, insert ''other than 2004 and 2005'' after ''for each year''.

On page 349, between lines 4 and 5, insert the following:

(3) PAYMENT RATES BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS IN 2004 AND 2005.—

(A) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(i) in paragraph (1)(A), in the flush matter following clause (ii), by inserting ''(other than in 2004 and 2005)'' after ''multiplied''; and

(ii) in paragraph (5), by inserting ''other than 2004 and 2005'' after ''for each year''.

(B) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (E)''; and

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

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for 2004 and 2005, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(C) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)) is amended by inserting ''(or, in the case of calculations for payments for months beginning on or after January 1, 2004, and before December 31, 2005, the average number of medicare beneficiaries enrolled in a Medicare+Choice plan that are)'' after ''medicare beneficiaries''.

(D) UPDATE IN MINIMUM PERCENTAGE INCREASE.—Section 1853(c)(1)(C) (42 U.S.C. 1395w–23(c)(1)(C)) is amended by striking clause (iv) and inserting the following new clauses:

''(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(v) For 2004 and 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.''.

Mr. SCHUMER. Madam President, I offer this amendment on behalf of myself and my colleague from Pennsylvania, as the lead sponsors of this amendment. I also ask Senators CORZINE, CLINTON, LAUTENBERG, and KERRY be added as cosponsors who support what we are doing here.

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

Mr. SCHUMER. Madam President, Senator SANTORUM has summed this up very well. We have a large number of senior citizens who have opted into a Medicare+Choice Program. The Medicare+Choice Program has been an experiment. Basically it said, let's let some providers, in this case HMOs, provide Medicare for senior citizens so they have an option to go into it.

What most of these programs have done, frankly, is they made a sort of deal with senior citizens. They say you have to go to the doctors and hospitals that are a part of our plan. In that way, we will reduce costs. Then we can provide prescription drug coverage or other types of coverage for you. It has been quite popular in a good number of places, in my State as well as many other States.

This program has had some trouble, there is no question about it. The reason is the cost of prescription drugs has gone way up. Health care costs have gone way up. As a result, many have pulled out of Medicare+Choice. Many seniors—not all but most of the seniors I know—went into it so they could get some prescription drug coverage.

I agree completely with Senator SANTORUM. We are, in 2006, going to provide all kinds of different help to private providers who will provide either prescription drug coverage or a whole Medicare+Choice-type situation. But it absolutely makes no sense to let these programs go under, which they will because there is not enough money for them now, in 2004, 2005, until 2006 funding kicks in, and then whole new infrastructures would have to be set up.

In addition, the premiums have gotten so high because the costs have gotten high and we have been unable to put in the money that many of those providing Medicare+Choice have either pulled out entirely of large regions in this country or so many have pulled out there is not the competition we would like to see.

In Suffolk County, in my area, I think it is 80,000 senior citizens who were in Medicare+Choice; but where there were once 6 providers, there are now only 2.

In addition, and really galling to the seniors, with good reason—I completely agree with them—the premiums, the copayments on these programs have been large. They once were $10 or $20 or $30. Now, particularly in suburban areas, they are $140 to $170 a month. In fact, many of my constituents, with justification, cannot understand why Medicare+Choice is available in some areas with no copayments and no premiums, and in others the premium is so high that if you are a typical senior citizen on a fixed income, you can't afford it.

Our proposal does two things—and, again, Senator SANTORUM is exactly correct. No. 1, it provides the money so these programs can stay in effect until 2006. Once we get to 2006, they are taken care of because of the structure of this bill. But to have them collapse makes no sense.

Second, it provides some equity. Because costs are higher, for instance, in Suffolk and Nassau Counties, they should not be treated the same and given the same dollars as New York City.

Who is paying the higher costs in the end? The senior citizen who is having the same kind of expenses as a senior citizen in New York City.

We add just the formula and make it more flexible so high-cost areas get some reimbursement. This is a problem in the suburbs of New York, in the suburbs of Philadelphia, in the suburbs of Texas and California. It tends to be a suburban problem.

But make no mistake about it: Many of the senior citizens who live in these suburban communities are not wealthy. They are not middle class. They are struggling. They are on a fixed income. Medicare+Choice originally was a salvation to them. Now it is becoming a real burden.

I would add, I do not believe this is the fault of the HMOs providing the service. It is the Federal Government that has not put in enough money to make these things viable. We have corrected this in this proposal, but only in 2006, when it takes effect. Again, it makes no sense, no sense whatsoever, to let these HMOs that do Medicare+Choice fold and then have to start up again.

So this is an important amendment. Unfortunately, we cannot bring it to a vote because in the rules of the Senate, we would have to get 60 votes to adopt this, and that is too uphill a burden. But the good news is, it is in the House bill which has different rules.

I know Senator SANTORUM, as well as all my cosponsors, joins me in saying we want this program to be put in the final bill when it comes out of conference committee. We know there will be the kind of dollars that might be available, and this is an extremely high priority.

So I am offering this amendment to underscore that importance, to let our diligent leaders of the Finance Committee—Senator GRASSLEY and Senator BAUCUS—know how important it is to a good number of us, and to make sure it has its place at the table when the conference committee occurs.

I just want to make a few more points about Medicare+Choice Programs. These do not benefit well-to-do people. Let me give you some numbers. Among Medicare beneficiaries who have annual incomes between $10,000 and $20,000 and who do not have Medicaid or group health coverage, 40 percent are in Medicare+Choice. These are the very people who cannot afford the high cost of prescription medicines.

Medicare+Choice, when it came in, was a godsend to them. And I, for one, am on this side of the aisle, but I do not let any ideological blinders get in my way. If Medicare+Choice, a private program, is going to solve their problem, great, but let's provide it with the funds, particularly in more suburban, high-cost areas so it can actually work.

Here is another statistic. In addition, 52 percent of Hispanic and 40 percent of African-American Medicare beneficiaries who do not have Medicaid or group health depend on Medicare+Choice. So this is an area that affects typical Americans: hard-working retirees, who have not made a windfall, who made a decent living just by the sweat of their brow, and now they are retired and are on a fixed income, they need some kind of help that goes beyond Medicare because they have a large prescription drug bill or they need something else. Medicare+Choice becomes a health care safety net.

Again, it would be a shame if we did nothing. If we did not have this bill,

most of the Medicare+Choice Programs would have faded away or made the premiums so high they would be out of the reach of all but very comfortable people. This amendment provides the bridge between now and 2006 when we know this will work.

I know there are many Senators who are enthusiastically for this approach. I want to add that Senator KERRY, who could not be here today, wanted me to let my colleagues know how enthusiastic a supporter he is.

I hope we will work this out in the conference because it is one of the most important things that are not in this bill, once you overcome the basic disagreement we have of Medicare versus private.

AMENDMENT NO. 1040 WITHDRAWN

So I am going to withdraw the amendment because, again, we do not want to put ourselves, because of the Senate rules, under a burden of having to get much more than a majority, a 60-percent vote. We have hope because it is in the House bill. We are going to work hard in conference to see that it is kept in the conference agreement. But at this point, Madam President, I ask unanimous consent to withdraw this amendment on behalf of Senator SANTORUM, myself, and the other cosponsors.

The PRESIDING OFFICER (Mrs. DOLE). The Senator has the right to withdraw the amendment, and the amendment is withdrawn.

Mr. SCHUMER. I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. Madam President, I ask unanimous consent that I be allowed to yield to the Senator from New Mexico and then retain the floor after he offers his two amendments.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from New Mexico.

Mr. BINGAMAN. Madam President, I thank my colleague from Rhode Island very much for yielding to me.

Madam President, I ask unanimous consent that the pending amendments be set aside.

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

AMENDMENT NO. 1065

Mr. BINGAMAN. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN], for himself and Mr. DOMENICI, proposes an amendment numbered 1065.

Mr. BINGAMAN. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To update, beginning in 2009, the asset or resource test used for purposes of determining the eligibility of low-income beneficiaries for premium and cost-sharing subsidies)

On page 120, between lines 16 and 17, insert the following:

''(I) UPDATE OF ASSET OR RESOURCE TEST.—With respect to eligibility determinations for premium and cost-sharing subsidies under this section that are made on or after January 1, 2009, such determinations shall be made (to the extent a State, as of such date, has not already eliminated the application of an asset or resource test under section 1905(p)(1)(C)) in accordance with the following:

''(i) SELF-DECLARATION OF VALUE.—

''(I) IN GENERAL.—A State shall permit an individual applying for such subsidies to declare and certify by signature under penalty of perjury on the application form that the value of the individual's assets or resources (or the combined value of the individual's assets or resources and the assets or resources of the individual's spouse), as determined under section 1613 for purposes of the supplemental security income program, does not exceed $10,0000 ($20,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse).

''(II) ANNUAL ADJUSTMENT.—Beginning on January 1, 2010, and for each subsequent year, the dollar amounts specified in subclause (I) for the preceding year shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

''(ii) METHODOLOGY FLEXIBILITY.—Nothing in clause (i) shall be construed as prohibiting a State in making eligibility determinations for premium and cost-sharing subsidies under this section from using asset or resource methodologies that are less restrictive than the methodologies used under 1613 for purposes of the supplemental security income program.

''(J) DEVELOPMENT OF MODEL DECLARATION FORM.—The Secretary shall—

''(i) develop a model, simplified application form for individuals to use in making a self-declaration of assets or resources in accordance with subparagraph (I)(i); and

''(ii) provide such form to States and, for purposes of outreach under section 1144, the Commissioner of Social Security.''.

Mr. BINGAMAN. Madam President, just very briefly, let me state that this is the revised version of the amendment Senator DOMENICI and I had 2 days ago that would have eliminated the assets test. This keeps the assets test but reforms it very substantially.

I will explain this further when we get an opportunity to actually debate the amendment.

Madam President, I ask unanimous consent that the amendment be set aside.

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

AMENDMENT NO. 1066

Mr. BINGAMAN. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN] proposes an amendment numbered 1066.

The amendment is as follows:

(Purpose: To permit the establishment of 2 new medigap plans for medicare beneficiaries enrolled for prescription drug coverage under part D)

On page 137, line 6, strike ''Notwithstanding'' and insert ''Except as provided in paragraph (4) and notwithstanding''.

On page 138, line 2, strike ''or 'G' '' and insert '' 'G', or a policy described in paragraph (4)''.

On page 138, line 17, insert '', who seeks to enroll with the same issuer who was the issuer of the policy described in clause (ii) of such subparagraph in which the individual was enrolled (unless such issuer does not offer at least one of the policies described in paragraph (4)),'' after ''section 1860D–2(b)(2)''.

On page 140, between lines 13 and 14, insert the following:

''(4) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Prescription Drug and Medicare Improvement Act of 2003, with respect to policies issued to individuals who are enrolled in a Medicare Prescription Drug plan under part D or under a contract under section 1860D–3(e), the changes in standards shall only provide for substituting (for the benefit packages described in paragraph (2)(B)(ii) that included coverage for prescription drugs) two benefit packages that shall be consistent with the following:

''(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

''(i) The policy should provide coverage for benefits other than prescription drugs similar to the coverage for benefits other than prescription drugs provided under a medicare supplemental policy which had a benefit package classified as 'H' before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003.

''(ii) The policy should provide coverage for prescription drugs that—

''(I) compliments, but does not duplicate, the benefits available under part D; and

''(II) does not cover 100 percent of the deductible, copayments, coinsurance (including any cost-sharing applicable under the limitation on out-of-pocket expenditures), or any other cost-sharing applicable under part D.

''(B) SECOND NEW POLICY.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except that the reference to the benefit package classified as 'H' in clause (i) of such subparagraph is deemed to be a reference to the benefit package classified as 'J'.

(b) REPORT.—The Secretary shall enter into an arrangement with the National Association of Insurance Commissioners (in this section referred to as the ''NAIC'') under which, not later than 18 months after the date of enactment of this Act, the NAIC shall submit to Congress a report on the medicare supplemental policies described in section 1882(v)(4) of the Social Security Act, as added by subsection (a), that assesses the viability of the policies described in such section and, if viable, the details of those policies.

Mr. BINGAMAN. Madam President, just to indicate what this amendment does, this is an amendment related to Medigap and directs that a Medigap plan be developed to wrap around the prescription drug benefit that is currently in the bill.

Again, I will further explain this amendment and argue for it when we get the opportunity to do so.

I did need to have both of these amendments offered so that the Congressional Budget Office would do a score for them. Again, I thank my colleague from Rhode Island for yielding to me for that purpose.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. Madam President, I rise today to discuss the historic legislation that is before this Chamber. A year ago, this body undertook a similar endeavor to bring a Medicare prescription drug benefit to the 40 million aged and disabled beneficiaries who are on the program today, as well as maintain the promise for the tens of millions of future beneficiaries who will be joining the rolls in the coming decades.

Despite the fact that a majority of Senators voted in favor of a $594 billion plan for a drug program offered by Senators GRAHAM, MILLER, and KENNEDY, procedural barriers prevented us from delivering a benefit to our elderly and disabled last year.

Since that time, Congress has passed another round of tax cuts at the President's behest, and the Nation's fiscal condition continues to deteriorate at an alarming rate. Just last week, the Congressional Budget Office announced that this administration is now on pace to shatter previous Federal budget deficit records. CBO's latest fiscal year 2003 budget deficit forecast now tops $400 billion, an increase of $100 billion over the CBO's deficit forecast offered just a month ago.

The current record budget deficit was $290 billion set in 1992. In just the first 8 months of fiscal year 2003, we have already posted a deficit of $291 billion.

Congress and the administration are now turning their attention to the long-neglected problem of a prescription drug benefit for Medicare. This year, we are faced with an arbitrary cap of $400 billion under which a drug benefit must fit. This cap is the result of the administration's insistence on dealing with the drug benefit after the tax cut and not before. Madam President, $400 billion was not sufficient when we sought to enact a meaningful prescription drug benefit last year, and I believe it is even less adequate this time.

The issue of Medicare prescription drugs is extremely important to me, and even more important to the constituents I represent.

In of a State of slightly more than a million people, 14.5 percent of the population in Rhode Island is over the age of 65 years. This is a higher proportion of older persons than the national average of 12.4 percent. According to the Census Bureau estimates, the number of elderly is expected to increase to 18.8 percent of Rhode Island's population by the year 2025. Rhode Island also has one of the highest concentrations of persons age 85 and over. Consequently, seniors in my State tend to utilize higher degrees and greater levels of health care than their counterparts in other States.

My State is also unique in terms of its health insurance market. Being a small State, Rhode Island experienced a particularly tumultuous insurance cycle during the mid-1990s that resulted in basically one insurer remaining in the market. Being dominated by a single insurance company has resulted in artificially low reimbursement rates for providers in my State. In fact, I am told Medicare is often the highest payer, sometimes 30 to 40 percent higher than some of the private options.

This has created a tremendous burden on providers in my State who are struggling to keep up with the increasing cost of doing business while continuing to provide quality care to their patients.

As Senator GRASSLEY stated at the outset of this debate, his legislation contains a provision aimed at increasing the reimbursement rate for rural providers that fall below the national average. This will make certain rural patients are not denied access to doctors and quality care. However, I believe the same assurance must be given to all Medicare beneficiaries, regardless of where they live. I am constantly hearing from providers in my State who are struggling with the drastically increasing cost of doing business. I believe we must do more to recognize regional variations in the cost of providing health care services in this country to ensure all providers are equitably compensated for services under the Medicare Program and access to care for beneficiaries is assured.

I would like to take a few moments to outline the many concerns I have regarding this legislation. I commend the Senate Finance Committee and the leadership of Senator GRASSLEY and Senator BAUCUS for their efforts to move a package forward. This is a daunting challenge. They have invested their energy and their vision and their enthusiasm over many weeks. I commend them for that.

However, I believe the proposal before this body is deficient in many significant ways. Under the legislation, seniors below 100 percent of poverty and those between 100 and 135 percent of poverty would have much of their needs covered at minimal expense. This is one of the beneficial aspects of the legislation. I must commend the Senators for insisting upon this protection for low-income seniors. Seniors between 135 and 160 percent of poverty would face a variable deduction and coinsurance.

These are beneficial aspects. If we could do more along these lines to provide assurances to low-income seniors that their benefits would be taken care of, if we could close the gap in coverage and we could do many things, this legislation would be one that would be universally supported. But there are significant shortcomings as well as the beneficial aspects.

Our elderly and disabled beneficiaries need a comprehensive Medicare prescription drug benefit now, not 3 years from now. According to the Kaiser Family Foundation, a senior today pays an average of $999 in out-of-pocket drug costs. Under the Grassley-Baucus proposal, beginning in 2004, seniors would be entitled to the Bush administration's privately run discount card program. The Government-endorsed card would provide seniors with negotiated discounts on certain drugs.

Instead of taking the time and expense to implement and dismantle a temporary discount card, we should be dedicating ourselves to implementing today a meaningful comprehensive prescription drug benefit as expeditiously as possible. I recognize the proposal before us is highly complicated and relies on a private marketplace that does not even exist and will take time to put in place. Yet if the original Medicare program could be up and running within 11 months during an era when there were no computers to speak of, I see no reason why we can't phase in the basic elements of a prescription drug program starting immediately.

I greatly fear the beneficiaries of Medicare will never see this benefit take effect when 2006 rolls around. There are a number of very plausible scenarios such as increasing Federal budget deficits, competition with the never ending drumbeat for tax cuts, and the expiration of some of the 2001 and 2003 tax cuts, the lack of private companies willing to offer these new plans, technical problems, or any number of other potential stumbling blocks that could derail implementation of this benefit, leaving seniors with nothing more than the temporary discount card as a benefit. Indeed, the bill before us continues the temporary card more than 6 months after the benefit is supposed to start.

Given the fact that Medicare beneficiaries have already waited too long for Congress to enact a prescription drug benefit, we need to do all we can to deliver a Medicare prescription drug benefit as soon as possible. Yet an effort by Senator LAUTENBERG to move up the implementation date of the new Medicare Part D program to July 1, 2004 failed. I am extremely disappointed this amendment did not prevail, leaving seniors to wait even longer for us to deliver on this promise.

The current package relies entirely on the private sector to provide a Medicare prescription drug benefit to seniors. The new Medicare Part D program created by this legislation is a significant departure from the traditional Medicare Program structure. The expectation is that Medicare HMOs and PPOs will provide the complete range of health care services, including prescription drugs, under the new MedicareAdvantage option, while drug-only plans, which currently don't exist in the health insurance marketplace,

will provide drug coverage to beneficiaries who remain in the traditional fee-for-service Medicare Program.

It is important to point out that most seniors have a favorable opinion of the existing Medicare Program and are satisfied with the coverage they receive through the traditional program. According to a recent Kaiser Family Foundation Harvard School of Public Health survey, 80 percent of seniors have a favorable impression of Medicare and 62 percent felt that the program is well run.

Seventy-two percent of people age 65 and over surveyed thought seniors should be able to continue to get their health insurance coverage through Medicare over private plans and 63 percent favored drug coverage through Medicare over private plans.

The only time a beneficiary would have access to the Medicare prescription drug fallback option under the traditional program is when no other private plans are available in their service area. However, once two drug-only plans enter the market in a particular area, this fallback option automatically disappears and a senior's choice is eliminated. He or she is forced to move to a different plan. I believe seniors should have true choice when making a decision about Medicare. They should be able to choose the Medicare prescription drug plan that best suits their needs, even if it is the Government-administrated option, which has a proven record of lower costs to taxpayers.

I support providing a level playing field for all Medicare prescription plans and was a proud cosponsor of Senator STABENOW's amendment that would have guaranteed the availability of the Medicare fallback plan as the standard option for seniors. This was not an amendment to force some outmoded Government-controlled health care system. It was an amendment about choice; indeed, a choice seniors overwhelmingly favor. Apparently we rejected that choice when we rejected the Stabenow amendment.

The Federal Government already serves as a direct provider of prescription drug benefits to millions of active-duty military personnel and veterans, so we do have a compelling Government model rather than a private sector model on which to base our expansion of Medicare.

Advocates for private sponsored prescription drug coverage under Medicare contend the private sector is more efficient and generally better suited to providing a prescription drug benefit to the elderly and disabled. I have also heard arguments that private plans are more cost-effective. However, as history has shown, the Medicare program has operated with significantly lower administrative costs than their private sector counterparts—2 to 3 percent versus 8 to 10 percent. Moreover, the Federal Government already has a long track record of providing prescription drug benefits to millions of active duty personnel and their families.

The Government also has a wealth of experience as a bulk purchaser of medications for our Nation's veterans. The TRICARE program provides comprehensive health and prescription drug coverage to 8.6 million military and their dependents. Similarly, almost 5 million of our veterans have access to prescription drug coverage for free for service-connected conditions and for a nominal $7 copay for a 30-day supply of medication for nonservice-connected ailments.

Federal health care programs have a proven track record of offering comprehensive, stable, and reliable benefits in a cost-effective manner. The facts certainly do not necessarily reflect the rhetoric when it comes to private plans.

Indeed the best model for, I think, pharmaceuticals is the Veteran's Administration and TRICARE programs, all of which are run by the Federal Government.

Under the Finance bill, premiums will vary based on geographic location and the level of benefits offered by the plan. The most recent CBO estimates indicate that the average premium for the standard prescription drug plan would be $35 in 2006 and will increase to $59 by 2013. However, private plans are free to provide a different package of benefits so long as the minimum benefit is ''actuarially equivalent'' to the standard benefit package set forth by the Government. Plans would also be free to charge beneficiaries a different premium to reflect these benefit packages. For beneficiaries on fixed incomes, these unpredictable premiums will be a great burden.

Beneficiaries will also face annual unpredictable increases in their deductible. The bill sets the deductible at $275 for 2006 and will increase in subsequent years based on the average annual per capita expenditures on covered drugs. I fear that some of the cost saving measures in this bill are ''pennywise and pound foolish.'' We should be very clear that this legislation imposes a significant amount of cost-sharing on seniors, not only in terms of the $275 deductible, variable monthly premiums and 50 percent coinsurance under the prescription drug plan, but in other areas as well. Specifically, the Grassley-Baucus proposal increases the annual deductible beneficiaries currently pay under Medicare Part B to $125 in 2006 and it indexes future increases to inflation.

I am also deeply concerned with other provisions included in this legislation to offset the cost of the rural provider payments. In particular, it imposes for the first time a beneficiary coinsurance requirement of 20 percent for diagnostic lab tests to offset a portion of these rural provider payments. I have heard from literally hundreds of providers and beneficiaries from my State in opposition to this new cost burden. In essence, what this provision translates to is an $18.6 billion shift in cost onto beneficiaries over the next decade. From a regional standpoint, absolutely none of this funding will benefit providers in my State, nor will it ensure better access to care or improve quality of care to beneficiaries in my State. Yet the over 170,000 Medicare beneficiaries in Rhode Island will be forced to pay millions in additional costs. I believe it is extremely unfair and inappropriate to boost the payments of a select group of providers at the expense of beneficiaries. The purpose of the legislation is to bring new benefits—not impose new burdens—on our elderly and disabled.

The bill also reduces the reimbursement rate for certain cancer drugs administered in a physician's office. I fear that the cumulative effect of these provisions will be increasingly limited access to care for suburban and urban beneficiaries, either because they cannot afford the deductibles and coinsurance they are expected to pay, or because they are unable to find a physician who will take Medicare.

I am also skeptical of the new ''Center for Medicare Choices'' being created under this bill to administer parts C and D of Medicare. I don't understand why the new ''Medicare Advantage'' program under Part C and the prescription drug benefit program under part D are being separated from Medicare Parts A and B under the Center for Medicare and Medicaid Services.

Scarce Federal dollars that could be directed towards providing a more generous benefit to seniors are instead being used to create a new federal bureaucracy. I am also concerned that the time and effort needed to create this new agency will slow the implementation of a drug benefit plan for seniors.

When the Medicare program was originally created in 1965, it was done in response to the fact that elderly and disabled Americans were simply unable to get affordable health insurance coverage through the private market. While many aspects of our health care system have dramatically changed since then, I believe this same basic principle holds true today.

Should this legislation pass without significant changes, Medicare beneficiaries are going to be faced with a barrage of confusing and complicated options. If we expect seniors and the disabled to be informed consumers of health care, we need to be absolutely certain that we provided the resources necessary to educate them on their options. They are going to need assistance, at least initially, in sorting through all of the relevant information to determine which option is best suited for them, based on their overall health care needs. Indeed, one third of all seniors are probably better off it they do not participate in Part D, according to CBO.

While the Grassley-Baucus proposal does take some initial steps to bolster beneficiary education through the Medicare State Health Insurance Program (SHIPS) volunteers and through

local Social Security Offices, this new program, with all its options, and new features, is going to be very confusing to the public. I believe we need to do more on education and outreach to assist beneficiaries with this new program if the program is going to be successful and effective.

For example, even today, only about half the seniors who are eligible for the various low-income assistance programs (QMB, SLMB, QI-1) enroll in those programs.

I believe we can and must do more to ensure that beneficiaries, particularly those in hard-to-reach rural and inner city communities, have access to information describing these new changes, the importance of the low-income benefit, and encouraging enrollment. I hope to work with the chairman and ranking member of the Finance Committee to make sure that all Medicare beneficiaries are well informed in terms of the parameters of the temporary discount card as well as the more comprehensive benefit.

Medicare beneficiaries who are eligible for Medicaid, known as the dual eligibles, have disproportionately high medical and long-term care needs. These seniors, including most vulnerable elderly in nursing homes, are ineligible for the drug benefit in this proposal. This population represents about 11 percent of older Americans covered by Medicare. While Medicare covers acute care and major medical expenses for this group, Medicaid picks up the cost of their prescription drugs. Since many of the dual eligibles suffer from chronic illnesses and have multiple health problems, their drug costs are extremely high. With the Gassley-Baucus proposal, the Federal Government shirks its responsibility as the primary payer by failing to assist these Medicare beneficiaries with their prescription drug costs. Indeed, it prohibits these seniors from receiving the drug benefit. It is also unclear how States' efforts to help this population will work with this proposal. Currently, States struggling with tight budgets are cutting back on care for Medicaid beneficiaries, and they are cutting optional benefits. Prescription drugs are one of Medicaid's optional benefits that States could choose to cut. The Grassley-Baucus proposal does nothing to help lift the States' burden and enable them to provide needed health care to their populations.

Under the Grassley-Baucus proposal, those low-income seniors who are not eligible for coverage through Medicaid, would as I mentioned, receive substantial Federal assistance. Unfortunately, their plan relies on state asset tests, which as Senator BINGAMAN has illustrated, can be extremely confusing and onerous for beneficiaries. Moreover, it is estimated that roughly half of all beneficiaries who would be eligible for assistance under the plan would be disqualified because of the asset test. Consequently, they would be forced to pay significantly higher deductibles, premiums and coinsurance.

So the laudable attempts to cushion the blow for low-income seniors could be undercut by maintaining this asset test.

For a vulnerable senior or disabled person struggling to get by on a fixed income, their options will not be much better than what they face now. If they are unable to afford prescription medications without coverage today, they are not going to be any better off under this plan. Low-income Medicare beneficiaries are still going to be in the unenviable position to having to choose between their medications and other basic costs, such as food and transportation.

The bill provides $250 million to reimburse local governments, hospitals and other providers for emergency health services furnished to undocumented aliens, but does not offer aid to help cover uncompensated care provided to the uninsured Americans in health care facilities around the country.

Over half of the estimated unauthorized immigrants in the United States live in five states—California, Texas, New York, Illinois and Florida. However, all States in the Union face substantial costs due to uncompensated care, regardless of immigration status.

In 2001, people who were uninsured during any part of the year receive $98.9 billion in care, of which $34.5 billion was uncompensated care. Last year, my State of Rhode Island provided more than $120 million in uncompensated care, and this is expected to grow higher this year due to the weak economy.

Local governments, hospitals, and providers throughout the United States are facing rising care costs, trying to provide services to the uninsured, which includes undocumented aliens but includes many others.

With the sluggish economy and rising deficits, States cannot alone continue to shoulder the burden placed on the health care system by the uninsured. A recent Institute of Medicine report entitled ''A Shared Destiny'' documents the impact of the uninsured and uncompensated care on communities.

The consequence of uninsurance for communities can include reduced health care services, closure of local health care institutions, increases in local cost of health care and health insurance, and poorer health for residents in general.

Federal reimbursements for health services provided to the uninsured are needed by all States. It would be more equitable to States to distribute funding based on uncompensated care determined by the number of uninsured individuals in a State as a percentage of the total number of uninsured U.S. residents rather than simply immigration status. Under the current provision, over 50 percent of the funding would go to three States, and seven States, including Montana, might not receive any funding.

Distributing funding based on the number of uninsured will help all of us. I hope Senators GRASSLEY and BAUCUS will work to explore ways in which we can address this extremely pressing issue for all States.

Another aspect of the legislation is a very serious one and one which troubles me significantly. It is the projection by CBO that 37 percent of Medicare eligibles who presently receive prescription drug coverage through an employer retirement plan will lose that coverage as a direct result of this legislation. Under this bill, over 4 million people will lose their existing prescription drug coverage.

This effect is particularly troublesome because many seniors with retiree coverage currently enjoy more generous benefits than would be provided to them under this legislation. We are all aware that some employers are already eliminating coverage or trimming back on the benefits offered to retirees. However, this legislation will likely accelerate this disturbing trend because employers see no reason to pay for a benefit the Government already provides.

I am deeply disappointed that the amendment offered by Senator ROCKEFELLER, which would have permitted drug spending by employers to count toward the out-of-pocket spending requirements of the drug benefit, was not approved. I believe the Senator's amendment would have gone a long way toward eliminating a problem of employers dropping retiree health insurance coverage.

I am also particularly concerned that legislation may have negative implications for State and local government retirees and their families. States across the Nation are suffering from staggering budget shortfalls. This legislation might present an enticing opportunity for States to slash some of their costs by shifting their retiree health insurance costs on to the Federal Government by substituting what they currently offer for what is being proposed under the Grassley-Baucus plan.

I know this would have serious implications for the over 35,000 retirees and their families currently in the Rhode Island State employees pension system as well as the almost 20,000 employees who will be expecting these benefits when they retire.

Over the past several days, my colleagues and I have brought forth amendments that would have addressed the many recognized shortcomings in the pending legislation. We have repeatedly attempted to modify the bill in a way that would have provided a stable, universal, and affordable Medicare prescription drug benefit to the almost 40 million elderly and disabled beneficiaries in America.

I fear that the product taking shape in this Chamber is only going to disappoint beneficiaries by delivering a hollow benefit that will not meet their real health care needs. Even with an additional $12 billion in resources, this body is choosing to experiment with

the privatization of Medicare over providing enhanced benefits to seniors or eliminating the gap in coverage under this plan.

For these reasons, I am unable to support this legislation. I am deeply disheartened to be reaching this conclusion, but elderly and disabled Medicare beneficiaries deserve better than the proposal before this Chamber. I only wish we were seizing this historic opportunity to provide them with a benefit they need and deserve and can be sure they will get.

I thank the Chair, and I yield the floor.

The PRESIDING OFFICER. The Senator from New York.

AMENDMENT NO. 1040

Mrs. CLINTON. Madam President, I come to the floor in support of the amendment proposed and then withdrawn by my colleague, Senator SCHUMER, that would have helped Medicare+Choice programs continue to provide insurance for their beneficiaries. This is a serious problem in New York and, I have reason to believe, in many other parts of the country because, as costs have continued to rise, many health plans are being forced to drop people from their rolls. They are actually withdrawing from large regions of New York and elsewhere in the country, leaving people to scramble for alternatives. Even those who are continuing to provide coverage are raising their premiums drastically.

Like the rest of Medicare, Medicare+Choice plans are feeling the squeeze in a system caught between rapidly exploding costs and rapidly imploding finances. Here we are on the floor debating the future of Medicare and the structure of new benefits like prescription drugs, but while we debate the future of Medicare, we need to recognize that there are people right now in our States who depend on these plans today, and the plans, when they withdraw and then reenter from year to year, cause confusion and excess costs that fall directly on the backs of our seniors. So these seniors, who are already facing rising premiums, benefit cuts, and withdrawal of services, should not be forgotten in the context of the debate we are carrying on today which will actually try to encourage more seniors to move in to these kinds of private health insurance choices.

I hope that we do something not only about the future, but we start doing something about the present and take care of our seniors who were promised better benefits in these Medicare+Choice plans only to find the rug pulled out from under them, as the plans either raised premiums, sometimes 15, 20 percent, and withdrew from their region, leaving them without the coverage for which they thought they bargained.

I fear we are setting up many more of our seniors for this kind of disappointment, confusion, and disruption if we do not heed the lessons of what has already happened.

I thank the Chair for this attention, and I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Madam President, I do not think in my 19 years in the Senate we have faced a more important and decisive issue than what is before us right now. The action the Senate will take on this bill, I believe, will set us on one of two courses.

If the Senate passes S. 1, as it is now constituted, and then goes to conference with the House—and the House bill is even worse than this one—we will have set this country on a course, inexorably, I believe, toward the privatization of Medicare and the privatization of Social Security. That is why I believe this upcoming vote is such a momentous vote.

There are those who say: We can pass it—maybe it is better than nothing—and then we can come back sometime in the future and make it better and fix it. I am not certain that is a gamble I want to take with the future of Medicare and Social Security.

The proponents of this bill are claiming that it is going to provide prescription drug coverage for seniors. Obviously, that is something we all hear about when we go back to our respective States—we know it; we sense it; we feel it; we see it—that more of our elderly are cutting their pills in half. They are not taking the prescribed medicine. They wind up in the emergency room of the hospital.

Under Medicare, if one is in the hospital, they get their drugs paid for. But if they are outside and they need drugs to keep them healthy, to keep them out of the hospital, then there is no help. I hear this from our seniors all the time.

So we know the need is there and that we should address it. We have been talking about it for a number of years.

Quite frankly, I think the bill before us, S. 1, moves the focus from the elderly and their situation and their need for an affordable, reliable prescription drug benefit, to a special interest: What is best for the drug companies? What can we do to make sure that they can continue to make the high profits they are making; to continue to be able to advertise and push these drugs on people who may demand drugs for which they could use cheaper alternatives?

The focus of this bill is a special interest focus to help the drug companies.

I have gotten over 700 phone calls in my office. Only four of them were for this bill. Seven hundred phone calls from the elderly, and only four in favor of it. I cannot believe I am the only person getting these kinds of phone calls. Funny, I have not gotten one phone call from a drug company. They are very happy and very satisfied with this bill.

So why do we find ourselves in this situation? Well, it is really only a matter of priorities. This administration and Congress had no qualms about passing enormous tax cuts amounting to $93,000 a year for millionaires and above, but now we have problems coming up with adequate funds for our Nation's seniors. This bill will not provide significant relief to the millions of seniors who need it.

Let's put it in perspective. During the last 3 years, this Congress has passed, and the President has signed, $1.6 trillion in tax cuts. That is assuming we do not continue the cuts that are already scheduled to sunset. If we do not sunset these tax cuts, it is going to amount to a lot more than that.

At the same time, we are told by CBO that seniors will have about $1.8 trillion in drug costs over the next 10 years. So do we have the picture? We have just passed $1.6 trillion in tax cuts, half of which benefit the wealthiest 1 percent in our country. Keep that figure in mind, $1.6 trillion. That is with the sunset provisions. Now, if we do not sunset them, it is going to be trillions more than that.

CBO says over the next 10 years our seniors are going to need drugs costing about $1.8 trillion. We do not have the money for that. Why? Because $1.6 trillion has already gone out for the tax cuts. After breaking the bank on these tax breaks for the wealthy, we are left with table scraps for our seniors. It is all due to a bad budget that many of us did not support. I did not vote for this budget. It was a bad budget.

We are going to see more about how bad this budget is when our appropriations bills hit the floor on education, health, and job training. We are going to see how bad this budget really was then.

Some examples of how bad I believe the provisions of this bill are: A senior living on $15,000 per year—that is just right over 160 percent of the Federal poverty level—with $1,000 in annual drug costs will actually lose money if enrolled in this program. My colleagues heard me right. If a senior is making $15,000 a year, and they have $1,000 in annual drug costs, if they join this plan, they pay more in than they get out. In fact, it is estimated that at least 35 percent, more than a third of all Medicare beneficiaries, will lose money if they enroll in this plan.

A married couple with a combined income of $20,000, again just slightly over the 160 percent of poverty level, if they had individual drug costs of $1,500 each—that is $3,000 a year in drug costs—they would save less than $400, barely 12 percent of their total drug costs.

Even seniors with high drug costs will only get modest assistance. In fact, a senior under Medicare will have to have drug costs approaching $9,000 per year before this plan will even cover a half of their expenses.

When we add together what a senior has to pay in premiums, deductibles, and cost sharing, then they have this coverage gap, the donut hole, where

they do not get 50 percent coverage until they hit $9,000 in drug costs and then they get a 50/50 split—$9,000 in drug costs before they even get 50 percent.

As I said, the plan has a donut hole, a gap, the coverage of the size of Texas, maybe Alaska. What this means for seniors is that they will pay 100 percent of their drug bill even while they are continuing to pay premiums, but they will not receive any drug coverage.

Now, there is an eruption coming. When this bill passes and it gets out there and seniors finally get in this in a couple of years, there is an eruption coming because there are going to be seniors out there saying: Wait a minute, I am paying into this thing and I do not get anything back because I fall in this gap? Wait until my colleagues start hearing from their constituents on that one.

Under this gap, once a senior's total drug costs reach $4,500, they are on their own until their catastrophic kicks in at $5,800, if I am not mistaken. But they still have to continue to pay premiums. Even though they pay for everything, they still pay the premiums. They are paying something, but they are getting nothing. That leaves a senior citizen with another $1,300 in out-of-pocket drug spending each year if they hit that gap.

That is what we call the Swiss cheese model of drug coverage. It is full of holes, and woe to you if you fall in one of them.

This bill provides too little to middle-class seniors. We tried to fix the problem. Senator BOXER offered an amendment to fill in this unfair coverage gap. The Republicans said: No, we cannot afford it.

Oh, we can afford $1.6 trillion to the wealthiest in this country, but we cannot afford to close the coverage gap. Priorities, my friends, priorities. That is what this debate is about, priorities.

The second flaw in the bill is it is a bureaucratic maze. Congress is trying to cram through one of the most significant changes in social policy in decades in 2 weeks. I am beginning to think it is because the leaders of this effort do not want seniors and the rest of the people in this country to see what is in the bill until it is too late. This is a complex, daunting, bureaucratic nightmare of a bill, and it will be for seniors.

This weekend the New York Times headlined in red ''Criticism of drug benefit is simple: It's bewildering. High level of complexity causes concern.''

With both houses of Congress poised to pass a Medicare drug bill next week, lawmakers are increasingly anxious about the complexity of the legislation and its reliance on new and largely untested arrangements to deliver drug benefits to the elderly.

This complexity, they say, may be daunting and confusing to beneficiaries, and even to insurance companies, which are supposed to manage the new benefits. Many lawmakers say they have just begun to examine the bill's intricate details and the web of political compromises behind those provisions.

Senator Larry E. Craig, Republican of Idaho, lamented the bill's ''high level of complexity and prescriptiveness.'' Senator Hillary Rodham Clinton, Democrat of New York, said it would create ''a Medicare maze, a whole new bureaucracy.''

Yes, it is bewildering. It is complex. If you think reading the bill is complex, 654 pages, I bet there are not a handful in this room who know what is in the bill—maybe a few in the committee, not many more. If you think that is bewildering, wait until the seniors start getting hit with this.

There is a reason why over the last several years when we put in Medicare+Choice for Medicare 89 percent of seniors chose to stay in traditional Medicare. Why? They want a simple, straightforward, understandable, reliable, guaranteed benefit, one in which they get coverage for the drugs they need, one they can sign up for and it does not put you in and put you out and put you in and put you out, year after year, but it is there solidly and one that is affordable.

What they are going to get under this plan is a series of befuddling and bewildering steps just to obtain substandard drug coverage.

Let's take an example. A senior citizen, we will call him Bob, next year is going to receive a drug card. Well, ladi-da, he will get a drug card. He might already have three or four drug cards in his wallet. In fact, I had an individual in Iowa a few weeks ago who took out his wallet and he already had five prescription drug cards: One from AARP, one from the State, one from a drug company, and a couple more I did not recognize. He said: Not a one is worth a hoot.

Millions of drug cards are out there now from CVS, State programs, other private organizations, AARP. If discount cards provided anything, if they amounted to anything, they would not need a drug benefit under Medicare. There are millions of them out there. Seniors will tell you they are not worth the paper they are printed on.

The reality is for the next 2 years, seniors like Bob will be left with virtually nothing. He gets a card. If Bob were low income, next year he will receive a debit card worth $600. Consider this. Bob gets a debit card worth $600, but what happens when Bob is going to the drugstore and he is getting his prescription drugs. It is now July and he goes to the pharmacist for his refill and the pharmacist says, sorry, you are out of money. The $600 is used up. What does he do then? He goes back and he sees his friend Fred, and Fred says, Well, I am still going to the drugstore and I am getting mine free. Bob wonders why he does not get his. Wait until that hits next year. Wait until your constituents start calling you up because their debit card has run out of money and it is July or August or September.

Now he has the card for a couple of years. After 2 years of having the card, it expires. It is done for. Now Bob is going to be forced to wade through hundreds of pages of health plan documents to choose which plan he wants. I decided to look at some of the plans that are out there and here are three of them. Here is Care First, Blue Cross Inc. Anyone want to try wading through this? Anyone want to read that and understand what is in there? I am a lawyer, probably not very good, but I have trouble reading that.

Here is another one from the Kaiser Foundation Health Plan of the Mid-Atlantic States. Bob will have to wade through this one, too, to figure out what he wants.

Here is one from MDIPA. This is a little smaller than the others but still pretty daunting.

In a couple of years, Bob will get a couple of these and he will be told to decide which he wants. He has to read through them and figure it out. What is he going to do, hire an accountant; hire a lawyer to figure out which plan is best for him? The plans could have different benefits, different rules, different prices, and different drugs.

Once Bob makes his choice, he could find out some of the drugs he needs are not actually covered by the plan. So he either has to change drugs or what, change plans? No, Bob cannot do that. He can do that at the end of a year. But if he finds out his drugs are not covered, he cannot switch. He has to wait until the end of the year. If Bob chooses one of the new PPO plans, the preferred provider plans, he might even have to change doctors to become part of it because they will list only certain doctors.

If that is not enough, once Bob chooses a plan and he is in it, his monthly premiums may skyrocket past $35 a month at any point in time. I have said to some people, That cannot be right; surely they cannot do that. But it is in the bill. It is in the 654-page bill. If you belong to a plan, any time that plan wants to raise the premium, you have to pay it. You cannot get out of the plan. You have to stay in it. So you have signed up for a plan. It says it will charge $35 a month. After a couple of months, the plan figures out it is not making enough money and now the premiums will be $45 a month. Why, you can write your Senator and tell your Senator how unfair this is. Guess what. Your Senator cannot do a darn thing about it. Nowhere in this bill does it guarantee seniors will not have to pay different monthly premiums.

Senator DASCHLE offered an amendment to try to fix this significant problem so seniors would be guaranteed some protection from fluctuating monthly premiums but, again, the Republicans said no. So we are supposed to vote for a bill that cannot even tell seniors what they are getting and how much it is going to cost them. In fact, Senator LOTT, who was quoted in the New York Times this week, said:

You are going to make a huge change in an entitlement program and you don't even know how it would work, if it would work.

At least we have one Republican over there who recognizes this as a bureaucratic maze. At least the amendment of Senator DASCHLE would have given seniors some peace of mind that what they bargained for is what they were going to get.

So we are back to Bob. Now, Bob is in the plan. His premiums might skyrocket. He might find that the prescription drug coverage is unaffordable. Now Bob is down at the coffee shop with his friends. None of them make very much money, but their income levels vary a little bit. They are all basically the same. They are retired, they worked hard all their lives, and they are spending a little time watching their grandkids grow. None of them are wealthy. They weren't born with silver spoons in their mouths. They don't have a lot of stock. They are just getting by.

You know, you see them on Main Street all the time. You see them in our towns, all over our States—average, middle class elderly Americans—and they are down at the coffee shop. They start talking. Bob finds out that all of his friends pay different amounts for their prescription drugs. Bob's friend George is paying a $50 deductible. Bob says, ''How can this be?''

Well, George earns just a little less than Bob. He earns $14,000 a year. So he pays a $50 deductible. He pays a lower premium and 10 percent copay for most of his drugs.

Their other friend Joe makes a bit less money a year. He is getting around $12,000 or so a year. He pays no deductible, no premium, and a 5 percent copay for his drugs.

Bob is sitting there and he is astounded. He doesn't make much more than they do. He makes $15,000 a year. He is struggling to make ends meet at that, and he is still stuck paying 50 percent copays, large deductibles, and large premiums.

Think about how you are going to hear from your seniors who gather at the local McDonald's in the morning to have their coffee and they start talking about this. One gets drugs practically free. Someone making just a few hundred dollars more pays the full premium, the full deductible, 50 percent copays. Try explaining that to your elderly citizens when this hits the streets.

Seniors are going to know immediately that this is not fair. This is the first time in Medicare's history that we are means-testing the program, where seniors are treated differently under Medicare. I believe there are serious consequences to creating this welfare class in Medicare, and that is what we are doing. We are creating a welfare class under Medicare.

It will be incredibly confusing for seniors to have four tiers of differing benefits. Seniors will not know where they fall in these income classes. Think of it, there are four. You have 75 to 100 percent of the poverty level; you have another class from 100 to 135 percent of the Federal poverty level. You have another class from 135 to 160 percent of the Federal poverty level. And now you have another class above 160 percent of the poverty level. There are four different classes.

How does Bob know where he fits? He is going to have to go through some tests. He is going to have to fill out some forms and submit the forms so people know how much money he makes.

I had some of those forms here. Here they are right here. Here is a set of forms right now for the Commonwealth of Pennsylvania. It is 16 pages long. It is what a person has to fill out in the Commonwealth of Pennsylvania to show they are poor, if I can use that word, that they are low-income, that they need some assistance, some benefits. This is the kind of paperwork they fill out.

Here is all the information about you: where you live, what you do, what you have done in your lifetime. Any cash on hand? Any savings accounts? Any checking accounts? Any certificates of deposit? Any stocks or bonds? A boat? Do you have a Christmas or vacation club?

Does anyone own or is anyone buying a car, truck, or motorcycle? You have to fill it in—the year, make, and model.

Do you have a life insurance policy? Do you own a burial space or burial plot? This is what the elderly are going to have to start filling out. And guess who gets it. Where do they take this?

Let's say Bob's friend George—how much did I say George is making? He is making about $14,000 a year. He has to prove that. He has to prove it by filling this out.

Who does he give it to? The IRS? No. Does he give it to his Senator? No. How about his Congressman? No, he doesn't give it to the Congressman either. He gives it to his pharmacist and his doctor.

So, now, our pharmacists all over America are going to have to keep all this stuff on file. Now they are going to have to look through it to make sure that George didn't make a mistake somewhere in filling this out. Think what is going to happen to elderly all over America who now say: Wait a minute, I don't necessarily want my pharmacist to know all my business. The pharmacists are going to say: I don't want all this paperwork. Wait until that hits the streets. More paperwork for our pharmacists, more paperwork for our elderly. And they aren't going to know how to fill this out.

Not only that—assets. What if George, let's say, or George and Betty, husband and wife, fall just slightly below the $19,000 level in both incomes. So they go to fill out this paperwork to get a cut in their drug coverage, to get a better benefit. But then they hit that page on assets. What kind of assets do you have?

I know people are going to laugh about this, but this is true. Betty is going to have to have her wedding ring appraised by somebody. How much is it worth? How about family heirlooms? Let's say George and Betty had some furniture that their grandparents passed down. It is now an antique, worth some money. How much is it worth?

I said the other day, it seems to me this portion of the bill is going to be a boon to the pawnshop artists around America. They are all going to be called out to assess things and determine how much they are worth. Who is going to pay that bill? That is in the bill. You may think I am joking. It is in the bill, an asset test, and it includes things such as jewelry and furniture and, yes, even a burial plot. We are forcing this humiliating process on seniors, to prove they are poor, by filling out this complicated paperwork—an assets test.

Finally, after all of this trouble, if Bob and his friends' health plan does not make enough money off of them, they will just pull out of the market, leaving them right back where they started. We have seen this happen time and time again with Medicare HMOs all over the country. It could happen over and over and over again as the new private, drug-only HMOs come in and pull out.

The Federal fallback may be available one year but not the next. So seniors will be bounced from one plan to another plan, maybe back to Medicare, maybe to another plan. There is nothing to stop it. And if a plan is in there, and it is not making money, they are out of it.

So I guess I could ask, by now are you confused? Is it a little tough to follow what all is going to happen? Imagine how our seniors are going to feel. Senator CLINTON prepared this chart. I looked it over, and it really does kind of give you the complexity of this bill we are talking about. I will not go through it all except to say that seniors starting here, in private plan ''one,'' with a $40-a-month premium, $275 deductible, 47 percent coinsurance, no limitations on doctors—well, let's say you join this plan and then find out the drugs you need are not offered there. You file a grievance. It goes to a hearing to see whether the drug is covered. Then, let's say it is a private plan, and it doesn't make enough money, and they drop out. Then you fall back into the Federal fall back and you start all over.

It is a maze. That is what we are asking our seniors to get involved in. Keep in mind that over one-third of all seniors will have to navigate this maze—just to lose money. They have to go through this just to lose money. One-third will go through this maze, and they will pay more in than they get out.

I suspect very strongly that this whole thing was developed by people who want the system to fail. They want it to fail. This bill is an example of ideology over fact, placing all the

bets on private health plans to provide the drug benefit to seniors. It is especially bad for seniors in rural States where private plans have shown no interest in participating in the Medicare Program. This private-sector worship is derived from the belief that the free market will take care of everything: The free market is the answer to everything; if only it is just put on the free market.

Well, private enterprise or the free market does very well, thank you, when you are doing automobiles or airplanes or wicker baskets or widgets, clothes, glasses, watches, television sets, computers, and a host of other things. That is where the free market works. But the free market, the private sector, by its very nature, leaves those people behind who are not profitable, people such as those with disabilities, mental illnesses, and the elderly.

The free market did not break down the barriers to people with disabilities in our country. It was this Congress and a President and the Americans with Disabilities Act that said: No more; we are going to provide opportunities and openness in our country to people with disabilities. It was not the free market because people with disabilities simply are not profitable.

Why do you think we have health care coverage now under Medicare and private health care plans for physical illnesses but not for mental illnesses, for which we have been trying for a long time to get parity? People with mental illness are not profitable. And why do we have Medicare? Because a long time ago the private insurance companies found out that the elderly were not very profitable either. And I speak about this from personal knowledge.

When I was a senior in high school, in the small town of Cumming, IA, population 150, my mother had passed away some years before. We were a bunch of bachelors living in a house. My father was 74 years old. It was 1958. He worked most of his life in the coal mines, and he had then what they call miner's lung, also known as black lung. He had a couple of injuries. He was not in very good shape. He had no stocks. He had no bonds. He owned no property. He did not own anything.

His total income—total income—per year was less than $1,500 because, thank God, during World War II, he had worked for a while and got covered under Social Security. See, before that he had worked all his life, and there was no Social Security. But, fortunately, during World War II he worked a little bit, and got covered by Social Security, so he was getting about $1,200 or $1,300 a year. Actually, he got a little more than that because he had kids under the age of 18, me being one, and Social Security gave him a little extra, $35 a month.

So here was my dad. He was 74. He was in bad shape. He had no assets, no money. There was no Medicare out there, folks. There was nothing. Could my dad afford to see a doctor? No way. And my father did not see a doctor. But every year, like clockwork, in the middle of the winter, my dad would get sick. It happened every year. He would get sick. He had this bad lung problem. He would catch a cold, and he could not get over it. He would get pneumonia, and we would get a neighbor, with a car, and rush him to Des Moines to the hospital. They would put him in a tent, dry him out, get his lungs down, and cure his pneumonia. They would send him home after a couple weeks.

How did we afford to do that? We did not have anything. I will tell you how we afforded it. Thank God for the Sisters of Mercy at a Catholic hospital in Des Moines, IA, who gave us charity because he did not have anything. That is the only way that my father got health care.

Now, why didn't some insurance company rush out to cover him at a price he could afford? Keep in mind, he was making less than $1,500 a year. He was not profitable. He was 74. He had black lung disease. He had a couple of other illnesses and injuries. My father was not profitable to an insurance company.

I can remember like it was yesterday when I came home from leave from the Navy. This was later on in 1966. I came home on leave from the Navy to see my father, who was now nearing his 80th year of life. I remember when he showed me his Medicare card and said: Now I can go see a doctor. I can go to the hospital if I have to. And I don't have to take charity anymore.

I often wonder, what would my father's later years have been like, what would it have been like if he had had Medicare earlier on? How much better his life would have been, how much healthier he would have been, how much more he would have enjoyed in his elder years if he had had decent health care.

So I don't want anyone lecturing to me about how wonderful the private market is for health care for the elderly. Go tell it to somebody else, but don't tell it to me because I lived through this. That is why when someone tells me that the private sector is somehow going to take care of the elderly, I say: Wait a second, maybe the elderly who have a lot of money, but how about those at the bottom?

That is why I say what we are doing here is setting up a welfare class. Once again, people like my father will have to fill out paperwork and beg, ask to be put in a system they can afford. I guess we haven't learned anything around here. We haven't learned a thing. Maybe we have too many people here who didn't go through what I went through. I don't know. I don't know everybody's situation. I would like to think if people went through with their fathers what I went through with mine, they might have a different perspective on Medicare.

There is no reasonable rationale for relying on private health plans for prescription drugs for the elderly, even in monetary terms and costs. We know administrative costs are much lower in Medicare. We have a history. The administrative costs in Medicare are between 2 and 3 percent a year; in private health care plans, 15 percent per year administrative costs. We also know that over the last 30 years, Medicare spending has grown at a slower rate than private health care plan spending: 9.6 percent compared to 11.1 percent.

Here is a story that appeared in the Washington Post recently. It is entitled ''Bush Pushes for Expanded Private Role in Medicare.'' It reads:

> President Bush yesterday renewed his call for market competition to play a large role in Medicare's future, as the Senate wrestled over how far to go in encouraging private health plans to deliver care and prescription drug coverage to older Americans.
>
> Bush disparaged a core tradition of Medicare in which the federal government has determined what medical services are covered and how much government pays doctors and hospitals to provide them. He said Medicare would be more effective if ''health plans compete for their business and give them the coverage they need, not the coverage that a Washington bureaucrat thinks they need.

Well, with all due respect, President Bush never lived through what I lived through. His father never had to rely on charity for health care like my father did. So he can disparage Medicare because no one in his family ever gave a hoot about Medicare. They didn't need it. He has turned a cold shoulder of indifference to those who rely on Medicare.

But not only that, the President ignores history. He says the private sector can do it better. Wait a second. We have a history. We have facts. We don't have to rely upon rhetoric. We have facts. Administrative costs in Medicare, 2 to 3 percent; private health care plans, 15 percent. OK, which is more efficient? In the last 30 years, Medicare spending has grown at a slower rate than private health care plan spending has grown. So what is he talking about? What is the President talking about when he says the private health care plans can do it better?

We have a history. We have facts. We have data. That private sector, when it comes to the elderly, does not do it better.

When it comes to this private plan program, it means there is going to be less money available to actually help seniors get prescription drugs. Billions will be wasted on advertising, marketing, glossy brochures, higher payments to private plans, billions of dollars that should be going directly to seniors. And how about CEO salaries? We haven't talked about that. All these private health care plans, they pay a lot of money for their CEOs. That is fine, if they are in the private sector. But that is money that is going to be siphoned off. Last year, the drug companies in America spent more money on advertising than they did on research. Wait until this plan gets out there.

I say to every senior citizen listening to me give this talk: Get prepared. You are going to get a lot of mail in your mailbox. You are going to get a lot of brochures for this drug and that drug and this plan and that plan. You are going to get inundated with advertisements, and you are going to see them on TV. You think you see a lot now. You wait, you will see more. Why? Because now they have all this money.

I understand we are about to have an amendment that is going to provide $6 billion to the private companies to entice them into providing these plans. If they are so doggone good, why do we have to do this? ''Senate GOP Eyes Billions to Encourage Private Plans, Employers.'' I am told it is going to be $6 billion. We haven't seen it yet. Whether it is $6 billion, $5 billion, $4.5 billion, I don't know. Whatever it is, it is too much.

I mean if President Bush is right and the private sector can do it better, why do we have to bribe them? Why do we have to bribe them with taxpayers' money, $6 billion, come on and get it? Talk about hogs feeding at the trough. This is it, folks. Six billion dollars, I am told. Well, maybe $5.5 billion. I don't know what it is. But they are going to give it to entice them into this program. Why are we robbing seniors to cushion the pockets of private plans with billions of dollars of a subsidy? ''President Bush Pushes for Expanded Private Role in Medicare.''

Well, you kind of see it all coming together. The President, Republicans are pushing for all these tax breaks for their wealthy friends. And now they reward the drug companies. No cost containment at all. Let the drug companies keep boosting their prices year after year after year. And guess what. We will just keep raising the premiums on seniors. Now we get the private plans in with their expensive CEOs, their expense accounts, and we are going to bribe them with $6 billion. What a deal.

Tom Scully, the Bush administration's top Medicare official, called Medicare ''an unbelievable disaster'' and ''a dumb system'' during a recent meeting in Pennsylvania.

The third-ranking Republican in the Senate, Senator SANTORUM from Pennsylvania, said:

I believe the standard benefit, the traditional Medicare program has to be phased out.

Senator ROBERT BENNETT of Utah, on March 1:

Medicare is a disaster. Medicare will have to be overhauled. Let's create a whole new system.

Of course, we all remember the immortal words of our former House Speaker, Newt Gingrich. He didn't want to kill Medicare, he just wanted to let it ''wither on the vine.''

So let's get this straight. Seniors are telling us not to privatize Medicare; 89 percent have already voted to keep traditional Medicare. They tell us they want a less expensive, more reliable, straightforward, simple benefit, guaranteed to be there.

The facts tell us that privatizing Medicare doesn't work. We have the facts. So why did the administration, in this bill and the House bill, insist on this privatization? Because it is the first step toward total privatization of Medicare and, I believe, the first step toward privatizing Social Security.

Senator STABENOW offered an amendment I supported which would have guaranteed a Government fallback in every area of the country, so that seniors could choose traditional Medicare regardless of what private plans are offered. As we said on the Senate floor that day, this bill offers two private plans. Senator STABENOW wanted to say: OK, we will give them more choice and offer a Medicare plan. Let them all compete. The Republicans said no. They want only to have two choices for seniors between two private plans. But they don't want to let seniors be able to choose Medicare, which they have already shown.

As the Senator from Michigan stated time and time again on the Senate floor, 89 percent have already chosen Medicare. Yet somehow we are turning a deaf ear to them.

It seems to me we have a lot of talk around here about choice, but they don't want to let Medicare be one of those choices for seniors. The only choice in the bill is for HMOs and private plans. They will be the ones choosing your premiums. They will be the ones choosing your options. They will be the ones choosing your benefits. Well, you tell that to my seniors back in Iowa who have never had a private option.

The Republicans say they want to provide seniors with choice. They claim seniors should get the same type of benefits we in Congress get. Well, all right. Let me tell you what I have for drug coverage. I pay 25 percent for my drugs. That is it. I go to the drugstore and I pay 25 percent. What a nice deal; simple, straightforward. Seniors won't have coverage anywhere nearly as generous in their plan. Look at it this way. If this plan provides $400 billion over 10 years, which is what it does, CBO has estimated that senior drug costs over the same period of time will be $1.8 trillion.

Figure that out. We are providing $400 billion. The estimated drug costs are going to be $1.8 trillion, and that is probably on the lower side. That means we are leaving the seniors to cover 78 percent of the tab for drugs. I get 25 percent; seniors have to pay 78 percent. You are going to tell me that is fair? Again, there is a storm coming, when the seniors in this country find out what is in this bill and how it affects them.

So why the insistence on privatizing Medicare? Well, I think the answer is clear. Congress is choosing a special interest over seniors' interests by following ideology over facts. I said earlier today there are three reasons we are passing this bill. The first reason is because the drug companies want it. The second reason is because the drug companies want it. You guessed it, yes. The third reason is because the drug companies want it.

You might think, from my comments, that I have it in for the drug companies. Nothing could be further from the truth. I have fought for years on the floor of the Senate for more money for research—the kind of basic research that is done through the NIH, done in coordination with drug companies, taking some of that basic research and investing their own money in these drugs and bringing them to the marketplace. Some of them have been wonderful. We are making new strides in drug development every day. I have a lot of respect for our drug manufacturers who have brought a lot of these drugs to market. However, that does not mean my esteem for the drug companies would compel me to vote for a bill that will continue to allow them to make the kind of profits they make on the backs of our senior citizens who are on fixed incomes.

No, in this one case, in this area—this is where Medicare ought to provide the drug benefit. It is where Medicare—just like we do in the Veterans' Administration—ought to be the one bargaining for the prices for our elderly. Let me and the others who can afford health plans, and pay generously for them, pay the drug companies, not the elderly.

So, again, drug companies stand to gain billions of dollars from this drug benefit—trillions.

Mr. DURBIN. Will the Senator yield for a question?

Mr. HARKIN. Without losing my right to the floor, yes.

Mr. DURBIN. I, like you, have been in the House and Senate. Can you ever recall a bill involving an industry like the pharmaceutical industry, such a grand bill involving a national program, involving that industry, where that industry has been so silent during the course of the entire preparation and deliberation of the bill? I ask the Senator from Iowa, in his vast experience and with his great insight, what does he make of the silence of the pharmaceutical industry about S. 1, the pending bill?

Mr. HARKIN. Well, the Senator asks an insightful question. Earlier, I had stated—and the Senator may not have been in the Chamber—my office has received over 700 phone calls. Only four have been in favor of this bill. I have not received one phone call from a drug company.

Now, the Senator understands when we have legislation that impacts powerful industries in this country, and if it impacts them negatively, they are all out here. Our phones are ringing off the hook; lobbyists are in our offices; the private jets are parked at Dulles. They are all over the place.

So it says to me that this bill must be a great benefit to the drug companies because I haven't heard one peep

from them. I have found in my experience, I tell the Senator, in the House and in the Senate that when you see a large industry silent on a bill that impacts them so greatly, you can only come to one assumption: They must love it.

Mr. DURBIN. Will the Senator yield for a further question?

Mr. HARKIN. I will.

Mr. DURBIN. I ask the Senator, if he has had the time to read the 654 pages of S. 1, has the Senator heard from staff or anyone during the course of the days and days of debate about this S. 1, the prescription drug proposal, that it contains anything that is going to reduce the excessive increase in the cost of prescription drugs for American families and American seniors?

Mr. HARKIN. I thank the Senator again for a very insightful question. I asked my staff—and I have good staff, and they do a lot of work on health care—to look at this 654-page bill.

I said: What in there will help keep the cost of drugs down? Anything at all?

Nothing. Zero. There is nothing in the bill that is going to help keep the cost of drugs down. In fact, I say to the Senator, I think just the opposite is going to be true because this bill will allow plans to increase premiums any time they want. So you signed up for a plan, and your premium is $35 a month. The plan is not making much money. The drug company jacks up the price of the drugs a little bit. That means the plan is not making much money, but the plan can increase the premium. The drug companies are always left harmless. They can just keep jacking up the prices.

Mr. DURBIN. If the Senator, through the Chair, will yield for one more question.

(Mr. SMITH assumed the Chair.)

Mr. HARKIN. I yield for a question.

Mr. DURBIN. I am aware of Senator HARKIN's background as a Vietnam veteran and a naval aviator. The Senator is undoubtedly aware that the Veterans' Administration, which is trying its best to provide medical care for the millions of veterans in our country, has negotiated with the drug companies to bring down the cost of drugs for veterans as much as 50 percent.

Mr. HARKIN. That is right.

Mr. DURBIN. Since we have established there is no effort in this bill to bring down the cost of prescription drugs for Medicare recipients in our country, we hear from the other side of the aisle that any effort to bring down the cost of drugs is tampering with the free market.

I ask the Senator from Iowa for his objective appraisal. Does he think the Veterans' Administration is guilty of socialistic, communistic, Bolshevik behavior, tampering with the market to bring down the cost of prescription drugs for the millions of veterans who desperately need their care? I think I know the answer to the question.

Mr. HARKIN. I think the Senator knows the answer to that question. He and I have both fought hard in this Chamber for veterans benefits. I yield to no one in my support of those who have put on the uniform of this country to defend our flag, to defend our way of life, and I know the Senator from Illinois will take a back seat to no one also in that effort. We fought hard to get a veterans drug benefit that had cost containment. That is what it does.

Today, I am proud to say—I am proud—because of what we fought for here, the veterans in this country today get the cheapest prices on drugs of anyone in our country. I am proud of that fact, and they deserve it. Has it ruined the drug companies? Of course not. They are selling more drugs. Maybe they take a little bit less profit, but they are selling more drugs because now people can afford to buy them. That is what we need today. We need that kind of system Medicare could provide in dealing with the drug companies for big purchasing, bargain down the prices so the elderly can get the same price on drugs as our veterans.

I ask rhetorically a question of the Senator from Illinois.

Mr. BYRD. Will the Senator yield?

Mr. HARKIN. Does the Senator from Illinois think the drug companies are losing money on every bottle of pills a veteran buys? I can see him shaking his head. Obviously not. Veterans get their bottle of pills cheaper than anyone else. I bet my bottom dollar the drug companies are not losing a penny on any one of them. They are making money. They are just not making as much money as they are, say, if I went in and bought them.

I yield for a question without losing my right to the floor.

Mr. BYRD. Mr. President, I do not have a question except as to what the status of the legislation is at this point.

Mr. REID. Will my friend from Iowa yield so I can respond to the Senator from West Virginia?

Mr. HARKIN. I yield, without losing my right to the floor, to the assistant minority leader.

Mr. REID. I say to my friend from West Virginia, the distinguished Senator, we are trying to get some votes lined up shortly. It is my understanding Senator BYRD wishes to speak for 10 or 15 minutes on the Durbin amendment.

Mr. BYRD. I would.

Mr. REID. Senator DORGAN wishes to speak for how long on the Durbin amendment?

Mr. DORGAN. Five minutes.

Mr. REID. Does Senator STABENOW wish to speak on the Durbin amendment?

Ms. STABENOW. Five minutes.

Mr. REID. And then Senator LINDSEY GRAHAM is here to speak on what?

Mr. GRAHAM of South Carolina. To call up my amendment, 2 minutes.

Mr. REID. Of course, the Senator from Iowa has the floor. How much longer does the Senator expect to speak?

Mr. HARKIN. I do not think I will be much more than a half an hour.

Mr. REID. That kind of defeats that theory.

Mr. HARKIN. I may not be that long. I think I can wrap up in a half an hour.

Mr. REID. So much for my ideas.

Mr. HARKIN. Mr. President, as I said earlier in response to the questions asked by my friend from Illinois, it is clear S. 1, the 654 pages, is a sham, a ruse, a bewildering, complex bill that is going to cause a lot of consternation for a lot of our elderly.

Again, to the Senator from Illinois, I say, our Government, instead of using our power and influence to negotiate for better drug prices and better drug coverage on behalf of American seniors, is choosing to nurture special interest groups and big campaign donors. Why is it other industrialized nations are spending between 30 and 50 percent less on drugs than the United States? To me it is a matter of priorities.

I end my comments by saying again, before this bill came, the Republicans took care of their friends, giving the wealthiest in this country nearly $1 trillion in tax breaks. Not only did we find the money to give every millionaire $93,000 in tax cuts, we made these tax cuts retroactive to January 1 of this year.

Less than a month later, here we are, and the Republicans tell us we do not have enough money to get seniors on a fixed income real help with their prescription drug costs. Instead, next year they get a card. If you are low income, you get a $600 debit card. And then 2 years from now—actually 3 years from now in 2006—we start this class business. Some are in this class, some in another class, and some in another class. Try to figure it out.

Our job in Congress should be to use our votes to provide security for seniors, not hand out profitable favors for special interest groups.

If we are going to live up to our promise to seniors—our promise to seniors—I ask, how many Senators in this body in the last couple of years have signed pledges not to privatize Medicare, not to privatize Social Security? Our senior citizens, I know in my State and I am sure around the country, have asked us to sign those pledges. I wonder how many here have signed them not to privatize Medicare and not to privatize Social Security.

If we are going to live up to those promises we made and those documents we signed and put their interests ahead of the special interests, the only vote on this bill is a resounding no, unless this Senate, in its wisdom, adopts the amendment offered by the Senator from Illinois, Mr. DURBIN, because the Durbin amendment will work.

The Senator from Illinois has developed a comprehensive and thoughtful alternative that truly gives what our seniors want and need: comprehensive coverage with the option of staying in Medicare.

Let's take a look at the key differences between S. 1 and the Durbin amendment.

Under S. 1, seniors have to pay a $275 deductible every year. Under the Durbin amendment, there is no deductible. Under S. 1, the bill before us, seniors pay a premium not set by law but set by insurance companies, which can be raised at any time. Under the Durbin amendment, seniors will know what premium they will pay because it will be set by law. Under the bill before us, even after the deductible, seniors will still have to pay 50 percent of their drug costs, the result of which means more than one-third of seniors will actually lose money if they participate.

I have a chart that illustrates the so-called savings for seniors under the proposed drug benefit. Let's say you are a senior citizen and you are making over $14,369 a year—let's say you make $15,000 a year. Your total drug costs are $500. Your monthly drug costs about $42. Your share is $389.50. Your premium is $420. Your total out-of-pocket expenses for that year are $809.50. That means you lose $310 on your drugs. You pay in but you lose.

Let's say your total costs are $1,000 a year. Your out-of-pocket expenses are $1,057.52. You lose $58. It is not until you reach just about $1,200 a year in drug costs that you break even. If your drug costs are less than that, you lose. Try telling that to senior citizens in your State.

Let's face it, if you have an income of $15,000 a year and you live up in some of our northern States and you have a high heating bill in the wintertime, maybe you have other extraneous expenses, maybe you have to rent a place, you are not a homeowner and you have to pay rent, you have to eat, you have to buy clothes, and you are paying $500 a year in drug costs, and yet you are going to lose money? Wait until that hits the streets.

Under the Durbin amendment, seniors will pay only 30 percent of their drug costs, getting much closer to what I pay now—25 percent to 30 percent. That is it. They will know in advance they are only going to pay 30 percent.

Under the bill before us, seniors will actually lose coverage for a period of time, even while they continue to pay their premium. That is that donut. When the drug costs reach $4,500, seniors stop getting any benefits until they reach $5,800. That is $1,300 they pay out of pocket, but they continue to pay their premiums.

Under the Durbin amendment, there is no donut hole, no coverage gap.

Most importantly, the bill before us will create mass confusion for seniors who stay in traditional Medicare because for the first time they will have to negotiate private plans and deal with the possibility, if not the likelihood, that plans will come into and pull out of States year after year. The result of this volatility will be a completely unpredictable system, where seniors not only will not know what plan they will be in from year to year, but they may have to switch drugs every year as plans with different formularies come in and out of the system.

Think about the confusion that is going to cause.

The Durbin amendment opens Medicare to private competition, but it includes a real and dependable prescription drug benefit delivered by Medicare. Basically, they have stated we will let them compete with Medicare and we will provide those choices to the elderly, but the Durbin amendment is real and dependable. The Durbin amendment makes other improvements on the underlying bill, but the bottom line for seniors is simple. The Durbin amendment delivers what the bill does not, a meaningful, dependable, reliable prescription drug benefit to all seniors in all States at all times.

Now, some might say, yes, but the Durbin amendment sunsets at the end of 2009. Well, before any of my Republican colleagues start screaming bloody murder and start casting aspersions about how this may be a gimmick and a hoax, let's remember this is exactly the same thing they did, with the support of the President, to shoehorn almost a trillion dollars in tax cuts for the wealthy into a $350 billion price tag.

I always say if it is good enough for the wealthy, it ought to be good enough for our seniors, too. Let them have the same deal.

Again this is about priorities. Earlier this year the President and the Republican Congress made it clear their top priority was tax breaks to those least deserving and least in need. That is the result of their first effort. I am sure there will be more before the year is out. I already hear them over in the House talking about it. It netted each millionaire in this country a $93,000 tax cut this year.

What the Durbin amendment says to our seniors is they are also our priority. Instead of bleeding our Treasury dry by giving every tax receipt back to the richest in the Nation, the Durbin amendment says before we get too far ahead of ourselves on tax breaks for the wealthy or anything else, we are going to get seniors the help they need.

Some will come and argue his plan is too expensive, that it is not sustainable. All I can say is, this plan has roughly the same short- and long-term costs as the tax breaks we passed.

All I ask is, what are the priorities of my colleagues? As luck would have it, both the tax breaks for the wealthy and under the Durbin amendment would sunset at roughly the same time. So in the not too distant future, the new Congress and new President can again set their priorities and decide which should be continued. Should we continue the tax breaks for the wealthy or should we continue a reliable prescription drug benefit under Medicare for the elderly? That is a choice a future Congress could make.

We should not foist upon our elderly a misguided, complex, befuddling, bewildering—and these are not my words; these are words used by others—system of prescription drug coverage that will not meet their needs, that will cost them more money, that will actually cost some of them more than what they get out of it. That is what we are doing. That is what we are going to foist upon the elderly of this country, unless we adopt the Durbin amendment. If we do, then this Senator can wholeheartedly support this bill and vote for it. If not, then I will not be a part of a sham, of a ruse, to tell our elderly they are going to get something when they are not, to hold out a false hope when in fact they are not going to get the benefits they have asked us to give to them.

This Senator's priority is with the elderly. Let's deal with them first. Let's meet their needs first. Then if we have something left over, let's think about tax breaks for the wealthy. Let's not do it the other way around.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. SUNUNU. Mr. President, I ask unanimous consent the following Members be recognized to speak: Senator GRAHAM for 5 minutes, Senator BYRD for 10 minutes, Senator STABENOW for 5 minutes, Senator DOMENICI for 10 minutes, Senator DORGAN for 5 minutes, and Senator ENSIGN for 5 minutes.

Mr. REID. Mr. President, reserving the right to object, we had some votes tentatively scheduled after and that appears to have fallen by the wayside. I therefore ask that Senator BYRD be recognized for up to 15 minutes rather than 10 minutes, and Senator STABENOW for 10 minutes instead of 5 minutes, and I ask that the Senator from New Hampshire accept that modification to the unanimous consent request.

Mr. SUNUNU. Mr. President, I am happy to accommodate that request. In addition, I ask that Senator DOMENICI be recognized for 15 minutes.

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

The Senator from South Carolina.

AMENDMENT NO. 948, AS MODIFIED

Mr. GRAHAM of South Carolina. I ask unanimous consent the pending amendments be set aside so I can offer my amendment. I have a modified amendment at the desk that I call up, amendment No. 948.

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

The clerk will report the modified amendment.

The assistant legislative clerk read as follows:

The Senator from South Carolina [Mr. GRAHAM] proposes an amendment numbered 948, as modified.

The amendment is as follows:

(Purpose: To provide for the establishment of a National Bipartisan Commission on Medicare Reform)

At the appropriate place in title II, insert the following:

Subtitle ____—National Bipartisan Commission on Medicare Reform

SEC. ____01. MEDICAREADVANTAGE GOAL; ESTABLISHMENT OF COMMISSION.

(a) ENROLLMENT GOAL.—It is the goal of this title that, not later than January 1, 2010, at least 15 percent of individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act and enrolled under part B of such title should be enrolled in a MedicareAdvantage plan, as determined by the Center for Medicare Choices.

(b) FAILURE TO ACHIEVE GOAL.—If the goal described in subsection (a) is not met by January 1, 2012, as determined by the Center for Medicare Choices, there shall be established a commission as described in section 2.

SEC. ____02. NATIONAL BIPARTISAN COMMISSION ON MEDICARE REFORM.

(a) ESTABLISHMENT.—Upon a determination under section ____01(b) that the enrollment goal has not been met, there shall be established a commission to be known as the National Bipartisan Commission on Medicare Reform (in this section referred to as the ''Commission'').

(b) DUTIES OF THE COMMISSION.—The Commission shall—

(1) review and analyze the long-term financial condition of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(2) identify problems that threaten the financial integrity of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under sections 1817 and 1841 of such Act (42 U.S.C. 1395i and 1395t), including—

(A) the financial impact on the medicare program of the significant increase in the number of medicare eligible individuals; and

(B) the ability of the Federal Government to sustain the program into the future;

(3) analyze potential solutions to the problems identified under paragraph (2) that will ensure both the financial integrity of the medicare program and the provision of appropriate benefits under such program, including methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals and trends in employment-related health care for retirees;

(4) make recommendations to restore the solvency of the Federal Hospital Insurance Trust Fund and the financial integrity of the Federal Supplementary Medical Insurance Trust Fund;

(5) make recommendations for establishing the appropriate financial structure of the medicare program as a whole;

(6) make recommendations for establishing the appropriate balance of benefits covered under, and beneficiary contributions to, the medicare program;

(7) make recommendations for the time periods during which the recommendations described in paragraphs (4), (5) and (6) should be implemented;

(8) make recommendations on the impact of chronic disease and disability trends on future costs and quality of services under the current benefit, financing, and delivery system structure of the medicare program;

(9) make recommendations regarding a comprehensive approach to preserve the medicare program, including ways to increase the effectiveness of the MedicareAdvantage program and to increase MedicareAdvantage enrollment rates; and

(11) review and analyze such other matters as the Commission determines appropriate.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 17 members, of whom—

(A) four shall be appointed by the President;

(B) six shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 4 shall be of the same political party;

(C) six shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 4 shall be of the same political party; and

(D) one, who shall serve as Chairperson of the Commission, shall be appointed jointly by the President, Majority Leader of the Senate, and the Speaker of the House of Representatives.

(2) DEADLINE FOR APPOINTMENT.—Members of the Commission shall be appointed by not later than October 1, 2012.

(3) TERMS OF APPOINTMENT.—The term of any member appointed under paragraph (1) shall be for the life of the Commission.

(4) MEETINGS.—The Commission shall meet at the call of the Chairperson or a majority of its members.

(5) QUORUM.—A quorum for purposes of conducting the business of the Commission shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(6) VACANCIES.—A vacancy in the membership of the Commission shall be filled, not later than 30 days after the Commission is given notice of the vacancy, in the same manner in which the original appointment was made. Such a vacancy shall not affect the power of the remaining members to carry out the duties of the Commission.

(7) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(8) EXPENSES.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(d) STAFF AND SUPPORT SERVICES.—

(1) EXECUTIVE DIRECTOR.—

(A) APPOINTMENT.—The Chairperson shall appoint an executive director of the Commission.

(B) COMPENSATION.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule under title 5, United States Code.

(2) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(3) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(e) POWERS OF COMMISSION.—

(1) HEARINGS AND OTHER ACTIVITIES.—The Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties under this section.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties under this section.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE AND OFFICE OF THE CHIEF ACTUARY OF THE CENTERS FOR MEDICARE & MEDICAID.—

(A) IN GENERAL.—The Director of the Congressional Budget Office or the Chief Actuary of the Center for Medicare & Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties under this section.

(B) REIMBURSEMENTS.—The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties under this section. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties under this section.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties under this section, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairperson of the Commission, the head of each such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of Congress.

(f) REPORT.—Not later than April 1, 2014, the Commission shall submit to the President and Congress a report and an implementation bill that shall contain a detailed statement of only those recommendations, findings, and conclusions of the Commission that receive the approval of at least 11 members of the Commission.

(g) TERMINATION.—The Commission shall terminate on the date that is 30 days after the date on which the report and implementation bill is submitted under subsection (f).

SEC. ____03. CONGRESSIONAL CONSIDERATION OF REFORM PROPOSALS.

(a) DEFINITIONS.—In this section:

(1) IMPLEMENTATION BILL.—The term ''implementation bill'' means only a bill that is introduced as provided under subsection (b),

and contains the proposed legislation included in the report submitted to Congress under section ___02(f), without modification.

(2) CALENDAR DAY.—The term ''calendar day'' means a calendar day other than 1 on which either House is not in session because of an adjournment of more than 3 days to a date certain.

(b) INTRODUCTION; REFERRAL; AND REPORT OR DISCHARGE.—

(1) INTRODUCTION.—On the first calendar day on which both Houses are in session immediately following the date on which the report is submitted to Congress under section ___02(f), a single implementation bill shall be introduced (by request)—

(A) in the Senate by the Majority Leader of the Senate, for himself and the Minority Leader of the Senate, or by Members of the Senate designated by the Majority Leader and Minority Leader of the Senate; and

(B) in the House of Representatives by the Speaker of the House of Representatives, for himself and the Minority Leader of the House of Representatives, or by Members of the House of Representatives designated by the Speaker and Minority Leader of the House of Representatives.

(2) REFERRAL.—The implementation bills introduced under paragraph (1) shall be referred to any appropriate committee of jurisdiction in the Senate and any appropriate committee of jurisdiction in the House of Representatives. A committee to which an implementation bill is referred under this paragraph may report such bill to the respective House without amendment.

(3) REPORT OR DISCHARGE.—If a committee to which an implementation bill is referred has not reported such bill by the end of the 15th calendar day after the date of the introduction of such bill, such committee shall be immediately discharged from further consideration of such bill, and upon being reported or discharged from the committee, such bill shall be placed on the appropriate calendar.

(c) FLOOR CONSIDERATION.—

(1) IN GENERAL.—When the committee to which an implementation bill is referred has reported, or has been discharged under subsection (b)(3), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for any Member of the respective House to move to proceed to the consideration of the implementation bill, and all points of order against the implementation bill (and against consideration of the implementation bill) are waived. The motion is highly privileged in the House of Representatives and is privileged in the Senate. The motion is not subject to amendment, or to a motion to postpone, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the implementation bill is agreed to, the implementation bill shall remain the unfinished business of the respective House until disposed of.

(2) AMENDMENTS.—An implementation bill may not be amended in the Senate or the House of Representatives.

(3) DEBATE.—Debate on the implementation bill, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours, which shall be divided equally between those favoring and those opposing the resolution. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the implementation bill is not in order. A motion to reconsider the vote by which the implementation bill is agreed to or disagreed to is not in order.

(4) VOTE ON FINAL PASSAGE.—Immediately following the conclusion of the debate on an implementation bill, and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the appropriate House, the vote on final passage of the implementation bill shall occur.

(5) RULINGS OF THE CHAIR ON PROCEDURE.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate or the House of Representatives, as the case may be, to the procedure relating to an implementation bill shall be decided without debate.

(d) COORDINATION WITH ACTION BY OTHER HOUSE.—If, before the passage by 1 House of an implementation bill of that House, that House receives from the other House an implementation bill, then the following procedures shall apply:

(1) NONREFERRAL.—The implementation bill of the other House shall not be referred to a committee.

(2) VOTE ON BILL OF OTHER HOUSE.—With respect to an implementation bill of the House receiving the implementation bill—

(A) the procedure in that House shall be the same as if no implementation bill had been received from the other House; but

(B) the vote on final passage shall be on the implementation bill of the other House.

(e) RULES OF SENATE AND HOUSE OF REPRESENTATIVES.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of an implementation bill described in subsection (a), and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

SEC. ___04. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary to carry out this subtitle for each of fiscal years 2012 through 2013.

Mr. GRAHAM of South Carolina. Mr. President, I offer this amendment with the hope we can negotiate a resolution and have it accepted as part of the package. The chairman of the committee has been very gracious in trying to bring that result about. Briefly, this amendment costs no money. The whole idea of reform in the bill is a new alternative traditional Medicare that will be created, called Medicare Advantage, to which people will gravitate, that allows preventive medicine practices that currently do not exist, bringing modernization to Medicare, making it more user friendly and cost effective. That is the goal of the bill, by creating a new option.

Estimates range from 2 to 43 percent participation. For those looking for reform, the only vehicle for reform in this bill I can find is the idea of Medicare Advantage, and that is somewhat minimal.

This amendment addresses the problem of ''what if.'' What if in 2010, after 4 years of enactment of this bill, the traditional Medicare is the primary choice made? What if the Medicare Advantage Program does not receive 15-percent enrollment? If it has not achieved 15-percent enrollment, creating efficiency and modernization is going to be lost.

This is the last time maybe in a generation to look at traditional Medicare and not only improve it for the senior citizen but improve it for their grandchildren who are going to have to pay for it.

Traditional Medicare, as I understand this bill, is pretty much unaffected in terms of reforms. Having a prescription drug benefit can be a good idea because it emphasizes preventive medicine practices. Having prescription drugs reasonably available can keep people healthier longer and improve the quality of life and keep them out of the hospital and do a lot of good things. But Medicare is $13 trillion short of the money we need. This bill is going to be $4 trillion additional liability. This is a chance as a body to look at the structural problems that Medicare faces.

We are increasing the age limit to 67 for Social Security eligibility. It seems to me that is a good idea given the fact people are living longer. I would like to do that with Medicare. I don't think that is oppressive. I think that is fair to grandparents and grandchildren. I believe we should have a means test. If we have a prescription drug benefit, I believe you should be asked to participate based on your ability to participate because $3 out of $4 coming into Medicare Part B comes from the General Treasury. It is truly a subsidized entitlement. These are the type of reforms I would like to see happen. I don't think they are going to happen. And the Medicare Advantage Program is the only alternative that has a reform element to it.

My amendment says in 2010, after 4 years, if 15 percent of Medicare recipients are not enrolled in Medicare Advantage, if you cannot get 15 percent to pick Medicare Advantage—you get 2 years to reach 15 percent, January of 2012. If you have not achieved 15 percent by January 2012, it is a chance to have a fail-safe mechanism requiring a commission to be appointed. The President, the House, and the Senate would appoint nine members to this commission who would study and report back to Congress in a timely manner what would be needed at that point in time to save Medicare from bankruptcy to make sure it does not blow a hole in the budget and make sure it is efficiently run. This commission has 18 months to create a work product, legislation that comes back to the House and Senate, and we vote up or down on that legislation.

This amendment will force in the future reforms that may not be achieved if we do not have adequate participation in Medicare Advantage. It takes the issue away from Congress in the sense of the commission is required to look at it and bring it back to Congress

for our input and our vote. I believe we need an element like this in this entitlement bill because if we do not have a way down the road to take a second look at this program, we are all going to suffer greatly in this Nation.

It costs no money. Hopefully, it will never have to happen. If we cannot get 15 percent of Medicare recipients to enroll in Medicare Advantage, there will be no way to reform this program. I hope we can find a resolution in a bipartisan fashion and this amendment will be accepted.

I yield the floor.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. BYRD. Mr. President, before we pat ourselves on the back, pop the champagne bottles, and fan out across America to tell seniors that their prescription drug worries are now an issue of the past, let's take a closer look at the Medicare proposal before us.

The more I read through this Medicare bill, the more I become convinced that history is once more repeating itself. I can recall a painful experience during my majority leadership when an outraged citizenry, composed mostly of seniors, forced Congress to repeal the ill-fated Medicare Catastrophic Coverage Act back in 1989. The year before, Congress was engaged in a Medicare debate eerily similar to the one we are having at this time. A bipartisan compromise was reached to make the most sweeping change in Medicare's then 23 years of existence.

Congress agreed to two key changes to the Medicare program—a prescription drug benefit and a ''stop-loss'' protection from catastrophic medical bills. Facing deficits as we do today, Congress, in its infinite wisdom, decided that beneficiaries should pay for the new benefits themselves, with the wealthiest paying the most. The new law included a complicated benefit that was too difficult to explain and a lengthy delay in the benefit's taking effect. In the end, seniors saw the bill, were confused as to what they are were getting in exchange, and wanted no part of it. Hence, it was repealed in the next session. We are poised to make the same mistake again.

I foresee a great deal of confusion and dismay occurring around kitchen tables and in corporate boardrooms across America when people actually start to read beyond the newspaper headlines and see the fine print of this plan 3 years from now. Seniors may not know whether to laugh or weep. And if no one signs up for this new Medicare plan, it will fail and fail miserably.

What incentive do seniors have to sign up for a plan that is full of coverage holes, up-front costs, and confusing paperwork? What incentive do insurance companies have to enter an untried, untested, drug-only insurance market? How can an insurance company make a plan work when almost every single participating insuree makes a claim?

Many of the 335,000 Medicare beneficiaries in West Virginia are struggling just to make ends meet and pay for the prescription medicines that sustain them. In West Virginia, the average annual income of a Medicare beneficiary is a mere $10,800.

I have to wonder, what does this prescription drug proposal mean to a 75-year-old widow from West Virginia who lives off her late husband's pension of $21,000 a year, but has $5,700 per year out-of-pocket drug costs to treat her diabetes, high blood pressure, osteoporosis, and elevated cholesterol levels?

To take advantage of this new, so-called drug benefit, she would have to spend at least $420 in yearly premiums, a $275 deductible, and then she and Medicare would each pay 50 percent of her drug costs until the costs reach $4,500, after which she would pay the remainder of her $5,700 medical bill—about another $1,000 in other words. And she could very well have to spend more given that the deductible, premiums, and copay amount are not defined in this legislation. Does this sound confusing? I am confused just trying to describe it.

Ultimately, Medicare would pay about a mere $2,000 of this poor West Virginia widow's $5,700 drug costs, a benefit of only about 35 percent. What a flimsy benefit. It doesn't even come close to the approximately 70 percent prescription drug subsidy Members of Congress receive under the Federal Employees Health Benefit Program. We wouldn't dare design health benefits for ourselves in this way.

Under this legislation, seniors in similar situations in West Virginia and across the Nation would still be forced to resort to pill splitting and desperately foregoing the medicines their doctors have prescribed.

Let's slow down and take a better look at this legislation. President Bush says he wants the Senate to pass a bill before the July recess, and so we're now engaged in a headlong rush to do just that. Members have been sitting around for days just waiting for Congressional Budget Office staff, who have been working nonstop around the clock to produce, and in some cases, reproduce cost estimates that fall within the too small budget parameters that we have required for passage. This is no way to legislate on a program of such great importance to the citizens of this country. We need more time to explain this plan to our elderly citizens. Don't we need their feedback?

I doubt that our Nation's seniors will be excited about accepting a mere half-loaf benefit. Seniors will probably want no part of it. Just like they did almost 15 years ago, when I was majority leader they may revolt, and Members of Congress could be back here scratching their heads and scrambling to find a solution and save their seats.

Senator DURBIN and I and other Senators have offered a substitute Medicare amendment that actually makes sense, and I am proud to be a cosponsor of it. The Medicare benefit under the Durbin amendment has no deductible, a guaranteed $420 yearly premium, no gaps in coverage, and a catastrophic cap on drug spending at $5,000. The Durbin amendment would also allow seniors to receive their prescription drug benefit through the traditional Medicare program or through an available private plan if they desire. Seniors would receive their prescription drug benefit as soon as possible, rather than having to wait until 2006, after the next elections. Finally, the Durbin amendment would allow the Federal Government to use the leveraging power of millions of seniors to negotiate lower prices for prescription medications.

The same widow in West Virginia with $5,700 in drug costs, would only have to spend about $2,000 under the Durbin amendment plan versus the almost $4,000 she would have to pay under the Grassley-Baucus Medicare bill before us today. I think it is quite obvious which Medicare plan the elderly citizens from West Virginia would choose.

This legislation, as it stands, also does nothing to address the high cost of prescription drugs. We should do better for our seniors. And we can do better. I believe that we can improve this legislation through the adoption of the Durbin amendment. Let's not short-change our seniors. They deserve our very best efforts.

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, I rise also to support and I am pleased to cosponsor the Durbin amendment. But first, I ask unanimous consent to set aside the pending amendment so I may offer three amendments.

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

AMENDMENTS NOS. 1075, 1076, 1077

Ms. STABENOW. I send the amendments to the desk and ask the reading of the amendments be waived.

The PRESIDING OFFICER. Without objection, the clerk will report the amendments by number.

The assistant legislative clerk read as follows:

The Senator from Michigan [Ms. STABENOW], for herself and Mr. LEVIN, proposes en bloc amendments numbered 1075, 1076, 1077.

The amendments are as follows:

AMENDMENT NO. 1075

(Purpose: To permanently extend a moratorium on the treatment of a certain facility as an institution for mental diseases, and for other purposes)

On page 676, after line 22, add the following:

SEC. ___. EXTENSION OF MORATORIUM.

(a) IN GENERAL.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 and section 4758 of the Balanced Budget Act of 1997, is amended—

(1) by striking ''until December 31, 2002'', and

(2) by striking ''Kent Community Hospital Complex in Michigan or.''

(b) EFFECTIVE DATES.—

(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

AMENDMENT NO. 1076

(Purpose: To provide for the treatment of payments to certain comprehensive cancer centers)

On page 438, between lines 10 and 11, insert the following:

SEC. ___. COMPREHENSIVE CANCER CENTERS.

(a) IN GENERAL.—Section 1886(d)(1) of the Social Security Act (42 U.S.C. 1395ww(d)(1)) is amended—

(1) in subparagraph (B)(v)—

(A) by striking ''or'' at the end of subclause (III);

(B) by striking the semicolon at the end of subclause (IV) and inserting '', or''; and

(C) by inserting after subclause (IV) the following:

''(IV) a hospital that is a nonprofit corporation, the sole member of which was recognized as a comprehensive cancer center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that specifies in its articles of incorporation that at least 50 percent of its total discharges must have a principal finding of neoplastic disease, as defined in subparagraph (E), and that is a freestanding facility licensed for less than 131 acute care beds;''; and

(2) in subparagraph (E), by striking ''(II) and (III)'' and inserting ''(II), (III), and (IV)''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning after the date of enactment of this Act.

AMENDMENT NO. 1077

(Purpose: To provide for the redistribution of unused resident positions)

On page 438, between lines 10 and 11, insert the following:

SEC. ___. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in subparagraph (F)(i), by inserting ''subject to subparagraph (I),'' after ''October 1, 1997,'';

(2) in subparagraph (H)(i), by inserting ''and subject to subparagraph (I),'' after ''subparagraphs (F) and (G),''; and

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

''(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

''(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

''(I) IN GENERAL.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2003, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

''(II) REFERENCE PERIODS DEFINED.—In this clause, the term 'reference periods' means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2001.

''(III) REFERENCE RESIDENT LEVEL.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

''(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2002.

''(ii) REDISTRIBUTION.—

''(I) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

''(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2003, or before the date of the hospital's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2004.

''(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

''(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

''(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

''(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

''(iii) RESIDENT LEVEL AND LIMIT DEFINED.—In this subparagraph:

''(I) RESIDENT LEVEL.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

''(II) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) on the resident level for the hospital determined without regard to this subparagraph.''.

(b) NO APPLICATION OF INCREASE TO IME.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: ''The provisions of subsection (h)(4)(I) (determined without regard to clause (ii) thereof) shall apply with respect to the first sentence of this clause in the same manner as such provisions apply with respect to subparagraph (F) of such subsection.''.

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, the Secretary of Health and Human Services shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(i)(II) of the Social Security Act (as added by subsection (a)).

AMENDMENT NO. 994

Ms. STABENOW. Mr. President, I believe this is an incredibly important vote. This amendment really is about providing seniors with what they are asking. The seniors of this country, and those who are disabled, deserve our best effort. As we come together we have been spending this time putting together prescription drug coverage for seniors, debating about how to lower prices, and the Durbin amendment—which I am pleased to cosponsor—does just that. I believe the Durbin amendment is our best effort. That is what seniors are asking for.

They are not asking for more insurance forms to wade through. Most of them are not asking for more choice. They are asking for prescription drug coverage.

I was talking to someone today at lunchtime who is on Medicare. He said to me, Whatever you do, please do not do anything to Medicare. It is simple; it is easy; it is dependable; they handle my secondary insurance.

He said, I actually have a 1–800 number I call and a real person answers the phone.

He was going on and on talking about how successful and how helpful Medicare has been for him.

I said, Boy, I would love to have you come to the floor and share this with my colleagues, because we keep hearing about how awful the traditional Medicare system is.

The conversation I had with the gentleman at noon reflects what I commonly hear at home. As I said before, the seniors of this country consider Medicare—and I wish we would consider Medicare—a great American success story.

Why is the Durbin amendment the best effort we can provide? Why is it the best we can give to our seniors?

First of all, working within the dollars that have been put aside in the budget resolution, this does not require any additional funds. But, by doing this, by putting the priority on our seniors and those receiving the health care, by making that the focus, that the priority, you can create a very different benefit if your priority is to start with: What do our seniors need? What do those who are disabled need? Let's start with a system that is designed for them.

When we do that, we can create a system that does not have any deductible, no deductible at all. We can create a system that guarantees what the premium will be. Not a suggested premium like we have in the underlying bill, but we can say it is $35 a month; it is guaranteed; it is in the law. Seniors will know what to count on and what to claim for.

We can do a better job on cost savings. Instead of saying we will cover 50 percent of the cost, we can cover 70 percent. That is a big difference—70 percent of the cost.

We can make sure there is no coverage gap. In fact, no one will lose their benefits, their help with their medical payments, as they move up with greater and greater bills. The higher the bill, the more they would continue to get help.

One of the reasons this can be done is because there is a real effort to get the best possible price for our seniors. The real issue in all of this debate—and the reason we have all this convoluted, complicated process that has been going on—is the pharmaceutical industry wants to make sure all the seniors are not in one plan where they can negotiate a big group discount as with any other insurance plan. We know the veterans of this country do not pay retail because the VA gets a group discount. Well, the Durbin amendment would give our seniors that group discount. And if you do that, you can lower prices. It is still a fair return, but you can lower prices, and use those savings to provide a better benefit, to make sure there is no deductible, to make sure there is no gap in coverage for our seniors.

We also can deal with a very important issue for many of us; that is the question of employer benefits. We want to make sure our employers do not have the incentive to drop benefits. There are many people in my great State of Michigan who I have worked with in our great auto industry, and other manufacturing industries, and others that have good benefits now. We are grateful to the employers in the industries involved, and they have a history of good benefits, good wages, and good employees, I might add. We are very proud of the work that goes on in Michigan.

Now that many of our Michiganites have retired, we want to make sure we provide incentives for employers to maintain those benefits. Those lifesaving benefits are absolutely critical. And we know that in the underlying bill, unfortunately, the projection is there will be an incentive for many employers to drop or reduce benefits, which is not acceptable.

What we have in this option, in this best offer that is in front of us, is the ability to count the employer benefits toward out-of-pocket spending, which is an encouragement for employers to continue to provide the benefits they currently provide to their retirees.

Under the Durbin amendment, you would have the option of a private plan. If you would like to go into an HMO or PPO, if that is a positive experience for you, you have that choice. But it also makes sure there is a Medicare choice always, that you have an opportunity to stay within Medicare.

Then one of the most important parts of this amendment is the fact that it would take effect as soon as possible. I think one of my concerns is with all of the talk and all the news reports about a new prescription drug benefit, it is not clear to our seniors that, in fact, no help in terms of a benefit is available until 2006. There is a discount card, yes, but nothing in terms of the bill taking full effect until 2006. So this amendment would say ''as soon as possible.'' As soon as possible we want to make sure this takes effect.

The Durbin amendment puts forward our best effort. It is a better benefit. It is a defined benefit so there is dependability. It reduces prescription drug costs. It maintains choice for those who wish to have another choice other than traditional Medicare. It creates a reliable Medicare benefit fallback if you choose private insurance. If your private carrier drops you, such as happened to my mother with her Medicare+Choice plan, you would always be able to have Medicare as a permanent choice for you if that happens. We incentivize employers to maintain benefits. And, finally, the Medicare-delivered benefit can be implemented faster.

There is a lot of good work and good will among all of our colleagues to try to develop and pass a prescription drug benefit here in the Senate. I believe our seniors deserve the very best we can offer, something that is straightforward, is dependable, is reliable—a system that is based on what is best for them, not what is best for insurance companies or pharmaceutical companies or any other interest but what is best for them.

Medicare has been a great American success story. It works. It just needs to be updated. It just needs to be modernized to cover prescription drugs. I believe it also should be modernized to cover more preventive efforts and other kinds of improvements that will continue to strengthen Medicare and allow it to modernize and improve with the times.

We can do that. We can do that without going to a complicated, convoluted system that focuses more and more on efforts that ultimately could privatize Medicare.

I urge my colleagues to join in support of the Durbin amendment. Give our seniors what they are asking for.

I will share with my colleagues a chart I have used many times on this floor. Right now, 89 percent of the seniors of this country are in Medicare. They are asking—I am very confident they are asking—for the Durbin amendment. I encourage my colleagues to support it.

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

The Senator from Nevada.

Mr. REID. Mr. President, I ask unanimous consent that if there is not a vote called following the statement by the Senator from Nevada, Mr. ENSIGN, Senator DURBIN be recognized for 15 minutes, Senator SMITH of Oregon for 5 minutes, and Senator NICKLES for 20 minutes to speak on this bill or any pending amendment.

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

The Senator from New Mexico has the floor.

Mr. DOMENICI. Mr. President, I rise today to speak about this legislation. Perhaps some will not recognize my speech at all because I know there is $12 billion to be resolved, and I understand it is going to be resolved. I am speaking as if we have finished our work and we are going to vote. I am here to tell the Senate and anybody interested why I am going to vote for this legislation.

First of all, we need prescription drugs for our senior citizens.

Secondly, we have a situation, of which I am absolutely positive. From what I have heard, if I were attending the meetings in the Democratic caucus, I would hear the Democratic Senators who are informed on the subject stand up and talk about how bad this bill is. I would hear them say that it does not do enough, that it does not take care of enough poor people, that it does not have enough choice, and that all the seniors who are currently on Medicare are expected leave and go somewhere else. That is not any good.

And just as sure as that is going on, and I have inquired before making this speech if that is the case, I go to our Republican caucuses, and I hear one Senator after another speak about the shortcomings of this bill. Some speak about it with a clear-cut: ''I am not going to vote for it.'' But many speak of it in terms of: ''I just want to let you know how bad I think it is. I don't want to talk you out of it, I just want to tell you how bad it is.'' One Senator after another, then another: ''I just want to tell you how bad it is. It just won't work.''

Then somebody else on this side begins speaking about it from fiscal policy, and they say: ''It is going to cost too much. It is going to break us.'' And there are Senators in the other caucus saying: ''We are not reforming the Medicare system, and it's going to go broke. We are just adding more debt to that system.'' Now again, I have not been there, but I asked.

Then I go to our caucus, and I hear the same thing: ''The Medicare system is already somewhat bankrupt. It is not going to have sufficient money in a few years. We are going to have to start finding money for it somewhere. And this is going to add, some say, $4.5 trillion.'' That is what we have been hearing in our caucus. Some are saying: ''No, I don't want you not to vote for it, but I just want to tell you about all these problems.''

I want to tell you I am going to vote for it because I am a hope-filled Senator. I am hope filled about the future of the American economy and American prosperity. I am hope filled about American ingenuity, American breakthroughs, American science achievements, and American wellness achievements. I want to tell you about why I am hopeful.

First, we have mapped the human genome system during our lifetime. This means that we currently know where the aberrations in the human genome system are, and where all of the major diseases lie within the chromosome system of the human anatomy. That is an unheard of achievement.

Why do I speak of it while I try to talk about Medicare and prescription drugs? Because we are not living in a stagnant world. We are not living in a world that during the next 10 or 15 or 20 or 30 years that we are going to have just what we have today in terms of wellness, in terms of prescription drugs, in terms of curing illnesses. We are in the midst of the most gigantic breakthroughs in wellness. We are in the midst of breakthroughs in terms of finding cures to all kinds of human ailments and all kinds of drug breakthroughs which are going to cure people and make them well. There sits that breakthrough called the mapping of the human genome system.

At the same time we are passing this bill, science is far from stagnant. There is going on in science today something called nanoscience. Nanoscience involves the actual manipulation of atoms to create new systems and new products. While we are wondering if we are going to be able to afford this drug system we are currently putting in place, out there in all kinds of centers of higher learning, American scientists and scientists in the rest of the world are developing technology involving the manipulation of atoms to create new systems and new products.

I believe within 15 to 20 years there will be so many new products and things that will be manufactured and made that will add to the productivity of America. I mention it because it makes my vote tomorrow on this bill hope filled. I believe there are going to be productivity changes, there are going to be drug cures, there are going to be medicinal cures, there will be wellness cures. All of these things are going to happen because we are not going to be living in a stagnant system. We are going to deliver under this prescription drug bill the drugs our people need; principally with the money going to the poorest, who need the most help, and then moving it upwards so that those who are least in need will get the least help.

While we have Senators on each side finding fault with the proposal, which probably means it is pretty good, we also find them saying: ''We can't afford it.''

I am here to suggest we can afford it. As a matter of fact, I am here to say we can't afford not to do it. I am here to say with all the breakthroughs that are going to occur, we must put in place a system that is more apt to take advantage of those breakthroughs. I believe the distinguished leader of the Senate who has spoken on this subject is correct. If we have these HMOs and PPOs and these delivery systems, they are more apt to take advantage of the breakthroughs that are going to occur because of nanoscience, because of the genome, and then because there is also a huge new system called microtechnologies. Microtechnologies, believe it or not, are going to create all kinds of tiny little engines, engines that are going to be able to do all kinds of things that make products and solve problems and cure health problems.

The microtechnology system means that little tiny engines will be produced on a chip just like the chip that we now talk about. There will be engines on that chip. And, if you look at that chip with a microscope, you will actually see little engines working. Those engines may, indeed, be put in the human body to go after certain ailments and just take them on as little engines. And the illnesses will disappear or perhaps be ameliorated.

All of these things are going to happen. Nobody at the CBO, nobody at the other agencies who have evaluated whether we will be able to pay for this bill and whether we will be able to deliver on this bill, have figured in those kinds of gigantic breakthroughs that are going to occur in this American system. In fact, none of them are figuring the productivity breakthroughs that are going to occur, in this Senator's opinion, from nanoscience and microtechnology breakthroughs. Nor are they taking into consideration breakthroughs on the medicinal side that will result from our continuation of funding the NIH at about 10-percent growth a year.

I add one caveat. If I were voting on this bill and were asked, ''What should you do in addition to this bill?'' I would adopt a resolution that would require mandatory funding of the physical sciences at about 10 percent a year just like we did the NIH for the next 10 years. Then you would have the great instruments of breakthrough—the NIH, the National Institutes of Science, plus American ingenuity and business. You would have the physical sciences funded at a much higher rate than we are funding them so that nanoscience and the others I have spoken of can have their breakthrough day. So that we can, in fact, deliver what we plan to deliver under this bill.

I close where I started, by saying: For all intents and purposes, the bill is finished. It is probably not perfect, but no democracy can draw a perfect bill. It is probably better than those who are saying how bad it is, and it is probably slightly worse than those who are running around saying how great it is. But it is pretty good in terms of a delivery system that can get us started and that we can always change.

I don't fear the fact that we have a large group of Americans coming along, the generation that we are worried about, the baby boomers. I am not concerned about how we are going to pay for them and how we are going to take care of them. I believe the breakthroughs I have just discussed generally will be specific breakthroughs that will be occurring rapidly in large numbers, every year for the next 20 to 30 years. I believe that 20 years from now we will not recognize the prescription drugs being delivered today. We will not recognize what the drugs are being delivered to cure, and what they are curing because we will have made so many changes. And, almost all of these changes will be for the positive. By applying human ingenuity, human knowledge, human capacity to such basic research as the human genome or the mapping of the chromosomes and the aberrations on the chromosomes which create diseases, we are going to find cures so that we won't have to be paying the drug costs because we will have found the cures for the sicknesses.

I thought it would be a good 15 minutes, maybe 10, while we had a few lax moments, to at least let one Senator put some comments in the record that sort of set the tone for what he will be thinking about when he votes on this rather celebrated bill. I will be thinking about all the people we are going to help today, tomorrow, and next year. But I will also be thinking about all the changes that are going to occur because of these great sciences that I have just spoken of. We won't recognize what we are taking care of in 10 years. We won't recognize what medicines we are delivering. We won't recognize what diseases we are curing. And, frankly, it is entirely possible that we won't recognize the hospital system that we have delivering hospital care to our people if, in fact, the genome system really works as some people think it will.

Some are saying within 20 to 40 years we won't even have hospitals like the ones we have. There will be different kinds of institutions that will be delivering health care because of the capacity of the genome system to deliver health care in a completely different way. I hope that these words at least are helpful. They are to this Senator. They make me feel that I have something to say beyond coming down here and reading a bunch of numbers, which I used to have to do ad nauseam when I was chairman of the Budget Committee, and try to make all kinds of predictions on how you are going to have enough money for this, that, or the other thing.

To tell you the truth, this program is a close call in terms of whether we are going to be able to pay for it. It might be a close call as to whether it is the best program we can put together. But I tell you, it is the right thing to do. We don't have anything like it today, and our people, in particular poor people, suffer because of it. We ought to

fix this as soon as we can and then go to work keeping an environment in our economic system that is vibrant and healthy. We must do this so that our system can do the things that I have been discussing over the next 15 or 20 years as this prescription drug benefit delivers the prescription drugs we are talking about.

I understand my time has elapsed, and I yield the floor.

The PRESIDING OFFICER (Ms. COLLINS). Under the previous order, the Senator from North Dakota is recognized for 5 minutes.

Mr. DORGAN. Madam President, we are about to vote at some point in the coming hour or two on a series of amendments, one of which will be the Durbin amendment, called the MediSAVE amendment. I wanted to make a couple of comments about that amendment.

I regret there being a substantial difference between what is promised and what is delivered to senior citizens with respect to a prescription drug benefit in the Medicare Program. My colleague from New Mexico indicated this is not a perfect bill. It is not. It is not a terrible bill; that is certainly the case as well. It addresses an issue that almost every Senator says needs addressing, and that is adding a prescription drug benefit to the Medicare Program. But I confess, the more we have dealt with this, the clearer it is to me that we are creating the most complicated, byzantine system that we possibly could have created.

We had opportunities, and will continue to have them, to improve this bill. We have missed most of them in the last few days.

This is a horribly complicated proposal. The Durbin amendment is an amendment that provides substantially improved benefits, and I will describe all of them. These benefits are not in the underlying legislation. The average cost of prescription drugs for senior citizens in this country is about $2,300 a year.

I might say that senior citizens are about 12 percent of America's population and they consume one-third of the prescription drugs, because we know when people reach retirement age, that status of life, many of them need prescription drugs in order to deal with their health issues.

Miracle drugs provide no miracles for those who cannot afford to take them. So we understand when people reach their declining income years, we ought to put together a prescription drug plan, attach it to the Medicare Program, and give them the assurance that we did 40 years ago, that if they are sick, they can go to a hospital; they would have Medicare; and if they need prescription drugs now, give them the assurance that they will have that opportunity.

We all have talked to senior citizens, particularly women, I might say, who live on fixed incomes, alone, at an advanced age, and have a very minimal amount of income, and who tell us: I cannot afford to take the prescription drugs the doctor says I must take.

I have talked about the woman who came to me at a meeting one day and said, ''I have heart disease and diabetes.'' She must have been in her eighties. ''The doctor prescribes medicines and I have no opportunity to buy them because I cannot afford them.''

The fact is, we can do something about that. Now, my colleague, Senator DURBIN from Illinois, offers an amendment that creates a more meaningful benefit to senior citizens, No. 1. If they spend $2,300 a year, on average, for prescription drugs, the underlying bill will give them the benefit of somewhere around $600.

I will say that again. If they spend $2,300, we are going to say you have prescription drug coverage now. But the fact is, it only covers $600. My colleague's amendment will double that to $1,200.

Second, it creates a defined benefit. Under the plan before us, the Grassley-Baucus plan, there is no guaranteed benefit for seniors. The premiums are left to the insurance companies. Well, figure out what you can do, describe what the premium is going to be, and tell us later, would you?

That is no way for the Congress to define a prescription drug benefit. My colleague offers an amendment that has a defined benefit and that is exactly what our responsibility is, to define the benefit.

The other issue my colleague addresses is reduced cost. I offered an amendment that did pass that talks about the reimportation from Canada of prescription drugs, offering consumers the same drug, made by the same company, put in the same bottle, at a lower price because we pay the highest prices for prescription drugs in the world. You can buy exactly the same drug in Canada for a substantial discount.

My colleague says, with this prescription drug plan attached to the Medicare Program, what we ought to do is instruct Health and Human Services to negotiate the same group purchasing arrangements that we have done in the VA. We know how that works. We know what that saves.

There isn't any reason it should not be in this legislation. My colleague's amendment maintains a choice. People still have the opportunity to go into a private plan someplace, but they can come back to this plan, which will be a Medicare attached plan with better benefits.

So what my colleague from Illinois is offering is something that is much better, provides better benefits, provides defined benefits, provides downward pressure on prices, and it seems to me it represents what everybody in this Chamber has promised at one time or another but which none will deliver unless we start passing an amendment of this type.

We have missed a lot of good opportunities in recent days to pass amendments that would have improved this bill. I guarantee you, if we don't make some improvements, by the year 2006, when this becomes available—it should have been 2004, but the last amendment was turned down—there will be a lot of disappointed people, because they expect prescription drug coverage. Instead, they are going to get a fraction of that. We can remedy that.

The first step, it seems to me, is to vote for the Durbin amendment, the MediSAVE amendment. There are other amendments we can support as well which will make this the kind of prescription drug benefit in Medicare that senior citizens have been promised by virtually all of us.

Let's not deliver much less than we have promised. We have all promised to do something about this because we understand the need and we understand the urgency. When you reach those declining income years of life and need prescription drugs, the miracle drugs to save your life and to maintain a decent life, we understand the need to provide the help to finance those drugs. Many seniors simply cannot do it. They go to the grocery store that has a pharmacy in the back, and they have to figure out the cost of their drugs before they decide how much food they can afford. We have all heard those stories time and again.

The question is, are we going to do this? If the answer is yes, the question is, are we going to do it right? If the answer is yes, then it is voting for the Durbin amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Who is to be recognized next?

The PRESIDING OFFICER. Under the agreement, Senator ENSIGN of Nevada is to be recognized next.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Madam President, I ask that the time of the Senator from Nevada be reserved, and we now turn to Senator DURBIN who is under the consent agreement.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Illinois.

Mr. DURBIN. Madam President, I thank my colleague from Nevada. I say to my colleagues, the more they study S. 1, the more they get to know it, the more concerned they have to be. I agree with the premise that we are making a commitment for the first time to provide prescription drug help to senior citizens. This is historic. We are doing the right thing.

Then when you look at the way this has been written and try to put it in the context of your parents or grandparents making these decisions, you understand the complexity of it, the fact it does not provide the protection which a lot of people promised. Basically, when it gets down to it, this is fraught with danger and peril.

The seniors understand that. When you sit down with senior citizens and

say let me tell you what we are doing, what we are offering, the first thing they say to you is: Senator, what are you doing to keep the cost of drugs from running off the chart? I know you say you are going to help me by paying a certain percentage. What good is that percentage, Senator? My Social Security payments are going up, enough to keep up with the cost of inflation. So if you are not going to contain the cost of prescription drugs, what good is this?

That is a hard question, isn't it? But it is the right question. When you take a look at S. 1, the bill before us, the honest answer is nothing. What this bill says is we will rely on HMOs and private insurance companies to offer a prescription drug benefit.

My friend from Florida was an insurance commissioner. Senator NELSON has told us time and again what it means to deal with some of these insurance companies. As much as his expertise might bring to this debate, the greatest experts on HMOs are senior citizens. Ask them about coverage by HMOs. They despise HMOs. They know what these insurance companies are going to do.

First, they are going to nail them with a premium much more than 35 bucks a month. There is a provision in this bill which makes insurance sense but does not make common sense. It says if you have a chance to enroll in this voluntary program at the monthly premium—and let's assume for discussion it is $35—and you turn it down because it is voluntary and say you do not want to enroll in it, and then a year later or 2 years later, you think, maybe you should enroll in it, there is a provision in this bill that says your monthly premium may not be $35, it may be $100.

It makes insurance sense because it is called adverse selection. You do not want sick people to pay premiums just when they get sick. Think about that senior on a limited income who has to make a calculation as to how much they are going to pay. Look at that senior, if you are talking about a $1,000 annual prescription drug bill—I am sitting there with my mother or my grandmother, and she says to me: Son, should I pay this $35 a month? I know it is a $275 deductible.

I say: Mom, your payments are less than 100 bucks a month. You are going to end up paying more. You are not going to get any help from this plan because the first $1,000 your monthly premium is going to be added on to the help from the Government. You will be paying more than $1,000 for $1,000 worth of drugs. It may not make sense to you, mom.

OK, maybe I will not sign up.

Then a year or two later she starts getting sick and needs prescription drugs desperately, and now that monthly premium is no longer $35; it is $100. It makes insurance sense, but it does not make common sense, and that is one of the wrinkles in this bill.

When you ask the seniors about S. 1, this Grassley-Baucus bill, they are worried about this $35 premium that may be $50 or may be $100, and these are people, I hate to remind my colleagues, who are living on $400 or $500 or $600 a month.

To a Member of the Senate, $35 is not something you consider a life-threatening decision. For a senior citizen on a fixed income, a widow living alone in a small rural town in downstate Illinois or Florida, it is a big deal. Seniors have told us: I do not like this idea of $35 a month if it is not even certain that is what the premium is going to be.

Then you say to them: Incidentally, you are going to have to deal, once again, with HMOs and private insurance companies for your prescription drugs, and they start bailing out saying: What are you doing to me, Senator? I do not trust these people. That is why almost 90 percent of the people on Medicare do not sign up for the Medicare HMO. They do not trust these HMOs. They know what they are going to do.

I sat in this Chamber and heard the debates where HMOs and insurance companies make life decisions for seniors time and again, and they come down on the side of protecting their bottom line, protecting their profit, rather than protecting the health of the seniors. The seniors know this. When the Republicans come forward and say trust the HMOs, they will take care of you on prescription drugs, they will bring the prices down, you know they are not going to mistreat you, seniors are skeptical, and they have a right to be.

Let me tell you, there is an alternative which I offered. Madam President, I say to my colleagues in the Senate, I hope they will take a look at it for two reasons: No. 1, if this plan turns out to crater and bomb and the senior citizens across America say, What have you done to me; this is not what we were bargaining for, you will at least be able to say: I voted for an alternative. Sadly, it didn't make it. I hope it does, but if it does not make it, I voted for the right alternative that did not have the problems of S. 1. That is what MediSAVE offers.

For my colleagues in the Senate, unless you are sure you want to go to the bank on S. 1, that you want to walk into a senior citizens meeting and try to explain this to your constituents who live in the State of Maine or the State of Florida or the State of Pennsylvania, then for goodness' sake, think twice about a simpler, more honest, and direct approach. Let me tell you what it is.

It has a guaranteed $35-a-month premium. S. 1 guarantees nothing. No deductible and a payment by the Government of 70 percent of the drug cost; not 50 percent—70 percent. Does that sound overly generous? My colleagues in the Senate, guess what. That is what we get. That is our benefit in the Senate.

Is this lavish, luxurious, too much, over the top? I do not hear a lot of Senators complaining about it, nor Members of the House of Representatives. If it is good enough for my colleagues, is it not good enough for your mother? Is it not good enough for your grandmother? That is what it boils down to. The Durbin amendment says we are going to give seniors across this Nation the same percentage break on prescription drugs that Members of Congress get.

Yesterday, by a vote of 93 to 3, we said that is fine. We all know what that is all about. There is this little process where the bill passes the House and passes the Senate, and then there is this mystery gathering called a conference committee, the waltz kings of the House and the Senate. They waltz nonchalantly into the committee room and close the door. And out of that committee room in a day or a week or a month pops a bill twice this size that no one has read. They say: I am afraid we do not have time to read it; we have to get moving. We have to get back home. We will let our staff take a look at it.

Two weeks from now somebody will take a close look at it. They will vote and leave. How many times have we seen that happen?

After the waltz kings have gone into the conference committee and done their work, I bet you dollars to donuts MARK DAYTON'S amendment, which said Members of Congress are bound by the same prescription drug benefit as senior citizens in America, will be gone—out. We will be back at 70-percent reimbursement on our prescription drugs and say to seniors: You know, 20 percent is really all we can afford, and I hope you understand.

The alternative is 70/30. If it is good enough for Members of Congress, it is good enough for your mom and your grandmother.

There is no coverage gap under the MediSAVE amendment, and there is no coverage gap under congressional health insurance, congressional prescription drug benefits.

We have an amendment offered by Senator BOXER, and I hope my colleagues will think twice about this. To think that one could spend $4,500 in a year and then have their protection cut off for prescription drugs is something people just rationalize and say: Gosh, we wish we had more money; we would make it work. Senator BOXER brings it to the real world. What if someone you love has been diagnosed with cancer? What if they are facing some of the most expensive drug therapy—chemotherapy, radiation therapy—imaginable to save their lives and they are forking out dollar after dollar to get through this illness that could claim their life and you are praying for them every day and guess what. Come October, after they have been on this drug therapy for 9 months, this prescription drug benefit under S. 1 disappears.

What are you supposed to do? Fork it over out of pocket, if you can. Is that

an answer? MediSAVE, the alternative, says do not do that to people. Cover them completely. Make this a real insurance policy, not a game where if you are too sick we are going to nail you.

It also says let's negotiate the drug prices. That is what this is all about.

If we do not deal with the expensive drug prices in America, this is a fraud on the public. Think about it. We estimate over the next 10 years that seniors will spend $1.8 trillion on drugs. How much do we provide to help them—$400 billion. Do the math. It is less than 25 percent. But if we could bring down that cost from $1.8 trillion to a more manageable figure, that $400 billion goes further.

The Veterans' Administration has shown they can do it for our veterans. They brought down the price of prescription drugs in veterans hospitals by 50 percent. We can do the same thing for Medicare recipients if we care more about them than the profits of the drug companies. Trust me, the drug companies can bring those prices down and still continue to be the most profitable businesses in America.

These companies spend hundreds of millions of dollars a year showing people skipping through a field of wild flowers, saying, I no longer am sneezing; therefore, I need to have Claritin and Clarinex; and whatever the next generation of Claritin is going to be, please go to your doctor and beg for it.

They spend hundreds of millions of dollars on this marketing and then they say they cannot cut the cost of their drugs because it will cut into their research. Baloney. We know better. They spend more money on advertising than they do on research for new drugs, and that tells the story. They can bring down the cost of these drugs for seniors and families across America and have plenty of money left over for profit and plenty of money for research.

We say under this MediSAVE amendment this competition will reduce costs and make this drug benefit worth something to families and seniors across America.

I say to my friends, the last part of this is the most important part. Medicare will offer a drug benefit option. Those who stand back and say, Senator DURBIN, you have gone too far; Medicare is going to offer a prescription drug option; I ask them to please look back at 40 years of history and experience in America, where the Medicare Program has worked with doctors and hospitals in every city and town in America to provide the very best medical care for seniors. At the beginning of that debate, many people voted against it saying it was pure socialism, that was not the market at work, and they were right. It is not the market at work. It is the Government of this country representing the families of this country at work for them.

We believe the same should be true when it comes to prescription drugs. Medicare should offer an option. Let the Medicare administration, with no profit motive and low administrative overhead and the ability to bargain for a discounted formulary of drugs, compete with these private insurance companies, which my friends on the Republican side of the aisle insist are going to show the way in how to save money for seniors. If it is true, they will be ready to compete and the seniors can make the choice, but under this bill they cannot. There is no choice to be made.

Medicare does not offer a prescription drug option under this bill, and that tells the whole story.

The final point I will make to my colleagues is this: If they voted for Senator DAYTON's amendment yesterday, 93 to 3, saying Members of Congress are going to pay the same thing as seniors across America and my colleagues think we are going to get by with knocking that out in conference and nonchalantly passing the bill and we get 70 percent reimbursement while seniors get 20 percent reimbursement, I am sorry, the cat is out of the bag. The press corps and the American people are watching every move. Do the right thing. Bring seniors up to the level of Members of Congress. Do it now. Vote for the MediSAVE amendment and then my colleagues can go home and I think honestly say to seniors we have given them a real prescription drug benefit.

The drug companies will not like it, the HMOs will not like it, but I guarantee that parents, grandparents, and seniors across this country are going to understand they finally have a benefit that was worth the wait.

I reserve the remainder of my time.

Mr. NELSON of Florida. Will the Senator yield?

Mr. DURBIN. I yield to the Senator from Florida for a question.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON of Florida. I say to my colleague from Illinois, I think he has analyzed this about as well as anyone I have heard. We made promises to the senior citizens of this country that they would have a defined benefit that would cost a minimal amount with very little deductible, with no huge gap in the coverage, that would be a part of Medicare and that whatever it was to cost——

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

Mr. DURBIN. I ask unanimous consent for an additional 3 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. ENSIGN. Reserving the right to object, we have been waiting about an hour and a half to speak and all I can say is we have been waiting quite a long time.

Mr. DURBIN. Two additional minutes, and I will ask unanimous consent that the Senator be given 2 additional minutes for his patience.

Mr. ENSIGN. I do not need any additional time. I just wanted to speak if I could.

Mr. DURBIN. Two minutes. Does the Senator object?

Mr. ENSIGN. Okay.

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

Mr. NELSON of Florida. So I compliment the Senator and ask him why, if that was the promise that was made to American seniors, are we not considering this as the major bill on the floor, the MediSAVE amendment, instead of the package we have on the floor?

Mr. DURBIN. I thank the Senator from Florida. The answer is obvious: Because the drug companies won the debate and the seniors lost it. The drug companies have no pressure whatsoever to reduce prices. Secondly, an ideology that said the private side, the insurance companies and the HMOs, are the only answer to America's future in health care overcame common sense.

Common sense has shown seniors, and the Senator knows it better than anybody in this Chamber, when the HMOs get their hands on benefits like this, seniors are going to lose out. That argument has won the day, and that is what is in S. 1.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. ENSIGN. Madam President, what is the pending business?

The PRESIDING OFFICER. The pending amendment is No. 1077, authored by the Senator from Michigan.

Mr. ENSIGN. I ask unanimous consent that the pending amendment be laid aside.

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

AMENDMENT NO. 1024

Mr. ENSIGN. I call up amendment No. 1024.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Nevada [Mr. ENSIGN], for himself and Mrs. LINCOLN, proposes an amendment numbered 1024.

Mr. ENSIGN. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To amend title XVIII of the Social Security Act to repeal the medicare outpatient rehabilitation therapy caps)

At the appropriate place in title IV, insert the following:

SEC. ___. OUTPATIENT THERAPY CAP REPEAL.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395*l*) is amended by striking subsection (g).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2005.

Mr. ENSIGN. Madam President, there is a cap on the amount of therapy that can be given to seniors for physical therapy, occupational therapy and speech therapy, that is set to go into effect in July. There is a $1,590 cap that is set to go into effect. What we need to do is to repeal that cap and we need to do it for very good reasons.

First, the oldest and the sickest seniors will be in a situation where they have to pay 100 percent of the costs over the cap. MedPAC and independent analyses have found that one out of seven beneficiaries needing such therapies will exceed the cap. This arbitrary limitation would cause the greatest harm to the sickest and the most vulnerable of our beneficiaries. It would be those seniors who suffer from stroke, from Parkinson's disease or a similar condition that would likely exceed the therapy cap.

It would be the older, more vulnerable beneficiaries who will be most affected by this therapy cap. As beneficiaries continue to age and encounter multiple health problems, they are more likely to be the ones to exceed the cap. Unlike other requests for Medicare monies, this provision is truly a provision for the beneficiaries. It is the beneficiaries who will either bear the cost of the cap or not get care. It is a beneficiary cap on services.

In 1999, as part of the Balanced Budget Reconciliation Act, Congress passed a 2-year moratorium to prevent implementation of the caps. A year later, Congress passed an extension of that moratorium for 1 more year through 2002, and CMS has delayed implementation until July 1 of this year. So we need to act.

From a personal story, several years ago my grandmother had a total knee replacement. I visited her in the hospital when she was going through rehabilitation. Anybody who has had a total knee replacement understands it is one of the most painful surgeries you can have, as well as rehabilitation is painful. If the cap would have been in place at the time, she could have ended up being in a situation—at her income level, if she was a senior who could not afford to pay additional money—of not getting the care and rehabilitation needed for independent living. She is about 85 years old and lives on her own today because of the physical therapy.

There are many other people we will institutionalize if we do not repeal the cap. It is very important that truly needy seniors who are very sick get the rehabilitation they need for the occupational therapy, speech therapy, as well as physical therapy.

I urge our colleagues to look at this. I have talked to the chairman of the Finance Committee, and he is committed to making sure this cap does not go into effect this year. It truly would be harmful to many seniors in our population.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

AMENDMENT NO. 1073

Mr. SMITH. I ask unanimous consent to set aside the pending amendment and call up amendment No. 1073.

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

The clerk will report.

The bill clerk read as follows:

The Senator from Oregon [Mr. SMITH], for himself and Mr. FEINGOLD, and Ms. CANTWELL, proposes an amendment numbered 1073.

Mr. SMITH. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To allow the Secretary to include in the definition of special medicare choice plans for special needs beneficiaries plans that disproportionately serve special needs or frail, elderly beneficiaries)

On page 379, strike lines 9 through 13, and insert:

''(A) IN GENERAL.—The term 'specialized Medicare+Choice plans for special needs beneficiaries' means a Medicare+Choice plan that—

''(i) exclusively serves special needs beneficiaries (as defined in subparagraph (B)), or

''(ii) to the extent provided in regulations prescribed by the Secretary, disproportionately serves such special needs beneficiaries, frail elderly medicare beneficiaries, or both.

Mr. SMITH. I come to the floor on behalf of myself and Senator FEINGOLD and ask unanimous consent to add Senator CANTWELL as a cosponsor.

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

Mr. SMITH. Senator FEINGOLD and I have designed this amendment to help frail Medicare beneficiaries with special health care needs. This is truly one of those times when doing the compassionate thing is in harmony with what is cost-effective.

It is a fact that chronic illness is the highest cost, the fastest growing segment of health care. Seniors are disproportionately affected by multiple chronic conditions that require a wide array of services. More than half of all seniors have two or more chronic conditions.

Further, one in five Medicare beneficiaries has five or more chronic health conditions. These seniors account for two thirds of total Medicare expenditures.

They also see, on average, 14 different physicians annually and fill an average of 50 prescriptions per year.

These seniors require routine monitoring, treatment and coordination of care among multiple providers to prevent or delay a decline in their health.

And yet traditional Medicare does not include a care coordination benefit. However, a limited group of Medicare+Choice plans do.

''Specialized Medicare + Choice plans'' focus on frail and chronically ill Medicare beneficiaries with special needs—such as nursing home residents, nursing home certifiable beneficiaries who live in the community, and low income seniors who are eligible for both Medicare and Medicaid.

These plans provide important services absent from original Medicare such as care coordination, disease management and supportive services.

The Prescription Drug and Medicare Improvement Act of 2003 takes an important step toward providing a ''home'' for such plans to transition into mainstream Medicare by creating a designation for ''Specialized Medicare Advantage Plans for Special Needs Beneficiaries.''

The amendment I am offering today would also allow the Secretary of HHS to permit plans that disproportionately serve special needs beneficiaries to offer specialized Medicare Advantage plans.

For example, under my amendment, health plans serving a large number of seniors whose poor health places them at risk for entering nursing homes could become a specialized Medicare+Choice provider. These are known as social HMO's or SHMO's.

The Social HMO demonstration is an example of one such program that assists frail elderly with special needs but serves a mix of well and frail seniors.

One of the four Social HMO demonstrations—Kaiser's Senior Advantage II—is in my home State of Oregon.

This program is extremely popular with the seniors it serves—those with the most complex medical needs—while saving the state of Oregon millions of dollars in Medicaid costs that would have been incurred had these seniors required nursing home care.

I have several letters of support for my amendment, and I ask unanimous consent that they be printed in the RECORD.

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

KAISER PERMANENTE,
Portland, OR, June 24, 2003.

Hon. GORDON SMITH,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR SMITH: I am writing to thank you for your support of Kaiser Permanente's Social HMO Demonstration program through an amendment to the Medicare Prescription Drug and Reform Act of 2003. The underlying bill would establish a special designation for newly anointed ''Medicare Advantage'' plans that exclusively serve beneficiaries with special needs such as nursing home residents and dually eligible (Medicare/Medicaid) beneficiaries. Your amendment would allow the Secretary also to designate as specialized Medicare Advantage plans those that serve a disproportionate share of special needs beneficiaries.

Kaiser's ''Social HMO demonstration, Senior Advantage II, is an example of a specialized M+C plan that disproportionately serves these types of beneficiaries, including those that qualify for nursing home care but live in the community. We currently serve, 4,400 Medicare beneficiaries. Seniors with multiple chronic conditions, like many of those served by Senior Advantage II, are at greater than average risk of unnecessary hospitalizations, adverse drug interactions related to multiple drug usage, and contradictory information from different providers. Those with five or more chronic diagnosed conditions also are more than four times as likely to have functional limitations than someone with only one condition. The average Senior Advantage II members has 13 diagnoses. Like other specialty M+C plans, Kaiser has developed a wide range of chronic care and geriatric programs to efficiently respond to the health care challenges of our special needs beneficiaries. About 30% of our members are eligible for our Expanded Benefit package that allows our frailest members, those who

qualify for nursing home care, to remain independent and in the community. In fact, over three-quarters of respondents to a survey of Social HMO members indicated that the Expanded Care services were ''important or very important'' in helping them remain living at home.

Senior Advantage II has been making a difference in the lives of our most vulnerable Oregonians for two decades. The Kaiser Permanente SHMO also serves as model to integrate home and community-based care into the rest of the local organization and Kaiser nationwide. Your amendment would allow the Secretary to establish a new population-based designation for M+C plans like ours that recognizes their commitment to targeting and serving special needs beneficiaries.

Kaiser Permanente appreciates your continued support of our efforts to develop more effective programs of geriatric care and for your leadership on behalf of our nation's most vulnerable seniors.

Sincerely,

EUGENE SCANZERA,
Manager, Medicare Product Line,
Kaiser Permanente Northwest Region.

MEDICARE PAYMENT COALITION FOR FRAIL BENEFICIARIES,
Bloomington, MN, June 24, 2003.

Hon. GORDON SMITH,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR SMITH: On behalf of the Medicare Payment Coalition for Frail Beneficiaries, we offer our strong support for your amendment to the Medicare Prescription Drug and Reform Act of 2003. Your amendment would promote better care for frail elderly and seniors with complex medical conditions by establishing a special designation for certain Medicare Advantage plans serving this high-risk group.

Beneficiaries with multiple chronic conditions represent the most needy and costly group in Medicare. Those with five or more conditions see an average of 14 different physicians annually and have about 37 office visits each year. This segment of the Medicare population also is the most expensive, costing Medicare about 14 times as much as for beneficiaries who have only one chronic condition. To improve health outcomes for this vulnerable group of seniors and control Medicare costs over the long run, we need to establish a special approach for addressing the complex and ongoing nature of the problems faced by the highest-cost population.

Currently, there are only a few Medicare+Choice programs with the skill and expertise for serving special needs beneficiaries. Most of these programs operate under demonstration authority like Evercare, the Wisconsin Partnership Program, the Minnesota Senior Health Options Program and the Social HMO demonstration, although a few private plans offer plans targeted toward special needs beneficiaries. Care coordination, aggressive primary care interventions and specialized geriatric interventions used by these plans have led to improved outcomes and reduced use of expensive services such as inpatient hospital and nursing home care.

The Medicare Prescription Drug Act, as introduced, creates a designation for ''specialized Medicare Advantage plans'' for plans for exclusively serve special needs beneficiaries. Your amendment enhances this important provision by allowing the Secretary also to designate as specialized Medicare Advantages plans those that disproportionately serve special needs beneficiaries. This designation allows these plans to be recognized for intentionally targeting for service frail, chronically ill beneficiaries. This designation also could offer the Secretary greater flexibility in the administration of these plans. Historically, it has been difficult for specialized plans to transition from demonstration status to mainstream provider status because there is no mechanism for doing so. This legislation provides an important first step for this by establishing a population-based specialized plan designation and enabling an approach to managed care that simply cannot be implemented under traditional M+C arrangements.

Congress is on the verge of enacting the most profound changes to Medicare since its inception in 1965. Your amendment provides a framework for enhancing Medicare's responsive to our nation's most vulnerable and costly seniors. I extend our sincere thanks for your leadership in this important area.

Sincerely,

RICHARD J. BRINGEWATT,
Chair.

Mr. SMITH. Keeping seniors out of nursing homes by managing their health better while saving money is a win-win situation. Despite this, these specialized programs only exist in several States.

My amendment will further improve Medicare through the development of specialized programs that manage the care of Medicare's most medically complex and expensive beneficiaries more effectively, leading to improved quality of care and ultimately life for seniors with multiple conditions, while helping control Medicare costs.

It is not often that we see a proposal in the Senate that will simultaneously improve quality of health care while saving the government money, and I urge my colleagues to support this amendment. It is compassionate and it is cost effective.

AMENDMENT NO. 994

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Madam President, I rise in opposition to the Durbin amendment. I wish to make a couple of points to my colleagues about it.

No. 1, this is not a $400 billion amendment. I have been informed that the Congressional Budget Office scores this at $570 billion over 10 years. It attempts in the legislation to limit the cost by limiting the years—according to the Congressional Budget Office, effective in limiting the cost. So we are talking about $170 billion over budget allocation. That would obviously add an increasing amount of money to the unfunded liability and the Medicare Program.

One of the things we want to do, one of the reasons we were able to bring a bipartisan consensus, is to add a responsible benefit and focus the money we are going to put forward on Medicare prescription drugs to those who are the lowest income, the poorest of the poor.

We talked about that the other day; we talked about the assets test. One of the keys to this legislation is the greatest subsidies go to the lowest income.

If we take those above the Medicaid eligibility already covered by a prescription drug plan, under the plan before the Senate now the subsidy is 97.5 percent. So the Government picks up 97.5 percent of drug costs and the beneficiary 2.5 percent. That is a fairly generous subsidy for the poorest of the poor who are not otherwise covered. The very poor, Medicaid, who are already covered, are people at 75 percent of poverty up to 100 percent of poverty—obviously poor. Those who are slightly above the poverty level get a 95 percent subsidy. So for every $1 they spend 95 cents is picked up by the Federal Government. That is a very generous subsidy.

Some would argue—and I would be one—that we should have a generous subsidy. We can argue whether it is 90 or 95 or 85 or 99, but it should be a very high subsidy because these are very low income individuals who do not have assets, do not have any other way to pay for their prescriptions, and they are truly deciding whether to buy food or to take the medicine prescribed them. We do have a focus benefit on low-income.

The Senator from Illinois focuses in on those who are higher, above 160 percent of poverty, and says this program is inadequate for them. I make the argument that there are many who have said that for higher income individuals, given the fact that the vast majority of higher income individuals already have prescription drug coverage, well over 75 percent of people at 160 percent of poverty and above have existing prescription drug coverage, many provided through their employers, all of which are probably more generous than either this benefit or the one the Senator from Illinois is offering.

So what we are doing—and this is a big concern on both sides of the aisle—is our benefit plans are displacing private dollars with public dollars. The concern, at least on my part, and I think on others, is: Is that a wise thing to do? Should we be taking private plans and replacing them with public dollars? In some cases, and I would argue in most cases, under either formula—certainly under the one that is on the floor right now—probably the benefits are not as generous.

So there is an issue as to whether we should be doing this at all for higher incomes or whether we should have some sort of catastrophic benefit or some other benefit for higher income. That is what Senator ENSIGN is going to be putting forward in his plan with Senator HAGEL later on.

But I think the overwhelming sentiment among the American people is, yes, we should have a prescription drug benefit for those who have lower incomes, who can't afford it, and those who are high users of drugs because of chronic illness. But to spend a lot of additional tax dollars on higher income seniors, I think most Americans are saying that is probably not a wise expenditure of funds, to go to $570 billion or more when just a couple of years ago—less than that, I think it was a year ago—we were looking at $350 billion, or $300 billion. Now we are at $400

billion. There is no end as to how much we would like to subsidize, I am sure, from some people's perspective—everybody over the age of 65 in the Medicare Program. But I think the responsible thing to do is work within budget constraints and focus the resources on the poorest of the poor. That is what we have done.

The other criticism I have with this plan is it is a one-size-fits-all, Government-run plan. History has shown those are not necessarily the most efficient, the most cost-effective, and best-run kinds of plans.

The Senator from Illinois says we have this gap. We may have a gap, we may not, depending on how the insurer who bids on these plans structures the plan. The only thing fixed in the plan on the floor now is the deductible is $275 for those people who are at 160 percent of poverty and above; the deductible is fixed at $275.

Also fixed is the catastrophic insurance. What does that mean? That means where the Government comes in and pays 90 percent of all the costs of drug use. It comes in after the person has spent $3,700 out of pocket. So the plan does not kick in—the design between that is flexible, but the plan cannot kick in until you have spent $275, and your catastrophic benefit, that is where the Government comes in and pays 90 percent of the cost above a level of expenditures, out-of-pocket expenditures, which kicks in after you have spent $3,700. Beyond that, the plan can be structured to have all sorts of designs to provide prescription drug coverage.

The argument I would make is there are some people who would like some designs, other people would like other designs, and we should let people decide what plan fits their needs as opposed to a one-size-fits-all plan.

I see the Senator says there should be no deductible. I think most people would argue, when you have ''no deductible'' plans, you have very skewed utilization. In other words, you have people using this plan a lot more than if there were some constraint before you get your benefit. When it comes to deductibles and copayments, they are very effective in getting people to think twice as to whether they want to consume more because they have at least some stake in the consumption.

There is lots of evidence out there that suggests that people who do not pay anything for their drugs tend not to—the best way to put it—I guess—value them as much as people who do pay something. That sort of makes sense.

Mr. DURBIN. Will the Senator yield for a question?

Mr. SANTORUM. In one second. That makes sense. If you are not paying anything for something, you value it less than if you had to pay even $2 or $5 or some sort of copay.

That is important psychologically because you have better utilization, you have a better track record of people properly taking something because they have an investment, personal investment in this particular drug.

I am happy to yield for a question.

Mr. DURBIN. I ask the Senator if he would concede the point that both the underlying bill, S. 1, as well as the MediSAVE amendment require a percentage payment of prescription drug bills for every dollar spent: The underlying bill, 50 percent; the bill I proposed, 30 percent; even at catastrophic levels, 10 percent.

To say the individual is paying nothing overlooks the fact that there is a percentage requirement copay on every prescription drug for every senior under both plans.

Mr. SANTORUM. I see that you have a cost share of up to 70/30. I do not have that. I was just looking at the summary you provided, so I don't know whether there is no cost share for lower income or how the cost share works. All I know is it is up to 70/30. I do not know what that necessarily means.

I see there is no deductible, so I was commenting on those two.

If there is a cost share throughout, that is a positive thing. Maybe we would share the agreement there needs to be some sort of cost share, particularly for those who are not at poverty level. If you are at poverty level, then the cost share should be minimal because you don't want to use it as a great disincentive to the drugs prescribed to you. But if you have some income, you should have some responsibilities for putting forth some money for these drugs. That is ground we share.

As the Senator from Illinois suggests, there is cost sharing under our plan. It is a little bit more than the Senator's. But the Senator's plan is more expensive, a lot more expensive than the plan we have here.

The other problem I have is that it does not bring in any kind of private sector incentives, to try to reduce costs. One of the problems with the Medicare system today is it is a top-down, Government-run, one-size-fits-all plan, where the private sector, which administers this plan—Medicare administers it, but they do it through intermediaries which are really private sector entities.

The private sector, in a sense, administers the Medicare plan. But they are an intermediary. In other words, they are just folks who interface with the beneficiary and collect money and pay bills and do what Medicare just doesn't have the capacity to do. The problem with that is they do not have any risk in doing their job. In other words, all they do is a ministerial job. They get paid to provide a service as opposed to what we do in this plan, which is vitally important. We say to those who want to provide Medicare benefits, whether it is through the stand-alone drug benefit we are providing or through the Medicare Advantage Program, which is a PPO and HMO product which has the Medicare drug benefit integrated into the entire benefit which is inpatient and outpatient procedures, we want you to assume some of the risk.

Why is that important? What do I mean by risk? Insurance risk. The risk that if they do not manage the program well, they are going to lose money.

When that is done to insurance companies, they tend to behave differently, when they have no risk, if the plan is not run well. The risk is if they really do a bad job, they could lose the contract, and that happens on occasion. But there is no financial risk to them if they are not managing this benefit correctly.

Mr. DURBIN. Will the Senator yield for a question?

Mr. SANTORUM. Sure.

Mr. DURBIN. I thank the Senator for yielding. This is getting perilously close to a debate, which hardly ever happens on the floor of the Senate. I will gladly ask for time and yield to his questions so we can have an honest-to-goodness Senate debate. It will be a historic day.

My question is this: Is it not true that, although the Medicare agency does not provide the services but works through intermediaries, the Medicare agency attempts to control the costs by establishing what providers can be reimbursed, what hospitals and doctors can be reimbursed, as much as we are suggesting here that the drug companies would be told that they have to reduce costs for Medicare beneficiaries? Isn't that an analogy?

Mr. SANTORUM. The Senator from Illinois is correct. The way we control costs within the Medicare system is through price controls dictated by the Federal Government. There are a whole host of problems we run into all the time with the uneconomic decisions, in many cases, by CMS—which is the agency that runs Medicare—in reimbursing for services.

We have lots of places in this country where doctors will not provide services to Medicare recipients because the reimbursement does not match what their costs are. We talked to lots of hospitals and they will tell you, depending on the region—because it is different in different regions—this is a very convoluted price control system. They will tell you they are not getting the proper reimbursements for their services and they cannot afford to provide those services, or if it was not for private payers in certain regions of the country, these hospitals would be going under because of the reimbursement dictated, not by the market, not by what beneficiaries value, but by what is decided in Baltimore, MD, by a bunch of people sitting behind a desk who have no idea of what it costs in Coudersport, PA, to provide OB/GYN service, or gynecological services, in this case, because you don't have a private-sector service for Medicare recipients.

Nevertheless, the point is, you have an artificially imposed price control from a very far-removed entity. And I think at least most Members on this side of the aisle would like to see that change. We would like to see the system better reflect what the marketplace will bear as private insurance dictates. It is a much more flexible, much more dynamic system that takes into account what the beneficiary wants and what they value.

So I would argue that while I agree with the Senator from Illinois that this plan mirrors very closely the traditional Medicare plan—I do not disagree with him at all—I would argue the traditional Medicare plan is a command-and-control, top-down plan that does not work particularly well.

One of the reasons we are here today is that it takes an act of Congress to add a benefit. It should not take an act of Congress to add a benefit. We should have prescription drug coverage.

Had we had the Medicare Advantage Program in place 20 years ago, everybody in Medicare Advantage today would have a prescription drug benefit. Everybody would have it. They would have the ability to offer that benefit because they would be responding to what the consumer and the beneficiary wants. Just like today, Medicare+Choice—which is a Medicare HMO that was established 5, 6 years ago—has prescription drug benefits if you are in that program. Why? Because there are beneficiaries who want that.

Madam President, I understand the chairman of the committee would like the floor, so I will yield.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Let me say to the Senator from Pennsylvania, this is just for the purpose of a unanimous consent request. Then I will yield the floor.

Madam President, I ask unanimous consent that at 6:30 the Senate proceed to a vote in relation to Durbin amendment No. 994, to be followed by a vote in relation to the Clinton amendment No. 1000, with no second-degree amendments in order to the amendments prior to the votes, and with 2 minutes equally divided for debate prior to each vote after the first; further, that following those votes, the Senator from Iowa—me—be recognized to offer an amendment.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Reserving the right to object, in relation to the time between now and 6:30, I ask my friend from Pennsylvania, how long do you intend to speak?

Mr. SANTORUM. Madam President, I would be happy to divide the time between now and 6:30 equally between the two sides.

Mr. REID. I think that would be appropriate. I ask that the consent request of my friend from Iowa be modified to divide the time between now and 6:30 equally between the majority and minority.

The PRESIDING OFFICER. Will the Senator from Iowa accept the modification?

Mr. GRASSLEY. Yes.

Mr. REID. With the time controlled by Senator DURBIN on our side.

Mr. GRASSLEY. And the Senator from Pennsylvania on our side.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. SANTORUM. Madam President, another concern I have—and it is not a concern with the bill; it is just the marketing of the bill—is to suggest that their plan will move forward immediately. One of the comments made was that the plan before us does not take effect until 2006, and their plan will take place as soon as possible.

Let me just suggest, we went to CMS, which is the organization within the Government that runs Medicare, and other experts in the field and asked: When is the soonest possible we can have this drug benefit in place? And they said: It would not be prudent to do so before 2006, to promise before 2006, because it is rather complicated to put together.

So the reason we put in 2006 is we want a backstop. The Durbin amendment has no backstop. It just says: As soon as possible. Who knows how long that will be? We have a backstop, focusing on getting this ready for 2006, which I think is actually beneficial, and, at the same time, it does not rush the process that potentially could do something that would be imprudent and, potentially, ineffective in moving forward a plan.

So I think 2006, given all the expertise we have in this town as to what would be the proper timeframe, is the right answer. It is a good balance between making sure there is a date certain and that it is fairly quick and, at the same time, not too quick as to cause problems.

The other thing we do—and this is not mentioned in the marketing of the MediSAVE amendment—we have a plan that does go into effect immediately, unlike the Durbin amendment, which will probably be years—at least a year or 2—before it goes into effect. And there would be no coverage for anybody under that amendment.

We will have coverage immediately, starting within a few months, according to CMS, again, the agency that runs Medicare. They anticipate, with the drug card—which accomplishes much of what the Senator from Illinois has suggested they want to accomplish, which is to get a group discount or volume discount through the Federal Government—we will do that immediately, not in a year or 2 years or 3 years or however long the Durbin amendment would take, but it will do it immediately.

Within a couple of months, we will have out to every Medicare-eligible beneficiary a discount card that can replace all the other discount cards that a lot of seniors already have. It will be a single discount card that will give a discount nationally where we will be able to negotiate with a variety of different pharmaceutical companies. So it is an opportunity for us to use the volume discount to be able to reduce drug costs for seniors.

In addition to that, if you are lower income, you will receive up to $600 in money to help defray the cost of your prescriptions—not 2 years from now, not 3 years from now, but immediately—really, a few months from now, hopefully as soon as the first of the year, or maybe even sooner than the first of the year. So it really does accomplish a lot of what the Durbin amendment attempts to do.

By the way, once we move into the full-blown plan in 2006, you are going to be contracting under the stand-alone benefit which goes with the traditional fee-for-service Medicare system as well as Medicare Advantage, which is the PPO and HMO options that will be available to seniors—none of that will be available, by the way, under the Durbin amendment—but what we will do is provide the opportunity for them to negotiate these discounts with pharmaceutical companies because they will be bidding in large regions, multi-State regions, with lots of people, lots of scrips that will be filled. So they will be able to use their purchasing power to get a lot of these volume discounts.

Now, will they be as big as the Federal Government? No. But when you are looking at these kinds of volumes, there is only so much volume discount you can get. At some level you don't get any more discount. It sort of caps out. We think the prescription business will be big enough that they will get substantial discounts and accomplish exactly what the Senator from Illinois hopes to accomplish in his legislation.

It looks like the Senator from Illinois is ready to go, so I reserve the remainder of our time.

The PRESIDING OFFICER (Mr. ALEXANDER). The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank the Senator from Pennsylvania.

I say to the Senator, again, I am prepared, at any point, if the Senator would like to ask a question and debate, let's try it. Let's see how the Senate works in real debate. But I really appreciate the Senator from Pennsylvania coming to the floor.

I say to the Senator, you were the first voice in opposition to this amendment. I have been coming here day after day after day. I suspected there was some opposition here—don't get me wrong—but I am glad the Senator came forward to speak his mind about this amendment.

And I congratulate you on your choice of words. Those who oppose an amendment involving Medicare use words such as ''top-down,'' ''command-and-control,'' conjuring images of commissars, Bolshevik 7-year, 10-year plans—this kind of mighty hand of government pressing down on the poor, the

poor peasant, the poor American citizen.

The sad reality is, the seniors of America don't agree with you. They like Medicare. They even like it in Pennsylvania. Do you know what we find when we say to seniors: ''We give you a choice. You don't have to stay in Medicare. You can go to a private HMO''? Eighty-nine percent of them stay in Medicare—the ''top-down, command-and-control'' system.

Now, why do they stay there?

Mr. SANTORUM. I say to the Senator from Illinois, I believe the number is 12 percent of Medicare beneficiaries participate in the Medicare+Choice Program. So it is 88 percent.

Mr. DURBIN. I am sorry I said 89. I stand corrected.

Mr. SANTORUM. If the Senator will yield further, I would also ask the Senator if he knows that Medicare+Choice is not available in most communities because they are only available in most urbanized areas.

Mr. DURBIN. I will concede the point because I can remember so well when these Medicare HMO choice plans came rolling into Illinois and so many other States and realized they couldn't make the money off seniors they planned to and pulled the rug out from under them. They called my office and they said: What happened to this Medicare HMO we were supposed to turn to? We can't trust them. They are not there. We are sticking with Medicare.

So my point to the Senator from Pennsylvania is that we are dealing here with a Medicare option which most seniors don't view as an ugly, reprehensible, big government option. They view it instead as something they are comfortable with, that America for 40 years has lived with, and has been a dramatic success since the days when President Lyndon Johnson came forward and said: There is no reason, since your mother and father, once retired, now have a little Social Security check, why they shouldn't have health care. So we are going to create Medicare. In the 1960s, we did it. It worked.

What is the proof of its value and effectiveness? The fact that seniors are living longer. It is an indication to me that this Government-run Medicare Program has worked. It pains my friends from the conservative side of the aisle to concede the fact that a Government program works, but Medicare does work. And because it has worked, seniors trust it. But my Republican friends didn't like it to start with—at least their predecessors in the Senate—and they don't care much for it today. So they are trying to find a way to move us away from this command-and-control, top-down program, and they have decided they will use prescription drugs as their stalking horse for the elimination of Medicare. That is a sad outcome.

Now they are even talking about $6 billion with which they are going to subsidize private insurance companies, a Federal subsidy to create an alternative to Medicare as part of this bill.

The goal for some—I won't ascribe this to the Senator from Pennsylvania because I don't know if this is his own philosophy—is to get rid of Medicare. They believe it is outmoded and old-fashioned. I do not. I believe Medicare offers something to seniors which the private sector cannot offer: A nonprofit, low-administrative-cost system which treats seniors the same from one edge of America to the other and basically says: We will try to keep costs under control because we speak for tens of millions of seniors.

The same approach can work effectively when it comes to prescription drugs. The MediSAVE plan, which I offer with the support of major senior citizen organizations and organized labor, says just that. If you want a private insurance company to compete, God bless you, bring them in. Give them their best opportunity. If they can beat the socks off Medicare in a region of the country, that is to the benefit of seniors. But for goodness' sake, why are those who are in favor of the private sector so afraid of Medicare as an option, the top-down, command-and-control, bureaucratic government? That happens to be what we have lived with successfully for 40 years in America under the Medicare system.

Despite all the pejorative adjectives applied, seniors don't see it that way. They trust Medicare. Some Senators may not trust it, but seniors trust it. We ought to trust them to make a choice. What is wrong with their making a choice?

Frankly, you have to be honest about this bill. There is no guarantee in here about a $35 monthly premium. Seniors could face a much larger premium, and they know it. There is no guarantee that the private HMO company offering prescription drugs is going to be around in 2 years. It could be gone. And that infuriates seniors as well. They had the rug pulled out from under them with the Medicare HMOs. They don't want the same thing happening with prescription HMOs. That is why most of them are likely to gravitate toward the Medicare style plan. That is a dagger to the heart of styptic-hearted conservatives who want to see Medicare go away. But it is a fact.

Ask your seniors in Pennsylvania, in Illinois, even in Tennessee. They will tell you they like Medicare: Please, don't give up on it. That is why I think this alternative is so important.

Frankly, what we are saying to them is, we are going to have an issue which my friend from Pennsylvania has not addressed. We are going to have an effort by Medicare and others to bring prescription drug costs down. It has worked for the Veterans' Administration, and we have 25 times as many seniors under Medicare as we have veterans.

So let us give that bargaining power to Medicare and to the private insurance companies. And who is going to win? The winners will be seniors and their families.

Mr. SANTORUM. Will the Senator from Illinois yield for a question?

Mr. DURBIN. I am happy to yield.

Mr. SANTORUM. I want to ask you, first on the Medicare+Choice plan. You say it has failed. Are you aware that the Senator from New York, Mr. SCHUMER, offered an amendment today? I encourage you to read his statement. He talked about how the Medicare+Choice plan has been dramatically underfunded. I have a letter here from July 12 of last year signed by 11 Democrats, including Senators CLINTON, SCHUMER, LIEBERMAN, CORZINE, and WYDEN, talking about how the Medicare fee-for-service plan has grown by at least 10 percent, and yet the Medicare+Choice plan has been locked in by law and growing at only 2 percent. That is the reason a lot of the Medicare+Choice plans had to leave. Are you aware of all that information?

Mr. DURBIN. I am not. I thank the Senator for bringing to it my attention. Let me make it clear: Some Medicare HMO choice plans are good. Seniors want them, and they should have the option to turn to them. In my State, though—I don't know if it happened in Pennsylvania—some of these insurance plans came in and decided they couldn't make enough money, and they cut and ran.

Mr. SANTORUM. If the Senator will continue to yield, I would suggest you look at the statement of the Senator from New York today. I ask unanimous consent that the letter to which I referred be printed in the RECORD.

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

UNITED STATES SENATE,
Washington, DC, July 12, 2002.

Hon. TOM DASCHLE,
Majority Leader, Hart Senate Office Building, Washington, DC.

DEAR MAJORITY LEADER DASCHLE: We are writing to express our continued support for the Medicare+Choice (M+C) program. Currently approximately 5 million Medicare beneficiaries are enrolled in M+C plans across the country and many of them live in the states we represent. For these seniors, M+C represents a vital link to high quality, affordable health coverage.

Unfortunately, a serious funding crisis is threatening the Medicare+Choice option. Many participants live in areas where funding for their M+C health benefits has increased by only two or three percent annually since 1998 while health care costs have risen by at least ten percent. These increases are inadequate and they threaten the viability of the program in most areas. We believe Congress should assign a high priority to adequately funding the Medicare+Choice program.

We understand the difficult task you face in balancing so many competing demands in the health care areas. However, we believe that M+C plays an important role in the overall soundness of the health care system, and we would like to see it continue without disruption for the seniors we represent. We hope you will consider our support for M+C as you work on Medicare legislation this year.

Sincerely,

Joseph Lieberman, Jon Corzine, Barbara Boxer, Chris Dodd, Max Cleland,

Dianne Feinstein, Ron Wydem, Charles Schumer, ———, Jean Carnahan, Hillary Rodham Clinton.

Mr. SANTORUM. Take a look at this letter. It is very clear that the reason these plans left was that we set the growth rate for Medicare HMOs at one-fifth the growth rate of the traditional Medicare Program, and obviously they couldn't continue because health care costs continued to go up. Remember, they were the only ones providing prescription drugs. So while Medicare was going up 10 percent without prescription drugs, HMOs were going up probably 10 percent or more because they were offering prescription drugs. So they said: We just can't continue, under this artificial ceiling, to continue. What we are trying to do with this plan is to put that choice back to seniors.

Mr. DURBIN. Reclaiming my time, you don't put it back in that situation. You eliminate Medicare as a competitor to these private insurance companies. The Medicare agency itself cannot offer this prescription drug plan other than through a private agency with which they contract.

What I am saying to the Senator from Pennsylvania is: Take a look at the Veterans' Administration. The Veterans' Administration is a good indication of what can happen when a Federal agency such as the Veterans' Administration wants to bring down costs; it bargains on behalf of the people it represents and lowers prescription drug costs.

Under this bill, S. 1, as I understand it, you have to have two private insurance companies offering in a region or there is a Medicare fallback, which turns out to be a plan that they contract out to some private provider.

Mr. SANTORUM. If the Senator from Illinois will yield for a question.

Mr. DURBIN. I am happy to yield.

Mr. SANTORUM. Does your plan have the benefit actually administered by the CMS or do they, like the traditional Medicare plan, contract through an intermediary to provide the benefit?

Mr. DURBIN. This is a Medicare delivered benefit through the Medicare agency.

Mr. SANTORUM. So there is no intermediary. The plan is actually run—unlike the current Medicare plan, it is going to be run by the Federal Government without an intermediary?

Mr. DURBIN. If the Senator will allow me to consult with the expert.

Mr. SANTORUM. I am happy to.

Mr. DURBIN. I guess the difference is, we don't divide it into 10 regions when it comes to Medicare.

Mr. SANTORUM. It is provided through an intermediary, which is the exact same delivery mechanism of the fallback plan in this bill.

Mr. DURBIN. The difference is this: The difference is negotiating lower costs for prescription drugs. And in this situation, it is my belief that this underlying bill does not. The reason the Stabenow amendment was defeated the other day, the reason there is opposition here, is, once you put Medicare in the picture on a national basis, bargaining for lower prescription drug prices, you are more likely to succeed and the drug companies are more likely to have to reduce their costs.

I think that is why the pharmaceutical companies don't particularly care for my approach and the reason many people have opposed it here. But from where I am standing, if my interest is in the senior citizens of America having the lowest prescription drug prices and our giving a helping hand as much as we can, rather than the bottom line profits of prescription drug companies, I think this is a much more advisable approach.

I reserve the remainder of my time.

Ms. MIKULSKI. Mr. President, I rise in strong support of amendment No. 994 from my colleague from Illinois, Senator DURBIN. The MediSAVE amendment would provide a vastly superior Medicare prescription drug benefit to our seniors. But I am also disheartened. This is not the bill we are debating. I wish it were.

The MediSAVE amendment meets all of the principles I laid out for a Medicare prescription drug plan. In an earlier statement, I outlined the principles that I would use to grade any Medicare prescription drug plan. I think the MediSAVE plan gets an A. I commend Senator DURBIN for his hard work on this plan.

I have five principles for a prescription drug benefit.

1. The cornerstone must be Medicare. I am opposed to the privatization of Medicare. Any prescription drug benefit that relies on the private sector must be in addition to, not in lieu of, traditional Medicare. Seniors must not be forced to leave the Medicare system they trust to get the prescription drugs they need.

2. Voluntary. No one should be coerced or forced into a private program or forced to give up coverage they currently have.

3. Affordable. The benefit must be affordable. That means a reasonable premium and copayment.

4. Universal and portable. The benefits must be available to all seniors, regardless of where they live. And all seniors must have the same benefit, and be able to take it anywhere they go.

5. Meaningful. The benefit must cover the drugs your doctor says you need—not what an insurance executive thinks you should get.

How would the MediSAVE plan benefit seniors?

MediSAVE would create a more meaningful benefit. It would have no deductible for drug coverage. It would have a guaranteed premium of $35 per month. Rather than having to pay 50 percent of their drug costs covered, under this plan seniors would have to pay 30 percent of those costs. That adds up to a big savings for seniors, many of whom live on a fixed income. MediSAVE would also take into account the amounts that employers contribute toward retirees' drug costs which will help millions of seniors keep the employer-sponsored health care they earned. But most importantly, MediSAVE would deliver the prescription drug benefit through the Medicare that seniors trust.

I believe the Durbin amendment is a great improvement over the bill we are debating. I urge all my colleagues in supporting this amendment.

Mr. JOHNSON. Mr. President, today I join several of my colleagues to urge Members of the Senate to vote in strong support of the ''Medicare Savings Alternative that's Voluntary and Equitable,'' or MediSAVE amendment. I thank Senator DURBIN for working hard to create an amendment which will make this Medicare prescription drug package a meaningful benefit for seniors across this country.

I have been troubled over the course of this debate on many fronts. There are numerous holes in S. 1 that many of my colleagues have tried to fill. Many of my colleagues have offered targeted amendments to address this bill's specific flaws. So far, we have tried to put some reasonable limitations on the premium levels that can be charged to beneficiaries. We have tried to eliminate the coverage gap that will hit seniors hard in the fall of 2006. We have tried to extend the fallback period to two years to provide more stability to seniors living in areas where managed care is just not likely to work. We have attempted to ensure that the 37 percent of employers that are estimated to drop their retiree coverage would not do so. And all of these attempts have been unfruitful, due to the resistance of Members on the other side of the aisle.

We have tried to make this a better bill, and while we have had success on a few cost containment amendments, we have come up short on many of these other critically important provisions. Seniors in my home State will be scratching their heads in 2006, wondering where their affordable, comprehensive Medicare prescription drug benefit is. This is why I am a cosponsor and supporter of the MediSAVE amendment. This amendment will provide seniors with a real benefit, one that allows seniors to get their drug coverage through traditional Medicare, not forcing them into plans to get it. It has no deductibles, limited cost sharing and no coverage gap. It addresses a blatant omission in this bill to deal with the skyrocketing costs of prescription drugs in the U.S. It allows the Federal Government to utilize its bargaining power to purchase prescription drugs at reasonable prices, rather than providing a blank check to drug manufacturers as is planned under the current bill.

Let's try and make this the best bill possible. This amendment may require us to allot some additional funds down the road, but aren't our seniors worth

it? Isn't the security of average seniors, those who have worked hard all their lives to make this country what it is today equally, if not more important than big tax cuts for the elite? I urge my colleagues to support this important amendment today.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. SANTORUM. A couple of points, Mr. President. The Senator from Illinois said people prefer having the Government run this program and administer this program. I know the Senator doesn't like top-down command and control, but it is what it is. It is a one-size-fits-all Government benefit.

A survey was just done a few days ago that said voters trust private plans over Government to provide health benefits by a margin of 54 to 34, when it comes to providing medical and pharmaceutical benefits. So the American people are used to dealing with private sector entities when it comes to health insurance, and they are very comfortable to have them provide services. And, in fact, arguably even the Medicare system that the Senator from Illinois has put forward is going to be run—the drug benefit is going to be administered by a private sector entity. It will be a company that will be contracting through a Medicare agency to provide these services. The difference is—this is the real key difference between what we want to do and what the Senator from Illinois wants to do, one of them—that we want to have these private sector entities that we were contracting with to bear some of the risk of insurance.

Again, I repeat that the importance of having these private sector entities bear some of the risk of insurance is, if they are bearing the risk, and if they don't administer this program effectively, it is going to cost them money. So they are going to probably do a little better job of administering that program than if they are simply being paid a fee to write checks or collect fees. So we believe having a shared risk with the private sector and the public sector getting together to use the best of the private sector, which is to be able to have good beneficiary relationships and to go out and try to solicit—remember, if you are a private sector contractor, you have competition. You have to treat your beneficiaries well or they can go to the other player. Your ability to sign up beneficiaries will be diminished if you are not providing quality services.

Under the Senator's plan, there is one administrator, no incentive to save money, no incentive to be customer friendly. It doesn't matter because they have no place else to go. You can take it or leave it. If you have competition and you allow people to go somewhere else, they have an obligation not only to be better at providing services but they have an obligation, if they want to keep these beneficiaries in their program, to provide good services, quality services, to be responsive—not be open, as a lot of these organizations are, from 8:30 to 4:30, and if you have a problem, you have to call on Monday morning.

A lot of these ministerial organizations, again, have no risk involved. The beneficiary has no place else to go. They have no incentive to save money. So why not just basically save money on their side, cut back on what it costs to administer this program, and get paid the same fee. They can save a little money that way, and they have no chance of losing anybody.

I think having some incentive to provide quality services and to try to save money because they have some stake in it is a very important component of delivering better services for the consumer and a better product for the taxpayer. We keep coming back to this, and we seem to overlook it.

Millions of Americans are paying their hard-earned tax dollars for this benefit. We have an obligation to make sure the money is effectively spent. I think we have an obligation to put into place systems that are more efficient than the current system—more efficient not from the standpoint of how much it costs the Government in administrative costs. That is one of the things I hear, that this is much more administratively effective than it is for these other private plans. Well, if all you do is pay bills, and you don't worry about how much is being used, you don't worry about the quality or about anything else, all you are doing is writing checks in Baltimore or writing checks to companies like Blue Cross plans who are the intermediary, then it is pretty cheap. But if what you are doing is trying to coordinate care to try to make sure that quality is imbued through the system, if you are trying to actually provide a quality service, it is probably going to cost a little bit more. I think most people believe that is a good tradeoff, plus you have the competitive angle, which I argue could actually save money.

So while I respect the Senator from Illinois and the fact that he has put forth his amendment, it is, in fact, a straight extension virtually of the traditional Medicare delivery services. It is not $400 billion; it is $570 billion. It is $170 billion more than what we all have agreed upon in the budget to provide for a prescription drug benefit.

The American public has been very clear about this. Yes, they want prescription drug benefits for seniors, but they want those benefits focused on those who are lower income, who cannot afford it, and those who are high users of prescription drugs because of disease or chronic illness. So what we have done in this bill is to do that. They also want a fiscally responsible alternative. They want a fiscally responsible plan. In fact, in surveys over the past several years, they were asked a simple question: Are you for a $400 billion Medicare prescription drug plan or are you for an $800 billion Medicare prescription drug plan? Overwhelmingly, believe it or not, they are for a $400 million plan. The American public realizes there is not just an endless pot of money that is going to be available to provide benefits for anybody, and they want something fiscally responsible.

There are many on this side of the aisle who would argue that what we have even in the underlying bill is not fiscally responsible; it is too much money, too much of a subsidy to too many people. But we brought this bill forward to find a bipartisan compromise. Part of that was to make sure there is—and there is—a $389 billion drug benefit in this bill. There is a few billion dollars to help these PPOs get set up and organized—literally, I think, seven. So there is 380-some-billion-dollars for the drug benefit, which is one objective we want to accomplish.

The other objective this side of the aisle would particularly like to see is to have choices for seniors—the private-public partnership which we believe are so important to improve quality and efficiency for the taxpayer. We are spending only $7 billion on that. That is a paltry sum compared to this big expansion of the drug benefit. We think that is important. The Senator from Illinois would disagree with that. It is a very different point of view.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I say to my friend, thank you for expressing your point of view. You are the first person to speak on it in opposition. I hope you don't carry the day, but you might.

It is interesting that some are fiscal conservatives and deficit hawks when it comes to prescription drug benefits, but where were these voices during the tax cut debate? We were sunsetting tax cuts right and left, creating the biggest deficit in the history of the United States, and I didn't hear a word from the deficit hawks.

When it comes to helping senior citizens paying for drugs, we have to be responsible. This amendment is responsible. It is sunsetted. We have a report from CBO which says that. The $570 billion does not take into account the fact that this is sunsetted in 2010. It works within the $400 billion.

The second issue raised here is that there are people—and I think my friend from Pennsylvania is perilously close to this coalition—who don't care much for Medicare. They don't think it is a very good program. Well, the vote is in on Medicare, and it is 88 to 12. Eighty-eight percent of the people who had a chance to move out of Medicare didn't do it. They stayed. I hope you will vote for the MediSAVE amendment.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. STEVENS. Mr. President, I ask unanimous consent that I be recognized for 30 seconds.

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

MEASURE HELD AT THE DESK

Mr. STEVENS. Mr. President, I have a resolution at the desk. I ask that it be held at the desk so that I might be able to clear it this evening. It pertains to my great friend who is now 86. He was the first person to pick up the news of the World War II attack on Pearl Harbor. He is now getting along in years. We are going to honor him on Friday night, and I would like to have this resolution adopted by that time.

I thank the Chair.

Mr. REID. Mr. President, have the yeas and nays been ordered on the Durbin amendment?

The PRESIDING OFFICER. They have not.

Mr. REID. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

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

The PRESIDING OFFICER. There is a pending request for the yeas and nays.

There is not a sufficient second.

Mr. SANTORUM. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. REID. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to amendment No. 994. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL), the Senator from Illinois (Mr. FITZGERALD), and the Senator from Arizona (Mr. MCCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. MCCAIN) would vote ''yea''.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY), the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 39, nays 56, as follows:

[Rollcall Vote No. 245 Leg.]

YEAS—39

Akaka	Byrd	Dayton
Bayh	Cantwell	Dodd
Biden	Clinton	Dorgan
Bingaman	Corzine	Durbin
Boxer	Daschle	Edwards
Feingold	Landrieu	Pryor
Graham (FL)	Lautenberg	Reed
Harkin	Leahy	Reid
Hollings	Levin	Rockefeller
Inouye	Lincoln	Sarbanes
Johnson	Mikulski	Schumer
Kennedy	Murray	Stabenow
Kohl	Nelson (FL)	Wyden

NAYS—56

Alexander	Crapo	McConnell
Allard	DeWine	Miller
Allen	Dole	Murkowski
Baucus	Domenici	Nelson (NE)
Bennett	Ensign	Nickles
Bond	Enzi	Roberts
Breaux	Feinstein	Santorum
Brownback	Frist	Sessions
Bunning	Graham (SC)	Shelby
Burns	Grassley	Smith
Carper	Gregg	Snowe
Chafee	Hagel	Specter
Chambliss	Hatch	Stevens
Cochran	Hutchison	Sununu
Coleman	Inhofe	Talent
Collins	Jeffords	Thomas
Conrad	Kyl	Voinovich
Cornyn	Lott	Warner
Craig	Lugar	

NOT VOTING—5

Campbell	Kerry	McCain
Fitzgerald	Lieberman	

The amendment (No. 994) was rejected.

AMENDMENT NO. 1000

The PRESIDING OFFICER. There are 2 minutes evenly divided before the next vote.

The Senator from New York.

Mrs. CLINTON. This amendment is critical to the functioning of the plan now under consideration. If we are going to move toward creating a marketplace for drugs, then we need information about which drugs work better for the money they cost. Last December, we found out through a study by the National Heart, Lung and Blood Institute that the newer drugs such as calcium channel blockers and ACE inhibitors which cost 30 to 40 percent more than diuretics were not as effective for treating high blood pressure. There is much information about this.

My amendment is very simple. It asks NIH to do studies comparing drugs to give that information to physicians and to consumers so they can make good decisions in the marketplace. It also asks that we synthesize the literature out there, make it available over the Internet. If we are going to have a marketplace for drugs, the information about which drugs are more effective should not be the sole property of the great companies. Physicians, clinicians, consumers, and patients need that information. This will help us do that.

I hope you will support this amendment. It does not have any cost attached to it. It is about getting information to the people who will make the decisions about which drugs should be used when it comes to making these choices we are trying to provide for people.

Mr. ENZI. Mr. President, I rise in opposition to amendment No. 1000, offered by Senator CLINTON. This amendment would give the Federal Government new funding to manage comparative effectiveness studies of pharmaceuticals. While this may sound good on the surface, this amendment would end up as a tool for health care rationing by bureaucrats in Washington.

Comparative effectiveness analysis in the private sector can provide useful information. However, giving the Federal Government the power to make national determinations based on one or two comparative studies is dangerous, because these decisions would affect tens of millions of patients who rely on the Government for their health insurance.

This amendment would get the Federal Government even further into the business of making medical decisions. It would promote one-size-fits-all medicine.

Studies conducted under this amendment may be misused by the Centers for Medicare and Medicaid Services or other bureaucracies by encouraging broad and simplistic decisions about which patients should have access to new medicines.

Even worse, these comparative effectiveness studies might become a rigid benchmark adopted by payers across the health care system. Private insurers already look to Medicare for decisions on medical procedures and technologies, and doctors are already concerned about the way Medicare conducts those determinations.

Private insurers copy many of Medicare's limitations on the procedures and therapies from which physicians choose in determining the best course of treatment for their senior patients. If we extend this level of bureaucratic control to drugs and biotechnology, the Government's decisions about medical access would end up being imposed on many more patients than just Medicare beneficiaries.

In considering this amendment, we need to keep in mind that innovations in health care are usually incremental. This applies to drug developments, where ''next-generation'' advances yield incremental benefits compared to existing treatments.

Government studies on comparative effectiveness may fail to recognize or value fully these advances. If we had a Medicare drug benefit in place today that only paid for so-called ''breakthroughs'' in pharmaceuticals, we may not have reaped the benefits of many antibiotics, antivirial drugs, non-steroidal anti-inflammatory agents, and ''beta blockers'' for controlling high blood pressure.

Finally, centralized comparative analysis runs the risk of overlooking the value of specific medicines for individual patients. Prescription medicines to treat a specific disease or condition are different from one another. That is why patients and doctors need choice.

Population-based comparative effectiveness determinations such as those proposed in this amendment may fail to recognize important differences in the way individuals and sub-populations respond to different drugs and drug combinations. As a result, such studies can discourage access to new

medicines that can benefit many patients with diseases and conditions such as hypertension, diabetes, heart disease and mental illness.

Comparative effectiveness studies are not dangerous, and we ought to encourage more and better studies on the relative merits of various drugs for various people. What concerns me is how this amendment would put the Government in control of these studies.

If one branch of the Government is conducting these broad studies, and another branch of the Government is paying for the drugs that your loved one needs, it is just a matter of time before the results of the broad studies are imposed upon the freedom that your family doctor has to choose the best drug therapy for your loved one.

Coming from Wyoming, I am used to fighting against one-size-fits-all solutions from the Federal Government. I certainly cannot support an amendment that would impose such an approach on something as important as healthcare for seniors who rely on pharmaceuticals to make their lives better.

I urge my colleagues to vote against this amendment.

The PRESIDING OFFICER. Who yields time?

Mr. GRASSLEY. Mr. President, I appreciate the intent of the amendment. However, I have significant concerns and must oppose it. The research provided by this amendment is unnecessary. It duplicates, in fact, existing authority in the HHS.

More importantly, this amendment contains two damaging provisions. It directs the Food and Drug Administration to include information coming from these studies in approved product labeling, effectively taking the sole authority of the FDA to regulate prescription drug labeling and giving it to other, nonexpert sources.

This amendment also changes the fundamental research mission of the National Institutes of Health.

Further, these changes have not been considered by the Health, Education, Labor, and Pensions Committee, which has jurisdiction over these programs.

This amendment is unnecessary. I urge my colleagues to defeat it.

Mrs. CLINTON. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the amendment.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL), the Senator from Illinois (Mr. FITZGERALD), and the Senator from Arizona (Mr. MCCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. MCCAIN) would vote ''yea''.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea''.

The PRESIDING OFFICER (Mr. SUNUNU). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 43, nays 52, as follows:

[Rollcall Vote No. 246 Leg.]

YEAS—43

Akaka	Durbin	Lincoln
Bayh	Edwards	Mikulski
Biden	Feingold	Murray
Bingaman	Feinstein	Nelson (FL)
Boxer	Graham (FL)	Nelson (NE)
Byrd	Harkin	Pryor
Cantwell	Hollings	Reed
Carper	Inouye	Reid
Clinton	Johnson	Rockefeller
Conrad	Kennedy	Sarbanes
Corzine	Kohl	Schumer
Daschle	Landrieu	Stabenow
Dayton	Lautenberg	Wyden
Dodd	Leahy	
Dorgan	Levin	

NAYS—52

Alexander	DeWine	Miller
Allard	Dole	Murkowski
Allen	Domenici	Nickles
Baucus	Ensign	Roberts
Bennett	Enzi	Santorum
Bond	Frist	Sessions
Breaux	Graham (SC)	Shelby
Brownback	Grassley	Smith
Bunning	Gregg	Snowe
Burns	Hagel	Specter
Chafee	Hatch	Stevens
Chambliss	Hutchison	Sununu
Cochran	Inhofe	Talent
Coleman	Jeffords	Thomas
Collins	Kyl	Voinovich
Cornyn	Lott	Warner
Craig	Lugar	
Crapo	McConnell	

NOT VOTING—5

Campbell	Kerry	McCain
Fitzgerald	Lieberman	

The amendment (No. 1000) was rejected.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I believe there is a unanimous consent request that the next amendment be the Grassley-Baucus amendment. I think they are working on that. I ask unanimous consent to make a statement on the bill for not to exceed 20 minutes.

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

Mr. NICKLES. Mr. President, first I want to make a couple comments on the bill, then talk about a couple amendments we will be working on. I wish to compliment first Senator FRIST and Senator GRASSLEY, Senator BAUCUS for getting us here. I also compliment President Bush because he has been pushing for us to expand Medicare to include prescription drugs. I happen to share that goal so I compliment him because here we are.

I believe in the next 24, maybe 28 hours, we will eventually pass a Medicare bill that will provide prescription drugs. That is our objective. That is a good one. I hope we will be successful.

I also hope we will pass a bill that is affordable. I am not sure the bill before us now meets that definition. I want to talk about what is in the bill and maybe some of the challenges we have confronting us, but again I want to compliment the chairman of the Finance Committee.

This year we did have a markup in the committee, and we did report out a bill. I didn't vote for it. I will explain why I didn't vote for it. But I hope to vote for a bill either on the floor of the Senate or as the bill comes out of conference.

At least we had a markup. I am on the Finance Committee. The Democrats were in control of the Senate last year. We didn't have a markup in the Finance Committee. We basically had a markup on the floor of the Senate. We spent some time on it, several weeks, but we didn't pass a bill. It didn't become law. It was very frustrating. We didn't do the normal process.

This year I don't quite agree with the final outcome as it came out of committee, but at least we had a chance. We had a bill. We had a markup. We considered dozens of amendments. We reported out a bill.

Now, the Senate has been on this bill for 2 weeks. We have considered a lot of amendments. We will consider more both tonight and tomorrow. So my compliments to the leader and to the chairman of the committee for getting the bill to where we are.

Let me talk a little bit about the current status of Medicare. Medicare has big challenges confronting it today. It is a very popular program, but it is a program that really can and could and should be improved. It is a very expensive program. The cost of Medicare has more than doubled since 1990. In 1990 we were spending $100 billion. Today we are spending over $200 billion. But that doesn't show the liabilities that we already have in the system.

Medicare has a shortfall of $13.3 trillion. By ''shortfall'' I mean benefits that have been promised that are not funded, not paid for. That is an enormous sum of unfunded liability. The total unfunded liability of Social Security is $4.6 trillion. The total debt held by the public is $3.6 trillion. So we are looking at Medicare's shortfall actually exceeding or tripling the total amount of debt held by the public.

I heard many colleagues, when we talked about raising the debt limit, say we should not do this. What we are doing on Medicare and the bills we are considering right now will increase the unfunded liability in Medicare probably by $4 or $5 or $6 trillion, greater than the total Social Security shortfall and far greater than the debt held by the public. This is an enormous expansion of benefits we are saying we will pay for. People need to know it.

Is it affordable? Just to pay for the Medicare shortfall today according to the 2004 budget of the U.S. Government it says to pay the actuarial deficiency as a percent of discounted payroll tax base—we would have to increase Medicare taxes 5.3 percent on top of the 2.9 we are already paying just to pay for

this $13.3 trillion. We would have to more than double the tax. Actually, it would be, in effect, almost tripling the Medicare tax which is presently 2.9 percent on all payroll, not just on the Social Security base of $80,000-some. This is on all payroll. You would have to increase it an additional 5.23 percent, according to Government submissions and budget submissions, to cover the 75-year projections.

Social Security would only have to be raised 1.87 percent. So, again, it shows that at least actuarially, Medicare is in much worse shape, about three times worse shape as Social Security. And that is without us passing additional benefits on top of it. So I want my colleagues to be aware of that. This is a very unstable house, and we are getting ready to build another deck on top of it. That is the reason I am raising some of these concerns.

I want our colleagues to be aware. Maybe we will do it anyway. Maybe it is the popular thing to do. But at least I don't want it to go without saying: Wait a minute, did anybody not pay attention to the fact that these are enormous liabilities. They are going to be very expensive and somebody is going to have to pay the bill sometime. In the past, we paid for Medicare with the payroll tax. That has had some limiting effect. When trust funds were drawn down, people said: We have to do something. So there would either be a tax increase or there might be some reforms.

We passed Medicare reforms in 1997. We spent a lot of the last few years maybe undoing some of those reforms, but it did save money. Now we are getting ready to expand Medicare at a greater percentage than it has ever been expanded since its creation in 1965.

Again, I favor making significant improvements in Medicare. I find the system to be very obsolete in the benefits it provides. It has serious shortfalls. Medicare doesn't provide prescription drugs. It should. Medicare doesn't have preventive care, ordinary, routine checkups in many areas. It should. A good health plan certainly would do that.

It has a hospital deductible of $840. That is way too high. Then it has a different deductible for doctors. They should be a combined deductible, and it should be much lower than $800 and $900 combined.

It is a system that leaves a lot to be desired. It doesn't have catastrophic coverage. So if a person gets really sick and they are in the hospital for a long time, after a certain number of days Medicare doesn't pay it. That doesn't make sense. You really should have insurance to pay for something you can't afford to pay for, and this system doesn't do that.

As a matter of fact, a lot of our health care system, in my opinion, is broken because we end up insuring for relatively almost first-dollar costs, and we don't insure in some cases for the really expensive things or at least that is the way Medicare is. That is not a good example. We should change that. You should insure for those events that you can't afford. You shouldn't be insuring for ordinary, routine things that obviously individuals can pay for.

I make the analogy to automobiles. You should insure for the accidents, the collisions, for something very serious, something very expensive. You should not insure to fill the car up with gasoline or to change the oil.

In health care costs, I am afraid we insure for almost everything, and that greatly increases the cost. My major complaint with the bill before us is that I want to improve and expand and modernize Medicare. I want to improve Medicare. My mother is on Medicare. I want her to have a better health care system. I want her to have a health care system that is comparable to what we have for Federal employees. I would like for senior citizens to have a good base plan and then be able to choose any of a variety of other plans they wish to have—keep what they want or they can choose something better. They can have an integrated benefit system.

Unfortunately, I am not sure that is what we are going to pass probably tomorrow night. The bill we have before us—the reason I voted against it in Finance Committee, and I may vote against it on the floor of the Senate, is because I find the bill very expensive and very light on reforms. It doesn't make as many reforms as I would like and it is expensive on the subjects. I have mentioned we would have to increase payroll taxes by 5.23 percent just to make up for the shortfall. That doesn't include the drug benefit. I have been told by tax estimators that you would have to add another .7 or .8 percent to pay for the drug benefit we are adding.

I am concerned that the drug benefit we are adding will be much more expensive than anybody estimates. The budget resolution says it was $400 billion. I compliment the chairman and the House, who are staying with the $400 billion estimate, but I would project that many years from now, it will not be a $400 billion expansion; it will be much closer to $800 billion by the end of 10 years.

I am making this prediction and I mean it. This is not just a guess. Maybe it is a little more than a guess, but I think ultimately you will see a few things happen, and I will talk about the basic benefit we are offering and why I think the cost will exceed our estimates.

In the first place, the subsidies are very large indeed. For people below 160 percent of poverty, the Federal Government is going to pay almost all the drug expense. For individuals in this income category, as estimated by CMS—they estimate usage—drug usage is $3,200 for people below poverty, and then a little less than $3,000 for incremental levels above that. But the beneficiaries at the lower income levels pay very little. The Government pays almost all of it. I have heard some people say, wait a minute, you want to change that. I am questioning, is this affordable? For income levels in this category, the lowest income, the poorest of our seniors, an individual would pay $82 and the Federal Government would pay $3,214. An individual pays 2 percent and the Federal Government pays 97½ percent. That is a very high ratio.

The next level is not much different. The individual would pay 5 percent and the Federal Government pays 95 percent. The next level up—and this is with an income up to about 150 percent of poverty. For a couple, the income is about $19,576. So the Federal Government would pay 90 percent and the individual would pay 10 percent. Those are very generous subsidies.

Looking at the estimate, I would guess that if the Federal Government is going to pay 97 or 95 or 90 percent, you will have drug utilization go up maybe well beyond these figures.

These figures come from CMS, and they say those are figures for people with insurance, but I would guess the people who are on this level—Medicaid eligibles, and many States have a lot of restrictions on the number of prescription drugs they can have. In many States you are limited to three a month. If the Government is paying 97½ percent, and there is not a limitation of three or so many a month and it doesn't have the limitations of the States because the States are requiring cost sharing of 30, 40, or 50 percent, my guess is it will go up dramatically.

I think in all levels utilization will go up dramatically. Maybe I am wrong. I am concerned about it at least for these lower income levels, the income levels below 160 percent of poverty. The bill we have before us is probably too generous, but maybe not affordable. I hope I am proven wrong. But I have been in business. I took over management of a company when the company had a health care plan where the company paid 100 percent of health care premiums and costs. That really wasn't sustainable. I think a lot of other businesses found out, wait a minute, that is not affordable. Most businesses started putting in 80/20 ratios, where the beneficiary paid 20 percent, or 10 percent. I don't mind lower income people having to pay a smaller copay; I am fine with that. But I think we are starting out so generous that it will encourage overutilization, and costs will explode. Once you start out with a percentage like that, it is hard—I can see starting at 80 percent and maybe going to 90, but I don't see going from 97 percent to 90 percent. A future Congress may be forced to make those decisions. It may not be affordable or sustainable. The demands may be so great that it is not sustainable.

Is this a good deal for seniors? Certainly, people on the low end, below the 100 percent of poverty level, with an income of $9,600 and, for a couple,

$13,000, the copay is $82 and they will receive almost $3,300. Under present law, according to CMS, they pay $734. So the amount they pay goes down almost 80-some-odd percent. This is a great deal for low-income if we can afford it. The next level would pay $150. Currently, they are paying almost $1,200. Again, they are only paying about one-eighth of what they were paying previously and getting a very nice return. This is 136 to 150 percent of poverty—that would be for individuals with incomes, and for a couple it would be up to $19,500. They would pay only $343. Presently, they are paying $1,300. So it is a big improvement for them, and they are receiving about $3,000 in benefits.

So there is a very good and generous benefit—maybe the most generous benefit anybody could propose is for incomes below 160 percent of poverty. Above that, it is not such a good benefit. I have heard some colleagues complain it is not so good for individuals with incomes above 100 percent of poverty, with incomes of about $15,400 or, for a couple, of about $21,000. Above that level, the formula changes. Then they have to pay a premium of $35 a month. Then they have a deductible of $275 a month. Then they receive a drug benefit after they get through the deductible of 50 percent up to $4,500. Then above $4,500, for the next $1,300, they would have to pay 100 percent. Above that level, they get 90 percent.

Well, that is not a great drug benefit. It is not great. It is OK, maybe, but it is not as good as a lot of plans. Looking at a lot of plans people now have, at levels like this, an individual for this plan today would be paying, under the new bill, $1,600. The individual today is only paying about $1,162. They would pay about an extra $500 for maybe a similar benefit, and it is estimated they would receive a total of about $3,000. Actually, if you look at the upper income—above $21,000 for a couple—in every category they pay more under the proposal we have before us than they are under current law. So it is not a real good deal for them. It is voluntary. Maybe they will drop out. If they drop out—it depends on the health status, but if they are healthy, it may make things worse for the taxpayers. They may not help subsidize others who are less healthy. It is a very generous benefit for lower income, below 160 percent of poverty, and it is not such a good deal for upper income.

A lot of people above 160 percent of poverty have drug coverage. A lot of people below that have health care. Below 160 percent, you cannot beat this deal. Above it, you can beat it. A lot of people have better. You say what do you mean? They might have a union plan. We had amendments to make sure those were made whole. We wanted to subsidize them to make sure they didn't lose a dollar. The CBO estimated that 37 percent of the people who have private health care coverage are going to drop them and go into this Government plan. They have health care through their employer, and their employer is going to say if Uncle Sam is going to do this, why don't you get your health care and drug benefits through Uncle Sam instead of through the employer.

A lot of employers are struggling to pay for retirees' health care benefits, so they would welcome this. So you will see a lot of companies dumping or dropping their health care coverage, even though it may well be more generous than what we have proposed before us, the bill before us in the Senate. Likewise, many States have drug programs, many of which may be more generous, not necessarily for low-income, but they have a plan, or some system, or other type of entity that we will be picking up. States were making a contribution, maybe it is a combination of State and Federal, to Medicaid. They are dropping it. Where the States were making a contribution in the past, we will be assuming that contribution. This is a big federalization, frankly, of the benefit that is provided in the public sector and private sector.

Seventy-seven percent of seniors today have some type of drug insurance. This is going to preempt most of that and say the Federal Government is going to take it over and, in some cases, not do as good as the private sector has done, maybe not even as good as most of the public sector.

Is it affordable? The estimates are it is $400 billion. I already mentioned I am concerned, at least on the levels where the Federal Government subsidies are 97 percent or 95 percent or 90 percent, that utilization will exceed expectations. If the Government is going to pay most of the cost of the drugs, my guess is people are going to say: Give me more of those drugs.

There is not a restriction that is going to say you can go to one doctor, go to this specialist for whatever ails you, you can go to another specialist for whatever ails you, and, frankly, if the Government is going to be picking up 95 percent of the drug care costs, people are going to say: Give me some of those. They are going to see the ads on TV. They may see Celebrex—it has a great rhyme to it—or see some other ad that looks good, and they say: Doctor, give me some of that. And if Uncle Sam is going to be paying 97 percent of the cost, why not? That makes your patient happy. Maybe it will work, maybe it will not.

My guess is we are going to see, where the third party or Government is paying 90-some-percent of drug care costs, that utilization will soar and that will greatly drive up the cost.

I think in the drug benefit formula where we have basically a formula above 160 percent of poverty where the Government says you pay your $35 a month and you pay your deductible of $275 and then Government will match you 50 percent up to the first $4,500, a lot of people who might have a drug annual expense in the neighborhood of $1,200 or $1,300 may say: I do not get my money back until I use or consume $1,300 worth of drugs, and I am paying a monthly premium; therefore, I am going to start taking advantage of it. If Uncle Sam is going to be paying 50 percent, I want more. So their utilization may go up and may go up dramatically. So that could increase costs.

Then we have this so-called doughnut amounts above $4,500 to where presently individuals would have to consume or pay for 100 percent up to $5,813. A lot of people are going to say we need to fill that up.

I ask unanimous consent for an additional 8 minutes.

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

Mr. NICKLES. Mr. President, they are going to say we get 50 percent up to $4,500, and then it stops and we go to catastrophic, let's fill that in. The estimates were by some, if you filled that in, it would cost you another $200 billion. My guess is we are not going to do it this year, but we will do it sometime probably in the next 3 or 4 years. That will cost a bunch of money.

Then people are going to be complaining: This is really not a good deal. You get 90-percent subsidy over here but 50-percent subsidy over here. We need to make that 60, 70 percent. Frankly, that 60 percent is not high enough. Let's move that category up to 200 percent of poverty. Let's move it up higher.

When you make those kinds of incremental changes, and I know many of the advocates want to do that—they stated that. I acknowledge it, and everybody around here should acknowledge that is their desire—I expect they will be successful.

There are a lot of people who will say this is not near as good a deal as I have right now, and they are going to lobby Congress: We need a greater share; we need a greater match. Why not go 50/50? Can't we go 60/40, 80/20? Can't we fill in the donut and insure that whole amount?

When you make a few of those changes, you have a bill that is not going to cost $400 billion, it is going to cost $800 billion. In that last year, the line will be going straight up. I am concerned about that situation. I am concerned about the expense of it.

People say: What do we do to make it more affordable? Did we make some of the changes that would help make it more affordable? Did we make some of the reforms, some of which are not easy?

I have been an advocate for increasing the eligibility age, making Medicare the same age as recipients of Social Security. Right now with Social Security, you do not receive Social Security at age 65, you receive full retirement Social Security at 65 and 10 months. By the year 2022, you have to be 67 to receive Social Security.

I happen to think because people are living a lot longer and because Medicare has such enormous financial problems, we should make the Medicare-eligibility age concurrent with Social Security. Basically, by the year 2022, one would have to be 67 before receiving Medicare. I know that is not an easy vote, but, frankly, this Senate voted for it just a few years ago. We voted for it, I believe, with 62 votes. We passed it. We can, could, and should pass it again. It will save our kids a lot of Medicare taxes. That is one reform. I doubt we are going to offer that amendment, but it has been proposed and discussed, and I think it should be seriously considered.

Another amendment will be offered by Senator FEINSTEIN, myself, and Senator CHAFEE tomorrow that basically means testing Part B premiums. I will talk about Part B premiums, and it gets too confusing for a lot of people. We subsidize Medicare. Most people think we pay for Medicare just with the payroll tax.

The payroll tax, I already mentioned, is very deficient. As a matter of fact, it is 2.9 percent of all income, not capped. If somebody has an income of $1 million a year—Michael Jordan, I think, makes a little more than that—if they make an income of $1 million, they pay $29,000 a year into Medicare. Yet we are still going broke. The actuaries say we have to add another 5.2 percent on top. We have to have 8.1 percent to pay for the liabilities we currently have. That is without a drug benefit. If we add a drug benefit, we would probably need to add 1 percent on top of that.

Now we are talking about real money; we are talking about 8 or 9 percent of the liabilities in Medicare. We need to make reforms. One would be to means test Part B premiums. Payroll tax pays a lot of money, but general revenue pays a lot of money into Medicare.

To give an example, this year general revenue, not the payroll tax, general revenue coming from all taxpayers in the year 2003 will put in about $81 billion. In the year 2013, it will be $189 billion. So it more than doubles in the next 10 years, and it does not keep up.

That general revenue portion is the individual recipient pays one-fourth of Part B. This is what pays the doctors. The recipient pays one-fourth of it, and the taxpayer or the general revenue fund pays three-fourths of it. What that means is we are asking our kids to pay for three-fourths of our doctors visits.

At least for those with upper incomes we should not be asking our kids, who are maybe making $20,000 or $15,000 or $30,000, to be paying part of the doctor bills for at least the wealthier seniors. Not all seniors are low income. So the amendment we will be considering probably tomorrow evening says instead of having a 25-percent copay for beneficiaries on Part B, if your income is very high, it will be 50 percent; if it is much higher, it will be 100 percent.

I believe the levels are if an individual has an income of $75,000 and $100,000 for a couple, their percentage would increase from 25 percent to 50 percent. Likewise, for a couple, if an individual had an income of $100,000 or the couple had an income of $200,000, they would have to pay 100 percent of the premium. So we would not be subsidizing them. That would take a lot of pressure off the system.

The most recent trustee report states that SMI, that is Part B revenues, in 2002 were equivalent to about 7.8 percent of personal Federal income tax collected that year. If such taxes remain at their current level relative to the national economy, then Part B general revenue financing in the year 2077, 75 years from now, would represent roughly 32 percent of total income taxes. Now, that is staggering. About a third of all income taxes would have to be paid just to pay the Part B subsidies that we now have in the system. That is not sustainable.

My point is, we have to have a Medicare system that provides better benefits. Yes, I agree. We also have to have a Medicare system that is sustainable for future generations, for our kids and grandkids. We want to have a system they can afford.

I mention these as two reforms, and there is one other one I am going to mention. The primary reform that is in the underlying bill provides for a private sector health care plan—most of the time we call it a PPO, preferred provider organization—similar to many of the health care plans that are all across America providing an integrated structural benefit. They do not just provide drugs. They provide all health care benefits. They provide the hospital and the doctor, access to specialists and drugs. That is what is in most people's health care plans today.

That is not Medicare. We would like to update and upgrade Medicare to bring it into the 21st century so it has comparable benefits, so it can have an integrated management system, so that individuals who are in the system say, yes, they control your drugs and they control your visit to the hospital and the specialist, and you have really good quality care.

We do not have that in Medicare today. The real reform and what many of us are hoping we can do is improve Medicare so people can have preventive health care, so they can have more screenings, catastrophic, and prescription drugs all as one part of a package like Federal employees, like other health care, like a lot of the union plans that are out there today. We do not have that in Medicare today. So we are trying to make that a viable alternative to the present system.

So if some individual wants to stay in the present system, they can, but if they would like to choose a better, more modern system, more integrated system, they can do that.

I very much hope to see that the PPO model will actually become a reality that is a real viable alternative. CBO estimates that in the underlying bill only 2 percent would participate in the new PPOs. That is a failure. CMS, the Center for Medicare and Medicaid, estimates it might be as high as 42 or 43 percent. I would like for that to be the case. I think that may be overly optimistic.

I think we need to work to improve this section of the bill. I know that Senator GRASSLEY and Senator BAUCUS have an amendment to maybe make a small step in that direction, and I compliment them for it. For the life of me, I think if this is the only reform in the bill that we have, and we do not even have competitive bidding until the year 2009, that is not real reform.

I hope to be or expect to be a conferee on this bill, and I am going to work to try and see that we have real competition as a viable alternative to improve quality Medicare for all seniors. They should at least have that option. I do not see it in the bill we have right now, but I want to work to make that happen. That is one key we are hanging on for reform in the bill that is before us. We do not have Part B means testing. We do not have eligibility age. We did not make the tough decisions to help save Medicare and make it more affordable for future generations. What we are doing is basically spending a lot of general revenue money to provide benefits that frankly are long overdue.

I hope we would make some of these improvements in conference or maybe on the floor. We are going to try and make one or two of these tomorrow, and I hope that they would pass to make this a better bill.

I want to support this package. I want to pass Medicare. I want to improve Medicare for all seniors. I am afraid right now the bill is heavy on subsidies and short on reform, short on improvements, short on making real structural and substantial savings that will save the system for future generations. I want to save it for seniors today, and I want to save it for future generations tomorrow.

I will work with my colleagues both in the House and the Senate and the conference to try to achieve that objective.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, I begin by complimenting the distinguished Senator from Oklahoma for his remarks and his very important contribution to this debate. He is one of the most knowledgeable members of our conference on this subject. I thank him for the fine work he has been doing on this important bill.

Of course, Chairman GRASSLEY and the ranking member, Senator BAUCUS, have been doggedly pursuing this important legislation, not to mention our leader, the majority leader, the only physician in the Senate. He has had this as a top priority for the last 4 or

5 years, really for all of his term in the Senate. These individuals, along with Senator KYL and Senator LOTT, have made an important contribution in getting this legislation to the stage that we find it today.

For almost 40 years, since Medicare was created, we have debated how to help our most frail citizens acquire the miraculous but expensive prescription drugs that they need. After all the talking for decades, today we are finally acting to provide to our seniors, the poor and the fragile of our society, the financial aid and means to acquire these wonder drugs.

As we move deeper into this debate to provide Medicare assistance to those citizens most likely to need these miracle drugs but least able to afford them, some will ask, what took us so long? The question is really not rhetorical. The reason it has taken so long is the same reason why I suggest today that this Medicare debate has not been easy, nor do I believe it is preordained that a quality Medicare prescription drug and reform bill will pass this body.

The reason we have difficult work to do is because there is a riddle to Medicare drug benefits. The riddle of Medicare drug benefits is this: How can Congress take the fastest growing Federal entitlement, with the largest long-term funding gap, and add an expensive but needed new benefit without overwhelming the fiscal solvency of the program or imposing a crushing payroll tax burden? Simply put, how can we add prescription drugs to Medicare today yet still preserve Medicare tomorrow?

Yes, it is possible, and the President has solved the riddle of Medicare. To understand how, we can look to another riddle from ancient Greek mythology. Legend holds that the ancient city of Thebes suffered from a creature called a sphinx: part woman, part lion, and part bird. This creature would devour any who failed to solve the riddle of the sphinx.

The riddle asked: What animal walks in the morning on four feet, in the afternoon on two feet, and in the evening on three feet? The answer is, of course, man, said the legendary Oedipus. In childhood, he creeps on his hands and knees; in manhood, he walks upright; and in old age, he walks with the aid of a cane.

Oedipus first considered man in all stages of life, but only by considering the common cane did Oedipus find the answer. Thus, he solved the riddle, destroyed the sphinx, and ended his people's suffering.

I suggest a similar approach to the riddle of Medicare. We must consider Medicare as it relates to our people in all stages of life—yes, as seniors, but also as working adults and as children. The key is to consider the common cane, the ageless symbol of age, the cane. When the Government buys this quad cane through Medicare, it pays $44 for this cane. When the Government buys the same cane through the Veterans Affairs Department, it pays $15. Let's run that by us one more time. Two different departments of the Government: Medicare buys the cane and pays $44. Veterans Affairs buys the cane and pays $15. The same cane, same Government, same patient but different Government program—$44 versus $15.

Solve this and we solve the riddle of Medicare. Solve this and Medicare prescription drugs will not come at the expense of Medicare preservation.

The General Accounting Office has documented how Medicare habitually overpays compared not just to what the private sector pays for medical goods but what other parts of the Government pay for medical goods. Medicare pays $12 for a catheter that most Federal Employees Health Benefits Plans pay only $1. Medicare pays $9 for an infection drainage bag while Blue Cross/Blue Shield typically pays $2.25. Yet overpaying is only part of the problem. Fraud and abuse costs Medicare as much as $12 billion per year. Over 10 years that would equal almost one-third of the $400 billion we dedicate to Medicare in this bill we are considering.

Paperwork and redtape also waste Medicare dollars. With 110,000 pages of regulations, hospitals hire literally armies of clerks to handle everything but medical care. Some doctors are forced to spend as much time on Medicare patients' paperwork as they do caring for the Medicare patient.

Medicare's regulatory burden is so great that the world-renowned Mayo Clinic requested not to be named Medicare Center for Excellence because the paperwork and redtape linked to such a distinction exceeded the benefit of any additional funds, as well as the honor itself.

These are the aspects of Medicare that so many want to change yet so many seem to ignore.

If we provide these drugs without fixing how we continuously overpay for this cane, we will fail to fix Medicare. Medicare prescription drugs for our parents will come as Medicare preservation for our children. There is an answer to the riddle. In a word, it is reform. That is what the President's plan is all about and the key to the work we began earlier this week: Provide prescription drugs for our parents and ensure preservation for our children.

The President has sent us the right plan at the right price. It will strengthen and modernize the entire Medicare system.

As we continue to work on this modified version of the President's plan we must keep in mind that while the President likes what we have done so far, he wants us to do more. That is a good goal for all. This is not a political game. This is for real. This is not about the next election; it is about the next generation. This is not just about prescription drugs; this is also about preservation.

Yes, this is about our parents and grandparents, but this is also about our children and grandchildren. If we keep in mind all of our people and all that is at stake, I am confident we will produce a bill we can all be proud of and that the President can sign. That challenge continues today.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

AMENDMENT NO. 991

Mr. HARKIN. Mr. President, last week, I believe it was Friday, a number of amendments were laid down, one of them being an amendment that I offered. It is cosponsored by Senator SMITH of Oregon. It has been sitting there all week. I have not had much of a chance to say anything about it.

I thought, since there is a lull on the floor, I might take an opportunity to talk about that amendment and what it does, just so, when it comes up for a vote, I will not have to take a lot of time then to talk about it.

The amendment, I would say at the outset, is exactly the same as President Bush requested in his 2004 budget but for one small change. President Bush's budget requested $350 million a year for 5 years, under Medicaid, to get people with disabilities out of institutions and nursing homes and into community living.

The problem is that the cost of this to the States is very high for the first year. You can understand and appreciate, taking people out of an institution, out of a nursing home, means the State has to find housing; it has to find, perhaps, qualified personnel to help, maybe attendant services. So there are a lot of preliminary things a State has to do in order to provide for this transition from an institution to community-based living. Many States simply cannot afford it.

The good news is that States want to do this because it has been shown, in the States that have done this already, they save a lot of money. It is much cheaper to have a person with a disability in a community-based or home-based setting than in an institution or a nursing home—much cheaper. In fact, in a couple or three States that have already done this, we have had savings of over $40 million or $50 million a year to those States.

Again, the hurdle is that first year, getting people out of these institutions and into community-based living. What the President had requested in his budget was $350 million over 5 years as an enticement to States to do this. What the Federal Government would do is it would provide 100 percent of the funds per Medicaid beneficiary for that first year. After the first year, then the State would go back to the Federal/

State Medicaid match that the State had before. So, let's say a State had a 60/40 Federal/State match on Medicaid right now. During the first year, the State would have to come up with no money; the Federal Government would take 100 percent, would provide 100 percent. The State could use that money, then, that extra money, to set up community-based living systems for people and institutions and nursing homes. After that first year, then the State would go back to the 60/40 split it had before.

That is what this amendment is. It is called ''Money Follows The Person,'' and that is what President Bush called it in his proposed budget also.

What our amendment would do would be to provide, in the 5-year program, $300 million in the first year and then $350 million in each of the following 4 years. Then that would be the end of it. It would be 2004 to 2008.

Again, it has been 13 years since the Americans With Disabilities Act was passed. We will celebrate that on July 26 this year. In the Americans With Disabilities Act, we as a Congress, as a country, said no to segregation of people with disabilities. The Americans With Disabilities Act said: We are going to integrate people with disabilities into our society. No longer are we going to exclude and segregate them. However, our Medicaid Program today, 13 years later, still says yes to segregation.

Here is what I mean by that. Recent data indicates that 70 percent of Medicaid funds are spent on institutional care and only 30 percent to pay for community services. The thrust of our Medicaid spending today is for institution-based care. Our Medicaid system kind of flies in the face of the Americans With Disabilities Act in which we as a country committed ourselves to desegregate people with disabilities, fully integrating them in our society.

I have been trying for the last 10 years to get this change made. It is a bipartisan effort. I am not the first to do this. Others have tried it also. I do commend President Bush for putting it in his budget proposal for this year. It is the right thing to do, and I commend the President for doing that.

Now, again, I want to make it clear, this amendment is about choice. No one will be moved out of an institution who does not choose to be moved. This is not mandatory. Under this amendment, a State will be required to ensure that individuals and their representatives have the necessary information to make an informed choice as to whether they want to live in community-based situations or whether they would prefer to remain in an institution.

Now, again, regarding the offset, our amendment is fully offset by a Medicare secondary payer provision that is supported by the Department of Justice and was included in the House bill.

Mr. President, I have a letter, dated June 17, from William E. Moschella, Assistant Attorney General. It is to the chairman of the House Committee on Energy and Commerce, Congressman TAUZIN. The letter states:

This is to advise you of the Department's support for a provision in the Medicare Prescription Drug and Modernization Act—

Which we are about now—

set forth in Title III, Section 301, which would protect the integrity of the Medicare Trustee Fund by clarifying that Medicare must be reimbursed whenever another insurer's responsibility to pay has been established. The Section is consistent with the litigation positions taken by this Department and the Department of Health and Human Services in numerous court cases.

So the Department of Justice, speaking for the administration, is in favor of this offset.

Mr. President, I ask unanimous consent to have printed in the RECORD the letter from William E. Moschella, Assistant Attorney General.

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

U.S. DEPARTMENT OF JUSTICE, OFFICE OF LEGISLATIVE AFFAIRS, OFFICE OF THE ASSISTANT ATTORNEY GENERAL.

Washington, DC, June 17, 2003.

Hon. W.J. (BILLY) TAUZIN,
Chairman, Committee on Energy and Commerce, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: This is to advise you of the Department's support for a provision in the Medicare Prescription Drug and Modernization Act, set forth in Title III, Section 301, which would protect the integrity of the Medicare Trust Fund by clarifying that Medicare must be reimbursed whenever another insurer's responsibility to pay has been established. The Section is consistent with the litigation positions taken by this Department and the Department of Health and Human Services (''HHS'') in numerous court cases.

Congress enacted the Medicare Secondary Payer (''MSP'') statute in 1980 to protect the fiscal integrity of the Medicare program by making Medicare a secondary, rather than a primary, payer of health benefits. To ensure that Medicare would be secondary, Congress precluded it from making payment when a primary plan has already made payment or can reasonably be expected to pay promptly. Congress recognized, however, that in contested cases, payments under such plans would be delayed. To protect providers, suppliers, and beneficiaries, Congress authorized Medicare to make a ''conditional'' payment when prompt resolution of a claim cannot reasonably be expected. The Medicare Trust Fund must be reimbursed, however, once the primary insurer's obligation to pay is demonstrated.

Some recent court decisions have held, however, that Medicare has no right to reimbursement unless the primary insurer could reasonably have been expected to make prompt payment at the outset. *See, e.g., Thompson v. Goetzmann*, 315 F.3d 457 (5th Cir. 2002). These rulings make the statute's reimbursement mechanism inoperative in some jurisdictions. Section 301 of this legislation would end this costly litigation and provide clear legislative guidance regarding Medicare's status as a secondary payer of health benefits. The technical changes in Section 301 make clear that Medicare may make a conditional payment when the primary plan has not made or is not reasonably expected to make prompt payment.

The technical amendments of Section 301 clarify other provisions of the MSP statute, as well. They make clear that a primary plan may not extinguish its obligations under the MSP statute by paying the wrong party (i.e., by paying the Medicare beneficiary or the provider instead of reimbursing the Medicare Trust Fund. The Section clarifies that a primary plan's responsibility to make payment with respect to the same item or service paid for by Medicare may be demonstrated, among other ways, by a judgment, or a payment conditioned upon the recipient's compromise, waiver or release of items or services included in the claim against the primary plan or its insurer; no finding or admission of liability is required. In addition, Section 301 makes clear that an entity will be deemed to have a ''self-insured plan'' if it carries its own risk, in whole or in part. Finally, the Section makes clear that the Medicare program may seek reimbursement from a primary plan, from any or all of the entities responsible for or required to make payment under a primary plan, and additionally from any entity that has received payment from the proceeds of a primary plan's payment. These provisions of Section 301 will resolve contentious litigation and are designed to protect the fiscal integrity of the Medicare program.

We hope that this information is helpful. The Office of Management and Budget has advised that there is no objection to this report from the standpoint of the Administration's program. Please let us know if we may be of additional assistance.

Sincerely,

WILLIAM E. MOSCHELLA,
Assistant Attorney General.

Mr. HARKIN. So again, we have an amendment that is exactly what the President had in his 2004 budget request. We have an offset supported also by the administration. So this is truly a bipartisan effort.

This amendment Senator SMITH and I have offered is widely supported by older Americans and people with disabilities. AARP, the Consortium of Citizens with Disabilities, ADAPT, the National Council on Independent Living, the National Council on the Aging, and the National Association of Area Agencies on Aging all support this amendment.

Both parts of this amendment—the Money Follows Program and the offsets—are about fairness and justice. If this amendment is adopted, private insurers will pay their fair share of Medicare costs and people with disabilities will have the opportunity to live in their own communities.

I will just talk about a constituent of mine, Ken Kendall. Ken was injured in an accident and has a serious spinal cord injury. When he lost his health insurance, he was forced to go on Medicaid, and his only choice was a nursing home almost 2 hours from his friends and family.

Ken recently wrote to me that he went to dinner and a movie for his 30th birthday. No big deal, except he had not been to dinner and a movie in the 2 years since he went into a nursing home. He said: ''I was almost in tears. I felt like I had a real life again.''

This amendment would give people like Ken a real life again, and not just on their birthdays. Individuals with

disabilities should not have to continue waiting to enjoy the opportunities all other Americans take for granted.

So again, that is the essence of the amendment.

AMENDMENT NO. 991, AS MODIFIED

Mr. President, I ask unanimous consent that the amendment be modified with the modification I send to the desk. This is a modification to amendment No. 991.

The PRESIDING OFFICER. Is there objection?

Without objection, the amendment is so modified.

The amendment (No. 991), as modified, is as follows:

At the appropriate place, insert the following:

TITLE ___—MEDICAID DEMONSTRATION PROJECTS

SEC. ___01. SHORT TITLE.

This title may be cited as the ''Money Follows the Person Act of 2003''.

SEC. ___02. FINDINGS.

Congress makes the following findings:

(1) In his budget for fiscal year 2004, President George W. Bush proposes a ''Money Follows the Person'' rebalancing initiative under the medicaid program to help States rebalance their long-term services support systems more evenly between institutional and community-based services.

(2) The President, by proposing this initiative, and Congress, recognize that States have not fully developed the systems needed to create a more equitable balance between institutional and community-based services spending under the medicaid program.

(3) While a few States have been successful at achieving this balance, nationally, approximately 70 percent of the medicaid funding spent for long-term services is devoted to nursing facilities and intermediate care facilities for the mentally retarded. Only 30 percent of such funding is spent for community-based services.

(4) As a result, there are often long waiting lists for community-based services and supports.

(5) In the Americans with Disabilities Act of 1990, Congress found that individuals with disabilities continue to encounter various forms of discrimination, including segregation, and that discrimination persists in such critical areas as institutionalization.

(6) In 1999, the Supreme Court held in *Olmstead v. LC* (527 U.S. 581 (1999)) that needless institutionalization is discrimination under the Americans with Disabilities Act of 1990, noting that institutional placement of people who can be served in the community ''perpetuates unwarranted assumptions that persons so isolated are unworthy of participating in community life.'' (Id. at 600). The Court further found that ''confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.'' (Id. at 601).

(7) Additional resources would be helpful for assisting States in rebalancing their long-term services support system and complying with the *Olmstead* decision.

SEC. ___03. AUTHORITY TO CONDUCT MEDICAID DEMONSTRATION PROJECTS.

(a) DEFINITIONS.—In this section:

(1) COMMUNITY-BASED SERVICES AND SUPPORTS.—The term ''community-based services and supports'' means, with respect to a State, any items or services that are an allowable expenditure for medical assistance under the State medicaid program, or under a waiver of such program and that the State determines would allow an individual to live in the community.

(2) INDIVIDUAL'S REPRESENTATIVE; REPRESENTATIVE.—The terms ''individual's representative'' and ''representative'' mean a parent, family member, guardian, advocate, or authorized representative of an individual.

(3) MEDICAID LONG-TERM CARE FACILITY.—The term ''medicaid long-term care facility'' means a hospital, nursing facility, or intermediate care facility for the mentally retarded, as such terms are defined for purposes of the medicaid program.

(4) MEDICAID PROGRAM.—The term ''medicaid program'' means the State medical assistance program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(6) STATE.—The term ''State'' has the meaning given such term for purposes of the medicaid program.

(b) STATE APPLICATION.—A State may apply to the Secretary for approval to conduct a demonstration project under which the State shall provide community-based services and supports to individuals—

(1) who are eligible for medical assistance under the medicaid program;

(2) who are residing in a medicaid long-term care facility and who have resided in such facility for at least 90 days; and

(3) with respect to whom there has been a determination that but for the provision of community-based services and supports, the individuals would continue to require the level of care provided in a medicaid long-term care facility.

(c) REQUIREMENTS.—A State is not eligible to conduct a demonstration project under this section unless the State certifies the following:

(1) With respect to any individual provided community-based services and supports under the demonstration project, the State shall continue to provide community-based services and supports to the individual under the medicaid program (and at the State's Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act) reimbursement rate), for as long as the individual remains eligible for medical assistance under the State medicaid program and continues to require such services and supports, beginning with the month that begins after the 12-month period in which the individual is provided such services and supports under the demonstration project.

(2) The State shall allow an individual participating in the demonstration project (or, as appropriate, the individual's representative) to choose the setting in which the individual desires to receives the community-based services and supports provided under the project.

(3) The State shall identify and educate individuals residing in a medicaid long-term care facility who are eligible to participate in the demonstration project (and, as appropriate the individual's representative) about the opportunity for the individual to receive community-based services and supports under the demonstration project.

(4) The State shall ensure that each individual identified in accordance with paragraph (3) (and, as appropriate, the individual's representative), has the opportunity, information, and tools to make an informed choice regarding whether to transition to the community through participation in the demonstration project or to remain in the medicaid long-term care facility.

(5) The State shall maintain an adequate quality improvement system so that individuals participating in the demonstration project receive adequate services and supports.

(6) The State shall conduct a process for public participation in the design and development of the demonstration project and such process shall include the participation of individuals with disabilities, elderly individuals, or individuals with chronic conditions who are part of the target populations to be served by the demonstration project, and the representatives of such individuals.

(7) The Federal funds paid to a State pursuant to this section shall only supplement, and shall not supplant, the level of State funds expended for providing community-based services and supports for individuals under the State medicaid program as of the date the State application to conduct a demonstration project under this section is approved.

(d) APPROVAL OF DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall conduct a competitive application process with respect to applications submitted under subsection (b) (taking into consideration the preferences provided under paragraph (2)) that meet the requirements of subsection (c). In determining whether to approve such an application, the Secretary may waive the requirement of—

(A) section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) to allow for sub-State demonstrations;

(B) section 1902(a)(10)(B) of such Act (42 U.S.C. 1396a(a)(10)(B)) with respect to comparability; and

(C) section 1902(a)(10)(C)(i)(III) of such Act (42 U.S.C. 1396a(a)(10)(C)(i)(III)) with respect to income and resource limitations.

(2) PREFERENCE FOR CERTAIN APPLICATIONS.—In approving applications to conduct demonstration projects under this section, the Secretary shall give preference to approving applications that indicate that the State shall do the following:

(A) Design and implement enduring improvements in community-based long-term services support systems within the State to enable individuals with disabilities to live and participate in community life, particularly with respect to those practices that will ensure the successful transition of such individuals from medicaid long-term care facilities into the community.

(B) Design and implement a long-term services support system in the State that prevents individuals from entering medicaid long-term care facilities in order to gain access to community-based services and supports.

(C) Engage in systemic reform activities within the State to rebalance expenditures for long-term services under the State medicaid program through administrative actions that reduce reliance on institutional forms of service and build up more community capacity.

(D) Address the needs of populations that have been underserved with respect to the availability of community services or involve individuals or entities that have not previously participated in the efforts of the State to increase access to community-based services.

(E) Actively engage in collaboration between public housing agencies, the State medicaid agency, independent living centers, and other agencies and entities in order to coordinate strategies for obtaining community integrated housing and supportive services for an individual who participates in the demonstration project, both with respect to

the period during which such individual participates in the project and after the individual's participation in the project concludes, in order to enable the individual to continue to reside in the community.

(F) Develop and implement policies and procedures that allow the State medicaid agency to administratively transfer or integrate funds from the State budget accounts that are obligated for expenditures for medicaid long-term care facilities to other accounts for obligation for the provision of community-based services and supports (including accounts related to the provision of such services under a waiver approved under section 1915 of the Social Security Act (42 U.S.C. 1396n)) when an individual transitions from residing in such a facility to residing in the community.

(e) PAYMENTS TO STATES.—

(1) IN GENERAL.—The Secretary shall pay to each State with a demonstration project approved under this section an amount for each quarter occurring during the period described in paragraph (2) equal to 100 percent of the State's expenditures in the quarter for providing community-based services and supports to individuals participating in the demonstration project.

(2) PERIOD DESCRIBED.—The period described in this paragraph is the 12-month period that begins on the date on which an individual first receives community-based services and supports under the demonstration project in a setting that is not a medicaid long-term care facility and is selected by the individual.

(f) REPORTS.—

(1) IN GENERAL.—Each State conducting a demonstration project under this section shall submit a report to the Secretary that, in addition to such other requirements as the Secretary may require, includes information regarding—

(A) the types of community-based services and supports provided under the demonstration project;

(B) the number of individuals served under the project;

(C) the expenditures for, and savings resulting from, conducting the project; and

(D) to the extent applicable, the changes in State's long-term services system developed in accordance with the provisions of subsection (d)(2).

(2) UNIFORM DATA FORMAT.—In requiring information under this subsection, the Secretary shall develop a uniform data format to be used by States in the collection and submission of data in the State report required under paragraph (1).

(g) EVALUATIONS.—The Secretary shall use an amount, not to exceed one-half of 1 percent of the amount appropriated under subsection (h) for each fiscal year, to provide, directly or through contract—

(1) for the evaluation of the demonstration projects conducted under this section;

(2) technical assistance to States concerning the development or implementation of such projects; and

(3) for the collection of the data described in subsection (f)(1).

(h) FUNDING.—

(1) IN GENERAL.—There is appropriated to carry out this section—

(A) $300,000,000 for fiscal year 2004; and

(B) $350,000,000 for each of fiscal years 2005 through 2008.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) for a fiscal year shall remain available until expended, but not later than September 30, 2008.

SEC. ___04. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

Mr. HARKIN. Mr. President, all this modification does is it changes the first year, but it leaves everything else the same. This was $350 million each of the 5 years. This is now $300 million in the first year, and $350 million for each of the 4 years thereafter.

So again, as I said, 13 years ago we passed the Americans with Disabilities Act. We said no to segregation of people with disabilities. Ever since that time, Medicaid still continues to segregate people. When 70 percent of their money goes for institutional care, and only 30 percent goes for community-based care, it is time to break that down and give people with disabilities the right to exercise their own choice about where they want to live. And that, really, is the essence of the amendment.

I hope Senators will support the amendment overwhelmingly since, as I said, it was in the President's 2004 budget and the offset we have used is also fully supported by the administration.

With that, Mr. President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. GRASSLEY. I ask unanimous consent to set the pending amendment aside.

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

AMENDMENT NO. 1087

(Purpose: To permit the offering to consumer-driven health plans under MedicareAdvantage)

Mr. GRASSLEY. I rise to offer an amendment for Senator CRAIG. I send the amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY], for Mr. CRAIG, proposes an amendment numbered 1087.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. GRASSLEY. I am doing this for Senator CRAIG. I am going to yield the floor because Senator CRAIG is going to discuss his amendment tomorrow.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. I ask unanimous consent the order for the quorum call be rescinded.

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

AMENDMENT NO. 992 WITHDRAWN

Mr. BAUCUS. On behalf of the Senator from Michigan, Ms. STABENOW, I ask unanimous consent amendment No. 992 be withdrawn.

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

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

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

AMENDMENTS NOS. 941, 961, 983 EN BLOC

Mr. GRASSLEY. Mr. President, I call up amendments Nos. 941, 961, and 983 en bloc.

The PRESIDING OFFICER. The clerk will report the amendments.

The legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY], for Mr. WYDEN, proposes an amendment numbered 941.

The Senator from Iowa [Mr. GRASSLEY], for Mrs. MURRAY, proposes an amendment numbered 961.

The Senator from Iowa [Mr. GRASSLEY], for Mr. SPECTER, proposes an amendment numbered 983.

The amendments are as follows:

AMENDMENT NO. 941

(Purpose: To provide for a study by MedPAC on Medicare payments and efficiencies in the health care system)

At the end of title IV, add the following:

SEC. ___. MEDPAC STUDY ON MEDICARE PAYMENTS AND EFFICIENCIES IN THE HEALTH CARE SYSTEM.

Not later than 18 months after the date of enactment of this Act, the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) shall provide Congress with recommendations to recognize and reward, within payment methodologies for physicians and hospitals established under the medicare program under title XVIII of the Social Security Act, efficiencies, and the lower utilization of services created by the practice of medicine in historically efficient and low-cost areas. Measures of efficiency recognized in accordance with the preceding sentence shall include—

(1) shorter hospital stays than the national average;

(2) fewer physician visits than the national average;

(3) fewer laboratory tests than the national average;

(4) a greater utilization of hospice services than the national average; and

(5) the efficacy of disease management and preventive health services.

AMENDMENT NO. 961

(Purpose: To fund the blended capitation rate for purposes of determining benchmarks under the MedicareAdvantage program)

At the end of subtitle A of title II, add the following:

SEC. ___. IMPROVEMENTS IN MEDICAREADVANTAGE BENCHMARK DETERMINATIONS.

(a) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)), as amended by section 203, is amended by inserting ''who are enrolled in a MedicareAdvantage plan'' after ''the average number of medicare beneficiaries''.

(b) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)), as amended by section 203, is amended—

(1) in paragraph (1)(A)—

(A) in clause (ii), by striking the comma at the end and inserting a period; and

(B) by striking the flush matter following clause (ii); and

(2) by striking paragraph (5).

(c) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICARE+CHOICE PAYMENT RATES.—

(1) FOR PURPOSES OF CALCULATING MEDICARE+CHOICE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (E)''; and

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

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(2) FOR PURPOSES OF CALCULATING LOCAL FEE-FOR-SERVICE RATES.—Section 1853(d)(5) (42 U.S.C. 1395w–23(d)(5)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

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

''(C) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the local fee-for-service rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on and after January 1, 2006.

AMENDMENT NO. 983

(Purpose: To provide medicare beneficiaries with information on advance directives)

On page 676, after line 22, insert the following:

SEC. ___. PROVISION OF INFORMATION ON ADVANCE DIRECTIVES.

Section 1804(c) of the Social Security Act (42 U.S.C. 1395b–2(c)) is amended—

(1) by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively;

(2) in the matter preceding subparagraph (A), as so redesignated, by striking ''The notice'' and inserting ''(1) The notice''; and

(3) by adding at the end the following:

''(2)(A) The Secretary shall annually provide each medicare beneficiary with information concerning advance directives. Such information shall be provided by the Secretary as part of the Medicare and You handbook that is provided to each such beneficiary. Such handbook shall include a separate section on advanced directives and specific details on living wills and the durable power of attorney for health care. The Secretary shall ensure that the introductory letter that accompanies such handbook contain a statement concerning the inclusion of such information.

''(B) In this section:

''(i) The term 'advance directive' has the meaning given such term in section 1866(f)(3).

''(ii) The term 'medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A or enrolled under part B, of this title.''.

AMENDMENTS NOS. 941, 967, AS MODIFIED; 961, 974, 983, AND 1010, EN BLOC

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the following amendments be agreed to en bloc and the motion to reconsider be laid upon the table en bloc: Amendments Nos. 941, 967, as modified; 961, 974, 983, and 1010.

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

The amendments (Nos. 941, 961, 974, 983, and 1010) were agreed to.

The amendment (No. 967), as modified, was agreed to as follows:

(Purpose: To provide improved payment for certain mammography services)

At the end of subtitle B of title IV, add the following:

SEC. ___. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 13951(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: ''and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to mammography performed on or after January 1, 2015.

The PRESIDING OFFICER. The Senator from Montana.

AMENDMENTS NOS. 1088, 1089, 1090, AND 1091, EN BLOC

Mr. BAUCUS. Mr. President, on behalf of Senator MIKULSKI, I send four amendments to the desk and ask unanimous consent that the pending amendments be set aside so that the amendments might be offered. I don't know whether it is permissible to get consent to offer all four or we have to do it individually?

I send to the desk the four amendments en bloc and ask that the pending amendments be set aside. The amendments, for the purposes of consent, are to provide equal or equitable treatment for children's hospitals. Another is on the same subject. The third is to permit direct payment under the Medicare Program for clinical social worker

services provided to residents of skilled nursing facilities. And the fourth is to extend certain municipal health service demonstration projects.

The PRESIDING OFFICER. Without objection, the clerk will report the amendments by number.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Ms. MIKULSKI, proposes amendments Nos. 1088 through 1091 en bloc.

The amendments are as follows:

AMENDMENT NO. 1088

(Purpose: To provide equitable treatment for children's hospitals)

At the end of subtitle B of title IV, add the following:

SEC. ___. EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 13951(t)(7)(D)(ii)) is amended to read as follows:

''(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

''(I) CANCER HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(v), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

''(II) CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii), for covered OPD services furnished before October 1, 2003, and for which the PPS amount is less than the pre-BBA amount the amount of payment under this subsection shall be increased by the amount of such difference. In the case of such a hospital, for such services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions incurred in furnishing such services, the amount of payment under this subsection shall be increased by the amount of such difference.''.

AMENDMENT NO. 1089

(Purpose: To provide equitable treatment for certain children's hospitals)

At the end of subtitle B of title IV, add the following:

SEC. ___. EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 13951(t)(7)(D)(ii)) is amended to read as follows:

''(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

''(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

''(II) SPECIAL RULE FOR CERTAIN CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii) that is located in a State with a reimbursement system under section 1814(b)(3), but that is not reimbursed under such system, for covered OPD services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions of the hospital in providing such services, the amount of payment under this subsection shall be increased by the amount of such difference.''.

AMENDMENT NO. 1090

(Purpose: To permit direct payment under the medicare program for clinical social worker services provided to residents of skilled nursing facilities)

At the end of subtitle A of title IV, add the following:

SEC. ___. PERMITTING DIRECT PAYMENT UNDER THE MEDICARE PROGRAM FOR CLINICAL SOCIAL WORKER SERVICES PROVIDED TO RESIDENTS OF SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting ''clinical social worker services,'' after ''qualified psychologist services,''.

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) (42 U.S.C. 1395x(hh)(2)) is amended by striking ''and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2003.jennifer

AMENDMENT NO. 1091

(Purpose: To extend certain municipal health service demonstration projects)

At the end of title VI, add the following:

SEC. ___. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking ''December 31, 2004, but only with respect to'' and all that follows and inserting ''December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996.''.

Mr. BAUCUS. 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. GRASSLEY. I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. GRASSLEY. Mr. President, I ask unanimous consent that at 9:15 tomorrow morning, the Senate proceed to a vote in relation to Harkin amendment No. 991, to be followed by a vote in relationship to the Edwards amendment No. 1052; provided further that there be 2 minutes equally divided before each vote and that no second-degree amendments be in order to the amendments prior to the vote.

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

Mr. BAUCUS. 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. GRASSLEY. I ask unanimous consent that the order for the quorum call be rescinded.

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

AMENDMENT NO. 1092

(Purpose: To evaluate alternative payment and delivery systems)

Mr. GRASSLEY. Mr. President, I send an amendment to the desk for myself and Senator BAUCUS and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY], for himself and Mr. BAUCUS, proposes an amendment numbered 1092.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

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

(The amendment is printed in Today's RECORD under ''Text of Amendments.'')

Mr. GRASSLEY. This is an amendment I have worked out with Senator BAUCUS after considerable consultation with many colleagues on both sides of the aisle. The amendment has two parts. First, it would permit the Secretary, starting in 2009, to designate an alternative payment system for PPOs in a limited number of regions that the Secretary has determined to be highly competitive. This alternate payment system would permit the Secretary to set the Federal contribution for participation plans solely based on the bids they submit to the Secretary. The Secretary would still be required to choose the three plans with the lowest credible bids to participate. The Federal contribution would be set for the three plans participating by the second lowest bid submitted.

The second thing the amendment would do is authorize the Secretary, also starting in 2009, to establish a number of projects in the fee-for-service Medicare Program. These projects would be designed to provide enhanced services or benefits to improve the quality of care provided to Medicare beneficiaries, to improve the health care delivery system under the Medicare Program, and lower expenditures in that program. The enhanced services or benefits would include preventive services, chronic care coordination, disease management services, or other services the Secretary determines will advance the purposes of these projects.

The total cost of this amendment would be $12 billion starting in the year 2009 and would be equally divided between the alternative payment system and the fee-for-service projects.

Mr. President, this amendment represents a very reasonable compromise on the question of how to introduce into the Medicare Advantage Program a more competitive payment system.

I thank everyone, and most especially Senator BAUCUS, for working so hard and in a cooperative spirit to develop this amendment now before the Senate.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, first, I thank my good friend and colleague, the chairman of the committee, Senator GRASSLEY, for his Job-like patience, as we have worked extremely hard with various Senators to try to come up with—and I think we have—a compromise, balanced solution as to how we spend the newly discovered $12 billion.

I have a couple of points. The intent of this amendment and the language of this amendment accomplish a couple of purposes: No. 1, to evenly divide the $12 billion—$6 billion and $6 billion—to be available to be potentially used by PPOs in areas designated by the Secretary, and the other $6 billion to be spent in additional Medicare Programs for disease management, chronic care, and other ways to help particularly address the lack of coordination services for the chronically ill and those seniors who particularly need disease management.

The amendment also has a couple other provisions, and to maintain the balance, maintain the symmetry is so important. I will remind my colleagues that in an attempt to get prescription drug benefits to seniors—something we all want to do—we are faced with two competing ideas. One is competition and the other is traditional Medicare. So the underlying bill is an attempt to work those two concepts together. This amendment follows on that tradition. It follows the same spirit, the same symmetry.

I mentioned the $6 billion and $6 billion. In addition, the amendment provides the authority to continue in the applicable number of years—beginning in 2009 through 2013—and the $12 billion is not available until then anyway. That is the problem we have. It doesn't start until 2009. But it is $6 billion available for potential PPO use and $6 billion for disease management, starting in 2009, for a 5-year period. In addition, the authority for both under this amendment continues into the future beyond the 5-year period.

In addition, the language is written so it is an absolutely clear, ironclad guarantee that after the 5-year period no further dollars will be spent on either side, either the $6 billion available for PPOs or the $6 billion to be available for disease management, et cetera. It is very important to maintain that symmetry and balance in order to accomplish the spirit of cooperation so that we get this program started, get the prescription drug program that we want delivered and on its way.

This is not perfect, but I can tell you that many hours have been devoted by many Senators on both sides of the aisle to come up with this solution, which does achieve that balance.

I urge Senators to support this. This is going to break the logjam. This is the key amendment which has been topic A. Many Senators are wondering about this as they are thinking about other amendments they may or may not offer.

I hope with the passage of this amendment we will be able to take up other amendments Senators have tomorrow and debate them and finally, hopefully, by sometime tomorrow and Thursday—perhaps at a late time on Thursday—pass this legislation and send it to conference.

I yield the floor.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. Mr. President, I rise to speak in support of this amendment, which is a product of about 48 hours of discussion and negotiation, in terms of packaging. I really speak in support of both of the parts of this amendment to which the managers have just spoken.

In the next couple days—hopefully maybe tomorrow night or the next morning—we will indeed have a historic vote to provide America's seniors with coverage they simply don't have today, don't have access to today—prescription drugs, preventive care, and chronic disease management. That is in the underlying bill.

Seniors will have the opportunity, for the first time, to choose the sort of coverage that best suits their individual needs. At the same time, they will have access to a benefit they don't have today, and that is in the underlying bill.

I support the amendment just introduced because it makes the bill even better for two reasons. No. 1—and this is where about $6 billion is spent—it strengthens the competitive model.

Ultimately, I believe—and I think the majority of people in this body believe—the only way we are going to be able to increase quality over the long term, in 10, 20, or 30 years, at the same time we have this unprecedented increase in the number of seniors in this country, a doubling in the number of seniors over the next 30 years, is to take advantage of the dynamism of the private sector where we can obtain the efficiencies that a command-and-control type plan, a Government-type plan simply cannot capture. It is the only way. Half of this amendment concentrates just on that—about $6 billion—to make those competitive, private sector dynamic, marketplace principles, yes, regulated by Government, work.

The other half of the amendment, the other $6 billion, also does something which we stress in the underlying bill, but through this amendment we will spend an additional $6 billion in supporting and investing in what we call preventive medicine, chronic disease management, coordinated chronic disease management we know how to address, but we have insufficiently invested in to maximize the care, the health care security our seniors deserve.

I will refer to a couple charts to explain why I am so excited about both aspects of this bill. I will first take the half of the bill that has to do with chronic disease management, and it links with what I prefaced in my remarks; that is, doubling the number of seniors. The challenge is going to be to sustain this long term; that is, Medicare long term.

If we look at overall numbers of beneficiaries in Medicare today, we know there are about 40 million beneficiaries, and this chart shows the percentage of beneficiaries. As we look at the total amount of moneys being spent today by those beneficiaries, those patients, those seniors, those individuals with disabilities who are a part of Medicare, we find that 6 percent, or about 1 in 20, account for 50 percent of all the money that is expended in Medicare today.

Since we know that health care is expensive, what we need to do, I believe, to make sure we get the best value for each health care dollar, each tax dollar that is paid to Government or that is paid for by the beneficiary, is to make sure this money is spent effectively and efficiently.

How do we do that? We ought to spend a lot of time focusing on this 50 percent, which is really 1 out of every 20 people. So in this body of 100 people, there would be six—just these six desks around me—accounting for 50 percent of all the expenditures. So why don't we figure out why these six people are so expensive?

Who are these six people? In this next chart, I will show you who they are because once we identify them and give them the very best coordinated care possible, I believe that number will reduce over time.

On this next chart, these ''CCs'' stand for chronic conditions. By ''chronic condition,'' I mean heart failure, diabetes, chronic obstructive pulmonary disease, or emphysema.

What we find if we look at all Medicare expenditures—say this pie chart is all the money we spend on Medicare—most of the expenses are on individuals who have five chronic care conditions, and then those who have four chronic care conditions is about 13 percent; three chronic care conditions about 10 percent; two chronic conditions, say heart failure and diabetes, 7 percent.

By concentrating on people with chronic conditions, and if we give them coordinated care, seamless care, if we give them prescription drugs, which this bill does for the first time, if we help them with maybe a nurse calling once a week to help manage their care, use resources appropriately, over the long haul, this program will be sustainable.

I walked through these two charts because all of us know that Medicare is expensive, and we know that over time we need to fund whatever program we do, so let's concentrate our policy on where the expenses are, these six individuals, if we use this body as an example, and those are the people who have chronic care conditions.

Thus, this amendment, $6 billion of $12 billion, is being spent, focused like a laser beam on people with chronic care conditions. That is what the amendment does.

The underlying bill does that by setting up these PPOs, Medicare Advantage and Medicare+Choice, which gives seamless coordinated care built in a competitive marketplace. The underlying bill does that, but what this amendment does is focus an additional $6 billion on people with chronic conditions.

Also, part of that money is to improve preventive care, and we all know it is a lot cheaper to figure out who is going to get sick from heart disease and treat them accordingly than waiting until they get sick and are hospitalized and they develop what is called end stage cardiomyopathy. To me it is exciting.

I mentioned diabetes because diabetes is one of the conditions that I think best demonstrates how modern medicine today can, if properly managed, both have better outcome and lower cost. Today there are about 17 million Americans who suffer from diabetes. Another 16 million adults are at risk for developing the condition, and over the past decade, the number of diagnosed cases of diabetes has risen sharply.

Just in the last several weeks, the American-Diabetes-Association-sponsored study indicated that one-third, one out of every three children born in the United States this year will develop diabetes in their lifetime—one out of every three. So if you are a parent and listening to me now, and you have three children, one of those statistically will develop diabetes over their lifetime. It is huge. The National Health Interview Survey projects that 45 to 50 million Americans will have diabetes by 2050.

If we ineffectively manage diabetes, if we do not have access to the latest drugs, the appropriate management, the cost of managing and treating diabetes is huge. According to the American Diabetes Association, $91.9 billion was spent last year just in direct medical expenses for diabetics. Today, more than $1 in every $7 spent on health care in the United States is spent on behalf of diabetic patients.

I mention all of this because we know that health care costs for diabetes, if not managed in a coordinated system, are huge, and based on the statistics I just said with this dramatic increase in diabetes will increase over time.

How do we address it? We address it through an integrated health care model where you look at diet, you look at exercise, you look at drugs, you look at the appropriate testing to monitor blood sugars, and you have coordinated care. That is what we do in this Medicare PPO, Medicare Advantage model, and diabetes would fall into one of these chronic conditions. And we are going to be investing another $6 billion through this amendment in the overall management of conditions like diabetes.

The other—and I will close in a minute or so—the other $6 billion of this amendment, the other half of this amendment, is invested in increasing the competitive model.

I commented on this briefly, but what this allows us to do is to take advantage of what we know is in the marketplace today. We know that command and control and price controls run out of Washington, DC, do not work. We have tried it. We have seen it in Medicare in the past, and it resulted in a system that, yes, has been good for seniors, but it has not stayed abreast with the great advances we have seen in health care delivery or the new technology today. So we need a more responsive system, one that takes advantage of new innovation, new technology in the marketplace, that captures those dynamics of market-based competition. It is the private sector working in partnership with the public sector.

I will close by saying that I feel strongly that this amendment will incrementally, greatly improve health care for our seniors today. It will be debated, I am sure, over the course of the evening tonight and early in the morning. It is a product of a lot of working together, Democrats and Republicans, over the last 48 hours to put together the very best ideas for improving competition and market-based fundamentals and, at the same time, focusing on preventive medicine, prevention of disease, management of those chronic conditions, where many of the challenges exist in Medicare today.

We are nearing a historic vote to provide America's current and future seniors comprehensive health care coverage. Friday, we will pass legislation to improve and strengthen Medicare. The transformed program will offer modern and innovative coverage for procedures ranging from physical exams to hospital visits. And most significantly, the updated Medicare system will, for the first time, offer seniors prescription drug coverage. As a doctor who has served thousands of Medicare patients, I am committed to ensuring health care security for our seniors. Prescription drugs must be a part of that security.

The bipartisan bill offers seniors more choice and flexibility. Seniors will be able to stay with traditional Medicare, or they will have the option of being covered under Medicare Advantage. Medicare Advantage will offer better benefits and up-to-date medical care, including: preventive care; disease management; and protection from catastrophic costs. It will also, of course, offer comprehensive prescription drug coverage.

Seniors all across the country, including in rural areas, will have a Medicare plan that offers them similar types of benefits 8 million current and retired Federal employees now enjoy. Medicare Advantage is designed to combine the best of the Government and private sector and provide security, choice, quality, safety, flexibility and innovation. Chronic health problems especially will be tackled with more resources and better results.

The amendment will significantly strengthen the bill in this regard. Most importantly, it allows the Secretary of Health and Human Services additional flexibility to institute a true competitive bidding model for PPOs and other Medicare Advantage coordinated health plans. It does this by allowing payments to plans without regard to a benchmark linked to current payments under the Medicare+Choice or Medicare FFS system.

The second part of the amendment will devote up to $6 billion additional funds, beginning in 2009, for the Secretary to conduct broad demonstration projects that will likely lead to improvements in the disease management, chronic care management, and preventive care provided to seniors who choose to remain in the traditional Medicare program. This is great progress for seniors. We are modernizing Medicare to keep pace with modern medicine and tackle chronic disease.

Diabetes is a good example of how modern medicine, through prescription drugs, is offering both therapeutic benefits today as part of an integrated care regimen and promises effective treatments and new types of health care delivery in the future.

Approximately 17 million Americans—6% of the population—now suffer from diabetes. Another 16 million adults are at risk for developing the condition. Over the past decade, the number of diagnosed cases of diabetes has risen sharply. A recent American Diabetes Association sponsored study indicated that one third of children born in the United States in the year 2000 will develop diabetes in their lifetimes. The National Health Interview Survey projects that 45 to 50 million Americans will have diabetic by 2050.

Undiagnosed and improperly treated, diabetes can cause a host of complications, including: kidney failure; heart disease; and loss of limb. Medical expenditures for persons with diabetes are four times as high as their non-diabetic counterparts, in large part, because of these complications. According to the American Diabetes Association, $91.9 billion dollars was spent last year just in direct medical expenses for diabetics. Today, more than one in every seven dollars spent on healthcare in the United States is spent on behalf of diabetic patients.

Indeed, the healthcare costs for diabetes threaten to add a significant financial burden to Medicare. But the good news is there is much we can do to prevent the illness. We know that patient education, weight control, exercise and treatment can significantly reduce the incidence of adult onset diabetes.

Meanwhile, since 1995, five new classes of medicine have been introduced to treat diabetes. These medicines, coupled with health management and coordinated care programs, are powerful tools to increase a patient's health status and reduce complications due to the illness.

For example, one comprehensive disease management program treated approximately 7,000 diabetic patients and produced savings of $50 to $100 per diabetic patient, per month. Pharmaceutical costs increased under the program, but total health care spending declined.

Why? Because of fewer emergency room visits, substantially fewer inpatient hospitalizations and reduced lengths of stay. At the same time, (HEDIS) measures of the quality of care these patients received significantly improved.

In other words, a modern, coordinated health approach to diabetes which included prescription drugs, led to reduced costs and improved outcomes. And diabetes is only one of many chronic conditions for which prescription drugs help clinicians optimize care and improve the quality of life for patients. This amendment will go far in advancing life saving prescription drug approaches.

This is an exciting week for the Senate and for the American people. We have built on years of research, discussion, and debate. We now have a bill that reflects broad bipartisan support. Thanks to the leadership of my colleagues in the Senate, and the commitment of President Bush, America's seniors will finally receive the health coverage they need and the security they deserve.

Medicine has come a long way since 1965. Now, so too, will Medicare.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Arizona.

AMENDMENT NO. 1093 TO AMENDMENT NO. 1092

(Purpose: To evaluate alternative payment and delivery systems)

Mr. KYL. Mr. President, I have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Arizona [Mr. KYL] proposes an amendment numbered 1093 to amendment No. 1092.

Mr. KYL. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. KYL. Mr. President, this is a second-degree amendment to the Baucus-Grassley amendment. I will explain it in just a moment, but while the majority leader is still in the Chamber, let me compliment him, not only for the fine presentation he just made based upon his personal knowledge of how the medical health care system in this country works but also for his leadership and the enormous amount of time and effort he has put into crafting this legislation and working with Members to try to resolve the many disputes that have arisen. I think without the patience he has shown in dealing with all of the Members, we would not be to this point that we are today, literally on the brink of passing, in the Senate, very historic legislation. So I compliment the majority leader and personally thank him for his patience in dealing with some of my concerns about the bill and the good work he has done in working with those problems.

I also want to thank Chairman GRASSLEY, who has shown a lot of patience and has worked hard in a very bipartisan way to put together a plan that could pass this body. I know that people on both sides of the aisle would prefer that it be closer to their particular points of view, but the chairman was always cognizant of the fact that in order to get a bill passed, it had to be done in a bipartisan way. So I compliment the chairman and ranking member for working in that fashion.

I also want to compliment and tell my colleagues a little bit about the efforts of the Secretary of HHS, Tommy Thompson. He, too, has become very personally involved in this effort and has worked very hard to effect the President's goals and plans in ensuring that we can strengthen, protect, improve and preserve Medicare. I appreciate his strong role as well.

I say all of that to make it clear that the amendment I offer is in the spirit of this bipartisan work, hopefully my work will be deemed to be cooperative with our leadership, although there is one element of the amendment Chairman GRASSLEY and Senator BAUCUS have laid down that I disagree with and this is what I am proposing to amend.

What I would like to do is explain the history of this and then come to my amendment. The amendment is very simple. It strikes a sunset provision, but that does not mean anything unless one knows the context, so let me speak for a moment about that context.

When the President first proposed this year that we legislate to add a new prescription drug benefit to Medicare, he said we should do it in the context of a real effort to strengthen Medicare so that we can preserve and protect it for the future. It has served our seniors well, but we are now in the 21st century and two things basically have occurred.

First, we now know that medicines, prescription drugs, are used as the preferred treatment for many illnesses and diseases, which was not the case back in 1965 when Medicare was first created. So all of us have become convinced that we need to add a prescription drug benefit to Medicare. This was the President's first great goal.

The second thing he said was, there is no way we can sustain the current promised benefits under Medicare if we do not create some new opportunities for Medicare beneficiaries, if we do not really strengthen the Medicare system we have. Among the things we can do to ensure that it will continue to work is to provide some choices for seniors, and so what he proposed was those people who would like to keep the existing Medicare, with a new prescription drug benefit, would be able to do that. But, especially for those younger seniors, people who have been in the workplace and are familiar with a PPO, or preferred provider, insurance plan or perhaps an HMO or Medicare+Choice kind of plan, we would provide that alternative as well so that the senior could choose. The idea was that a lot of the people that will be coming into the senior market, being used to an employer-provided plan, might like to keep that kind of plan rather than go into traditional Medicare. So we want to provide a choice, and it will be up to the senior to decide. So that is the direction that we sat down to work in as we developed this legislation.

I would have preferred that in creating this private market alternative, or the preferred provider organization—which we will hear referred to as PPOs—to the traditional Government Medicare system, we had made it much more like the FEHBP, the Federal Employees Health Benefits Program. That is a medical insurance plan that most of the people who are in this Chamber today have. It serves about 10 million Federal employees including family members and retirees. This is also the health plan for Members of Congress.

I would like to tell my seniors, if it is good enough for Members of Congress, then the seniors ought to take a look at it. It is a pretty good program. In fact, it is a very good program. I would have liked to have made this new Medicare Program alternative very much in the mold of the FEHBP, especially in the way that the preferred provider organizations work, bid, and are paid. We could have done that.

The way it works in the FEHBP is we do not have any limit on what kind of a bid the PPOs have to have. If they meet the basic criteria, providing the care we have mandated by statute, they can bid and provide the service and they can try to sell it to us. The federal government's share of the cost is determined by the use of a weighted average of all the health plans' costs.

If it is a good deal, federal employees and Members of Congress will sign up. If it is not a good deal, we will not. Generally, we do not tell the PPOs how much they can bid or how much they can charge. If they bid too much and charge too much, nobody is going to buy it. So they all have pretty reasonable bids and pretty reasonable costs, but theoretically they could bid themselves out of the market. It is up to them.

These insurance actuaries are pretty smart. They know how they can meet all of the requirements that they have. They have to be sure they cover the benefits they have promised. They have to provide those. They have to make a little profit, of course. They have to make sure the premiums are low enough so that people will sign up and, of course, most importantly in the beginning, they have to win the bid. If they do not win the bid, if they are so

high that nobody will sign up, well, then, there is no reason for them to be in the game in the first place.

They look at all of those things, and they figure out how much they can afford to bid, what the premiums will be, and so on. It is a pretty good plan, and I wish we could have been able to offer that to our seniors. But instead, the determination was made by Chairman GRASSLEY and others that we would take the key component of the President's plan with respect to the PPOs and write that up into the legislation, draft it up, and that section of the legislation says we are going to limit the number of bids because we really want to control the cost, and so we are going to say only the three lowest bids are going to succeed, and then the President proposed to pay the PPOs at the middle bid of the three bids.

So the insurance companies that bid have to figure out, how much is it going to cost us to provide care to each senior, and that is what they bid, but they have to be sure the bid is low enough that they win because only the three lowest ones will be accepted.

That is what President Bush proposed, and it is deemed to be a way of both providing a lower cost to the Government kind of care but a quality care because obviously people are not going to sign up and utilize it if they do not think it provides quality care.

There are a lot of things about the way PPOs operate that ensure good quality care. This is a good idea. The President proposed it, and that was the original idea in drafting this.

But then a very arbitrary thing happened. The people in this building know that everything we do has to be under the rules of the CBO, the Congressional Budget Office. Everything has to be scored by CBO. That is to say, we send it to CBO, and they tell us how much it is going to cost in their mind. When we said we were going to allocate $400 billion over 10 years to this new prescription drug benefit, we had to make sure that the CBO score fit within the $400 billion.

Well, CBO came along and they said this competitive bidding system was going to cost a lot more money—it was over a $100 billion—it was way more than Chairman GRASSLEY and Senator BAUCUS wanted to allocate to the preferred provider organization part of the system.

So they said, we have to do something that does not cost anything or does not cost very much. So they decided to solve the problem CBO had created by simply writing in, in effect, a limitation that said this will not cost anything because we are going to set it at the very same level as traditional Medicare payments. There is a complicated formula. I am not going to get into all the details, but essentially it is the higher of the Medicare+Choice payment rate or the traditional fee-for-service Medicare reimbursement level.

The bottom line is, they said we are going to cap the amount the PPOs could be reimbursed. If you want the contract, you can bid anything you want to bid, but you can't be reimbursed over a certain amount, and that amount is defined in statute. By definition, therefore, the score did not cost very much and therefore it could fit within this $400 billion. So they thought that might solve the problem.

But the problem with this is, it will not work. A lot of people realize it won't work, but we still have to comply with the CBO score, they say. I will get to a solution in a moment.

How do we know it won't work? CBO, the same organization that did the score, says all of 2 percent of seniors will sign up for this PPO alternative. Two percent. Why? Because this arbitrary capped rate is not going to be enough to provide the coverage for them that we promise. So why would they want to sign up with a PPO when they can get the coverage under traditional Medicare?

When I am eligible for Medicare, that is what I would do. I would not sign up if a plan cannot deliver the goods. CBO says only 2 percent will sign up. As a result, obviously, we have to find an alternative.

Let's go back to this question that CBO raised by its scoring and whether or not an arbitrary limit will actually work. CBO says it won't; only 2 percent are going to sign up.

Why do they say that? First, we have the experience of Medicare reimbursement over the last many, many years. Sadly, the government has a cap on what it pays the doctors and hospitals and other health care providers, too. We do that by statute. We say we are only going to pay you X amount if you do certain things and you cannot go above that.

What happens? After a while, there is so much upward pressure on that amount because it does not begin to keep track with inflation, especially health care inflation. Pretty soon the doctors are saying, we not only cannot make any money getting reimbursed at this low level, but we cannot pay our nurses, we cannot keep our doors open, there is no way we can stay in practice providing services to our senior citizens if you are going to pay this ridiculously low amount. In fact, a lot of doctors have retired, gotten out of the business, discouraged their kids from going into medicine, and we see real shortages, especially in certain specialties. There are other factors that lead to that as well, but this is a big one.

So every year or two, Congress, responding to that pressure, says: My goodness, we have to change that reimbursement level. It is too low. So then we have these big fits and starts where we hold it down for a while and then all of a sudden we raise it up to the level necessary to compensate the hospitals and the doctors and nurses to take care of our senior citizens. We did this for the physicians just a few months ago because they were getting cut significantly in the reimbursement rate and CBO said we paid $54 billion to fix the physician problem for basically one year. That is one-eighth of the amount of this entire bill, over a 10-year period, just to make sure that the cut did not go into effect last year for the doctors so they could stay in business.

We find there is supposed to be another cut in physician reimbursement levels this year, and again we are most likely going to have to make an adjustment.

The problem is artificial government controls, price controls, do not work. They do not work in Medicare any better than in rent control or the gasoline price controls we had in the 1970's or any other price controls. Free market countries like the United States have learned that lesson. Socialist countries have not. I would have thought we would have learned the lesson. But that is the way the Medicare system works. It is the perfect exhibit A if you want evidence of the fact these controls in providing health care services do not work. Just look at the reimbursement providers in Medicare today.

I mentioned it is a lot like rent control. There is always the inexorable pressure. Is it any wonder when you finally remove the rent controls that in some places the rents actually go up? The owners get enough to refurbish the place to keep it up and people are willing to rent the places that look a lot nicer and better than back when there were rent controls. Sometimes the prices do go up. That is the price of quality health care.

We should never get into the situation in this Congress where we are going to shortchange our seniors by trying to put artificial caps on what we pay the people who take care of them. It will not work.

There is no such thing as a free lunch. If you want quality health care, you are going to have to pay for it one way or another. It may work to have a price control for a little while, but it does not work for very long. We found that out, and that is why every couple of years we have to make the big adjustments.

So why would we think the price controls would work with the new preferred provider organizations that we are trying to establish as a credible alternative to traditional Medicare? A lot of people will find the benefits of those PPOs to their liking. Why do we think the price controls will allow them to work? CBO says it will not happen; only 2 percent will sign up. Clearly, we had to find a way out of this dilemma.

The bottom line is, under CBO's rationale, either nobody bids because they cannot get reimbursed or we have to do the constant adjustment. There is no adjustment provided for in this legislation. Or there is a modest adjustment, but not an adjustment that will take care of this problem.

What do we do to solve the problem? We do not want to create the PPO option and then destroy its effectiveness

before it can even work. I am very worried, to digress a moment, we will create some expectations on the part of our seniors that we cannot satisfy. That will be fundamentally wrong. It would be very wrong to suggest that we are going to do something for our seniors that, in fact, we are not doing. I, for one, am simply not going to be part of that. We cannot promise seniors an option that, in fact, we know, in advance will not work.

What is the solution? Obviously, the solution is to go back to the way we were going to do this in the first place, back to the President's proposal, and not have the arbitrary cap. Simply allow competitive bidding. Let the market decide what the right levels are. These people are smart. They will find the right level. It may be, in some areas, some time, below the Medicare reimbursement. That is what the Centers for Medicare and Medicaid Services, the organization that oversees these programs, believes. It may be the same. It may be more. It will be different from region to region and year to year. Let the market decide that.

Now, there was not enough money in the $400 billion to do this. So what happened was Chairman GRASSLEY and Senator BAUCUS were able to conclude that about $12 billion was available in the bill to be allocated for some purpose.

Very candidly, many Democrats did not want to do what I am suggesting. So they said you can only have half of the $12 billion to try to make your plan work. We want to use the other half to do something we want to do. What they want to do in the bill is perfectly reasonable, and I don't have any objection to the Grassley-Baucus amendment in that regard. In fact, I don't have any objection to most of the Grassley-Baucus amendment. I think it is a good amendment except for one thing.

What the amendment does for the $6 billion I spoke of, it says, starting in the year 2009, the Secretary of HHS can use competitive bidding that does not have this arbitrary payment cap on it, up to spending $6 billion if you have to spend it. The CBO scoring would suggest you could probably cover one or two of the 10 regions of the country if there were going to be 10 regions during one of the bidding cycles. It does not give us much of a chance to do this, but at least it establishes the principle.

The Secretary will at least have one chance, in one region, during one bidding period, to say at least in this situation we are going to eliminate our caps and see what happens.

Theoretically, if the bids come in below that cap, he still has the $6 billion to do that in another region. It is like somebody guaranteeing a loan. If the loans get paid off, then the person who guaranteed it never has to pay off. This is like $6 billion to guarantee the loan. This is $6 billion to see that the preferred provider organizations get paid, if in fact their bids exceed the Medicare cap level. It may exceed it; it may not.

Chances are, if it does not happen until 2009, which is the way the amendment is written, it will exceed it because of this pressure that inevitably builds when you have price controls keeping the prices down. So for 4 years the prices are going to be tamped down and finally then in the fifth year we get to go out to bids, and my guess is they probably will be higher and the proponents of the competitive bidding will say: See, we told you it would cost a lot of money. Of course. It might. If you tamp down something that the market would cause to rise a little bit every year and you tamp it down for 5 years and don't have some opportunity to adjust it, then naturally if you take the cap off it is going to rise. So CBO is probably correct, it probably will cost some money. That is the inevitable result of lifting the price control after you have kept things tamped down for too long.

The alternative, of course, is that there may not be any PPOs bidding because they cannot provide the services we have promised to seniors. But there is a little bit of an opportunity here to provide this unrestricted opportunity for bidding. That is what the amendment originally said that was drafted. I was originally going to be a cosponsor of the Grassley-Baucus amendment because even though it did not reestablish the competitive bidding process very much, there is a little sliver in there and at least we could go to conference, to the conference committee between the House and Senate, and argue that we had established the principle and we wanted to make sure that principle could continue on.

But, again, a funny thing happened. There were objections on the Democratic side to this process extending beyond the 5 years that it was in effect. What they said was you have to spend the $6 billion in that 5-year period. There will not be any money after that.

I said that's OK.

But then they said: And the authority to do this has to sunset at that moment, after 5 years. You cannot have the authority to do this, regardless of the cost, later on.

Later they said: Well, as long as it is cost neutral, but as I pointed out that is probably a false promise because of the price controls keeping the prices tamped down. So my amendment eliminates that sunset clause. It says: No, if this is a good idea, let it continue.

Ironically, if the CMS is correct, then it is not going to cost any more. And if CBO is correct, it is going to cost more and, as a result of that, we are going to have to have some alternative to the competitive bidding process with the price caps on it because there are not going to be any PPOs to offer the health care benefits. If, in fact, they cannot make it work under the money that is then available, there has to be an alternative available. That is why this should not sunset. It is why the authority to do this should continue on.

As to this point I just want to say I cannot imagine, after all the work that has gone into this—people have looked at how complex this is—we would think that we are smart enough in the Senate to know exactly what the price of this insurance contract ought to be for every Medicare beneficiary 10 years down the road. How do we know that? We cannot possibly know that. How do we know what a fair price for a Mercury automobile is going to be in 10 years? A price that is just exactly fair, that lets, say, Ford Motor Company make some money, just low enough to entice us to buy the car. We don't know that. That is why we have a free market. You charge whatever you want to charge and if it is a good deal, people will buy it; if it is not, they will not.

It is the same thing here. We are not smart enough to fix these prices and we are playing with the quality of health care of our senior citizens.

My fear is we are going to keep this ratcheted down so much that we will have an experience like we had not so long ago with the HMOs of this country, where they were squeezing the benefits and patients got pretty angry about it. They said, we don't want to have to go to a doctor we don't know, we don't want to have them tell us they can't see us for 6 weeks. We don't want them to say it would be nice to have a MRI or CAT scan but all we can give you is a X-ray. That is where the call for the Patients' Bill of Rights came in, and I supported it because I don't think patients should get squeezed down in their health care just because we are trying to save money.

Of course we want to save money. We are talking about taxpayer money here. But the whole concept of the preferred provider option, the private sector option, was to be able to save money in the long run for the Medicare system. That is why the President proposed it and why we, especially on the Republican side, said this is something we need to do to strengthen Medicare. We need to provide an option that will enable us to keep the costs of this under control as Medicare goes into the future. And for the reasons the majority leader articulated so well a moment ago, we believe these preferred provider organizations will be able to do that. So they can balance good quality care with efficiencies and effectiveness at cost control as well. That was the whole idea for it.

But we cannot get into a situation where we tie both hands behind their back and then tell them to go out and serve our senior citizens. We say: You can go do that but you can't get paid any more than X, and X doesn't go up unless we cause it to go up.

That is the reason for the fix that I proposed. It was in the amendment originally but then it was determined

that this had to be sunsetted. My amendment eliminates the sunset, allows the authorization for the pure competitive bidding to continue on. That is as simple as it is and is the primary reason why I did it.

Let me note a couple of other items. Some people, especially my friends on the Democratic side, have said, wait a minute here, this has to be balanced. And I said I agree. The drug benefit, according to CBO, right now in the bill, the underlying bill, is $402 billion over 10 years. It slightly exceeds the $400 billion. In the same bill we are spending $7.8 billion over 10 years on the PPOs and Medicare+Choice, which are the HMOs.

So it is $402 billion on the drug benefit, $7.8 billion on the PPOs and HMOs. I think we could afford to put a little bit more money toward ensuring that the PPOs can be successful here, that they will bid and provide these services to our senior citizens.

Another point: When we put these price controls on the providers, as we do today under Medicare, as I said, there is no free lunch. Somebody has to pay. What happens is that the private sector health insurance in our society is subsidizing Medicare. The hospitals and the doctors and all the other providers have to make it up somewhere and that is where they make it up. This raises the cost of private insurance. A lot of people find that very hard to pay. In fact, it takes some people out of the private insurance markets. So, ironically, one of the reasons not as many Americans are insured as should be is because the premiums are too high because the private sector has to subsidize the care that we are providing on the Government side of the equation through Medicare and Medicaid.

This price cap is going to further that subsidization, ironically at a time when millions of retirees are going to be leaving the private market because their employer will no longer want to provide a benefit that the Government is providing for at a taxpayer subsidy. So there is going to be a lot smaller private sector market to subsidize a lot bigger amount, which will cause more people to lose their insurance because of the higher cost of premiums. It does not make sense to underfund Medicare.

The final problem: Remember at the very beginning I mentioned the FEHBP, the Federal Employees Health Benefits Program. It is interesting that throughout the history of the FEHBP we have not had any of the problems I have been talking about here. Congress has rarely had to do anything to modify the FEHBP system. It works very well. Yet every year or so we have had to modify the reimbursement to Medicare providers in response to what we did through the Balanced Budget Act of 1997. We have had to do it ever since because we are not smart enough to know what every doctor in this country and every hospital ought to get paid to take care of us. Yet that is what we tried to say in the statute. So we have to keep changing it. Why would we want to not go with a system that we know has worked very well? We can do that by allowing this open bidding and allow the free market to work.

I think for all of these reasons it would be very wise for us to remove the sunset on the Grassley-Baucus amendment and let this process work, even a little bit, and show our colleagues in the House of Representatives and, frankly, all the country that we are committed to this principle of the free market ensuring the best deal for the American taxpayers but also the best deal for our senior citizens.

I am just going to close with this thought: Medicare is a mandatory system in the United States of America. There is essentially no option. When you are 65 years old, it is Medicare or no care. A doctor cannot take care of you outside of Medicare after you turn 65. There is only one exception, and that is if the doctor says: I will not treat any Medicare patients for a period of 2 years.

Now, we do not want to force our doctors into doing that. We want them to stay in Medicare, taking care of Medicare patients. But the only way a doctor can treat people outside of Medicare is to swear—there is a formal process for doing it—that he will not treat any Medicare patients for 2 years. We do not want them to do that, but that is the only way. You would have to find such a doctor. If your condition is diabetes, and that doctor is an orthopedic surgeon, you probably will not have too good of luck.

So most seniors do not have the option of searching around trying to find a doctor who works outside of Medicare because most of them do not do it. Fortunately, most of them stay in Medicare. But this is the only circumstance under which you can find a doctor outside of Medicare.

Since we are saying—literally mandating—that our moms and dads—pretty soon some of us—have to take the Government program for our health care after we turn 65—and nothing is more important to us than our health and our family's health—my mom's health—it bothers me a lot that we are setting up a system to take care of my mother that we know in advance is bound not to work. It promises a benefit it cannot deliver. But because of the scoring problem, we have to do it that way.

There is a better alternative: to take the time to do it right, to make the personal commitment to do it right, to understand there is no such thing as a free lunch—that I want to deliver the best quality care for my mother as I can because she does not have an option.

If she had an option to go into some other system, as they do in Great Britain, then I would not be quite as concerned.

But we are forcing everybody into a system, and then we are saying—as we tie its hands behind its back—now you make sure you can go out and serve, when CBO says only 2 percent of the people will sign up for that. So that means everybody is going to continue on with traditional Medicare.

Now, maybe that works for them, but we know there are going to be some huge problems not too far down the road with traditional Medicare. Are we going to be able to deliver the benefits we promised? If you look at the numbers, we are going to have big tax increases or we are going to have to go deeply into debt in order to do that.

There is an alternative, and that is this option I have been talking about. Because we are playing with real people's lives, and because the ultimate value here is the quality of medical care we are going to ensure our senior citizens get—because it is the only way they can get medical care—we have the highest obligation to give this matter our most serious attention and not simply rush it through because we want to finish the bill before the July Fourth recess—although I certainly understand the Secretary and our leadership's desire to try to do that to get the bill in conference—but to take enough time and to give it enough thought to do it right.

This is forever, in a sense. It is for a long, long time. And for those friends of mine who say, ''Oh, don't worry about it; we are going to make a lot of changes in this,'' how many changes have we made in some of the sort of ''sacred cow'' laws in the United States—things that everybody supports and so nobody wants to even suggest to change: Social Security, Endangered Species Act, Medicare itself?

It is easy to demagog these issues, and, as a result, Members are not very keen to make changes with them; you are accused of trying to destroy the program or whatever it might be. So I think my colleagues who say, ''Oh, don't worry; we'll fix it later,'' miscalculate the courage they are going to have later when they realize it has to be fixed.

The time to do it is now. The time to get it right is now. The President is right, this was the way to do it. And so, to support the President's program, I am offering this amendment to get back to what that program was. I hope my colleagues will support me in this because nothing less than quality health care for my mother and the rest of the senior citizens in this country is at stake.

Mr. President, I appreciate your patience, and I yield the floor.

Mr. ALEXANDER. Mr. President, I wish to voice my support for the inclusion of disease management as a permanent part of the Medicare fee-for-service program. I consider disease management a way to reform the fee-for-service program. I am concerned about the long-term fiscal viability of the Medicare program. As we add a much needed drug benefit to the Medicare program, we must do so in a way

that seniors can afford and that our country can afford. Consistent with a letter I signed to the President, I continue to look for ways that we can take this opportunity to reform the current program and ensure we keep the program strong for future beneficiaries.

I understand that the Medicare bill we are debating incorporates disease management as part of the new Medicare Advantage Program, so that private plans offer these services to beneficiaries and that there are several demonstrations to test out a variety of care management techniques in the traditional, fee-for-service program. That is a positive step in the right direction. But I think we need to go further.

I believe strongly that seniors will get better care in a private plan option under this bill, and I encourage them to do so. But I also know there will be seniors that choose to stay in traditional, fee-for-service Medicare. And these will likely be older seniors, the ones that do suffer from multiple chronic conditions and are in the most need for efficient management of their health care. I ask you, can we afford to allow these beneficiaries' health to worsen and to subsequently bear the enormous costs of their care? We cannot. I believe that adding disease management to the traditional-fee-for-service program is a way to reform the system, and to help bring down costs for these seniors. Disease management can reform the system to improve the long-term sustainability of Medicare.

Last week the House Ways and Means and Energy and Commerce Committees both voted in support of legislation that would incorporate disease management into all of Medicare—both private plans and the traditional, fee-for-service programs. I ask that as we move into conference, I hope we can accept the House language that phases in disease management as a permanent part of the Medicare fee-for-service program.

Without a doubt, it is critical to the health of seniors and to the pockets of taxpayers that we implement effective reforms such as disease management in Medicare now—to more rationally and effectively manage care for beneficiaries with chronic conditions, and to ensure the fiscal sustainability of the Medicare Program.

Mr. SMITH. Mr. President, I rise today with my colleague from North Dakota in support of critical drug coverage for beneficiaries who contend with the debilitating effects of multiple sclerosis.

This amendment would provide transitional coverage for the four FDA-approved therapies in the 2-year interim until 2006, when the prescription drug plan will take effect.

Approximately 400,000 Americans have MS. In my home State of Oregon, it is estimated that there are 5,800 people living with MS.

Currently, Medicare covers only one of the four FDA-approved MS therapies and only when administered by a physician. This amendment would cover all four MS therapies, including when they are administered by the patients themselves, providing better coverage and better care for Americans with multiple sclerosis.

While these therapies do not cure MS, they can slow its course, and have provided great benefit to MS patients. It is critical that MS patients have access to all approved drugs because some MS patients do not respond well to, or cannot tolerate, the one MS therapy that is currently covered.

Currently, many Medicare beneficiaries with MS are forced to take the less effective therapy, to pay the costs out of pocket or forgo treatment.

Equally, this amendment is important to rural Medicare beneficiaries with MS. By administering drugs themselves, rural beneficiaries can avoid the costs and hassles of traveling long distances to health care facilities to receive their MS therapy.

In the spirit of providing all Medicare beneficiaries with increased choice, MS patients need and deserve the full range of treatment choices currently available and self-administration helps ensure access to needed medications.

I urge my colleagues on both sides of the aisle to join me in support of this amendment and to provide adequate and comprehensive drug coverage for MS patients.

ADEQUACY OF MEDICARE PAYMENTS TO PHYSICIANS

Mr. SPECTER. Mr. President, I have sought recognition today to engage the distinguished chairman of the Finance Committee in a colloquy regarding concerns about the adequacy of Medicare payments to physicians.

Each year, Medicare payments to physicians are adjusted through use of a ''payment update formula'' that is based on the Medicare Economic Index, MEI, and the sustainable growth rate, SGR. This formula has a number of flaws that create inaccurate and inappropriate payment updates that do not reflect the actual costs of providing medical services to the growing number of Medicare patients.

As discussed above, the formula has resulted in numerous payment cuts to Medicare physicians. Earlier this year, Congress passed legislation as part of the fiscal year 2003 omnibus appropriations bill, H.J. Res. 2, that avoided an impending 4.4-percent cut in the Medicare conversion factor. This was accomplished by adding 1 million previously missed Medicare beneficiaries to the mix and recalculating the appropriate formulas. Although this change resulted in a welcomed 1.6-percent increase in the Medicare conversion factor for 2003, the Centers for Medicare and Medicaid Services', CMS, preliminary Medicare conversion factor figure predicts a 4.2-percent reduction for 2004. The reason for this latest reduction stems from the fact that the current formula that originally resulted in the need to fix the 2003 conversion factor cut, is flawed. The latest scheduled round of payment cuts will make Pennsylvania's Medicare practice climate untenable.

In its March 2003 report, the Medicare Payment Advisory Commission, MedPac, stated that if ''Congress does not change current law, then payments may not be adequate in 2003 and a compensating adjustment in payments would be necessary in 2004.'' We owe it to America's physicians to fix the system so that they can continue to provide Medicare beneficiaries with the vital care they need.

With 17 percent of its population eligible for Medicare, the Pennsylvania Medical Society has calculated that Pennsylvania's physicians have already suffered a $128.6 million hit, or $4,074 per physician, as a result of the 2002 Medicare payment reduction. If not corrected, the flawed formula will cost Pennsylvania physicians another $553 million or $17,396 per physician for the period 2003–2005. They simply cannot afford these payment cuts. I know you have worked very hard in preparing a bipartisan Medicare bill that represents a good solid beginning to improving our Nation's health care system. However, I firmly believe this is an issue that Congress must address.

Mr. GRASSLEY. Mr. President, I thank my colleague from Pennsylvania for raising this important issue. He is correct that I have been working with the physician community, as well as the U.S. House of Representatives, to obtain a fuller understanding regarding the adequacy of the current physician formula under Medicare. We have learned that Medicare's current payment formula for physicians is problematic, and I agree that this issue should be addressed. We will continue our discussion, and objectively evaluate proposals that will update the payment formula for physicians.

Mr. SPECTER. I thank the chairman for his willingness to work with me on this issue as the Prescription Drug and Medicare Improvement Act moves forward.

The PRESIDING OFFICER. The Senator from Missouri.

MORNING BUSINESS

Mr. TALENT. Mr. President, I ask unanimous consent that the Senate proceed to a period for morning business.

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

SALUTE TO THE 129TH MOBILE PUBLIC AFFAIRS DETACHMENT

Mr. DASCHLE. Mr. President, on July 12, the 5th U.S. Army will demobilize the 129th Mobile Public Affairs Detachment of the South Dakota National Guard. This unit, headquartered in Rapid City, was among more than 20 Guard and Reserve units from my State called to active duty in support

of Operation Enduring Freedom/Noble Eagle and Operation Iraqi Freedom.

Today, these soldiers and their service become a part of South Dakota's military heritage. Like those who served in the two World Wars, in Korea, in Vietnam and numerous other places, this new generation has answered the call. They have offered to make every sacrifice, including life itself, to protect our freedom and security. We must never forget them or the honor with which they served.

This unit participated in a mobilization with few precedents in South Dakota history. Nearly 2,000 Guard and Reserve troops were called to active duty in our State, by far the largest mobilization since World War II. At the time the fighting began, units from more than 20 communities had been called up, from Elk Point in the South to Lemmon in the North, from Watertown in the East to Custer in the West. Indeed, our State's mobilization rate ranked among the highest of all the States on a per-capita basis.

These soldiers were proud to serve, and their communities are proud of them. Across the State, thousands of citizens pitched in to participate in send-off parades, to lend a hand for families who suddenly had to get by without a mom or dad, and even to assist with financial hardships caused by the mobilization. This mobilization was a statewide effort, in many ways.

In addition to the service of this particular unit, I want to acknowledge the sacrifices and dedication of the families who stayed home. They are the unsung heroes of any mobilization. They motivate and inspire those who are far from home, and they, too, deserve our gratitude.

Today, I join these families and the State of South Dakota in celebrating the courage, commitment, and success of the members of the 129th Mobile Public Affairs Detachment, and I honor their participation in this historic event in our Nation's history. Welcome home. Thanks to all of you for your courage, your sacrifice, and your noble commitment to this country and its ideals.

NATIONAL PEACE ESSAY CONTEST

Mr. DASCHLE. Mr. President, I am honored today to present to my colleagues in the Senate an essay by Collette N. Roberts of Rapid City, SD. Collette is a student at St. Thomas More High School, and she has been awarded first place in the 16th annual National Peace Essay Contest for South Dakota. ''Justification of War: the Anglo-Zulu and Kosovo Wars'' examines the Anglo-Zulu war of the late 19th century as a paradigm for understanding Kosovo's struggle against the military campaign of Slobodan Milosevic's Serbia. Collette has tackled a vitally important subject with insight and maturity. I can only hope that she continues to share her wisdom with the world, and I commend her essay to my colleagues' attention. I ask unanimous consent that Collette Roberts's essay be printed in the RECORD.

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

JUSTICIFACTION OF WAR: THE ANGLO-ZULU AND KOSOVO WARS

(By Collette N. Roberts)

''. . . this has never been and never can be/ one territory under two masters'' (Judah, 2000, p. 4). The line in the poem by Anne Pennington and Peter Levi holds the ring of truth. Many wars have been waged over a piece of land such as the Anglo-Zulu and Kosovo Wars. The circumstances surrounding these wars are similar, but are justified only in part. In both wars, one side had reached the last resort: either defend their homeland or face subjugation. Both were waged by legitimate authorities; however, nothing justifies the genocide of a race and the slaughter of innocent civilians. Upon examination, the justness of the Anglo-Zulu and Kosovo Wars and NATO involvement in Kosovo is subjective, contingent upon the motives and actions of each party.

The eighteenth and nineteenth centuries mark the imperialistic age for Great Britain. by the 1870s, most of South Africa had succumbed to British rule. Zululand, however, one of the last independent African states in the region, presented challenge to an advancing white frontier (The Diagram Group, 1997, p. 105). Not only did the independent state disrupt Britain's confederation plans for the region, but also prevented sugar farmers from using the spacious tracts of land within the boundaries of Zululand. Furthermore, as long as the Zulu remained independent, they could not be sued for cheap labor. Zululand became a dollar sign in the eyes of the British. When the Zulu defied British subjugation, war inevitably ensued (Gump, 1949, p. 3).

British military forces, commanded by Frederick Thesiger (better known as Lord Chlemsford), began the invasion of Zululand in 1879. The Zulu, under the rule of King Cetshwayo, rose to defend their homeland. The first major battle occurred at Islandhlwana. Losses were heavy to both armies; but the Zulu, underestimated by the British, claimed victory. To justify his actions, Dabulamanzi, a Zulu general, said, ''It is the whites who have come to fight with me in my own country and not I that do to fight with them'' (Gump, 1994, p. 54).

Despite the intensity and valor with which the Zulu fought, the battle oNdini marked the end of the Anglo-Zulu War. Poorly provision and outgunned, the Zulu military system was broken. Between six and ten thousand Zulu men died defending their homeland (Knight, 1995, p. 270). Following the war, the British began decentralizing the Zulu royal house. Zululand was carved into thirteen regions, each headed by British sympathizers. Finally subjugated, young Zulu men soon found themselves traveling outside Zululand in search of work. The system of migrant labor, as in other parts of south Africa, had at last taken hold of Zululand. The economic seeds of apartheid, the racist system of black oppression, had been sown (Knight, 1995, p. 272).

Those, like the Zulu, who are invaded by a conquering power are faced with only two choices: subjugation or was (Gump, 1994, p. 3). Though the chances for success were poor for the Zulu, war was the only chance to defend their homeland and preserve their way of life. When the British could not easily lay their hands on what they wanted, they believed they had reached the last resort, and therefore initiated war. These attitudes are common throughout all imperialistic societies. Britain justified its actions through claims to ''savage'' Zulu; to expose them to a ''new and better way of living'' (Gump, 1994, p. 14). However, war, from the imperialistic standpoint not be the final option when a piece of land and the promise of a profit are found to be superior to human life.

The Anglo-Zulu War is not the only confliction history that has occurred over a piece of land. For centuries, opposition has brewed between the Serbs and Albanians of the Balkans. The source of conflict is Kosovo, a province of Serbia, sharing borders with Albania (Andryszewski, 2000, p. 9). The claim of the area is bitterly disputed between the Serbs and the Albanians. Serbs hold that, despite the ethnic shift only a few generations ago, the people of Kosovo have been primarily serbian. The Albanians, on the other hand, argue that their ancestors, the ancient Illyrians and the Dardanians, habituated the region prior to the Slavic invasions of the sixth and seventh centuries. Therefore, they believe, Albanians have the right to what they call ''first possession.'' The truth concerning the claim of Kosovo is unclear. However, as in most cases, the truth is not what matters, but rather is what the people believe the truth to be (Judah, 2000, p. 2).

In April, 1987, a politician from Belgrade delivered a speech glorifying the Serbian nation. Because of high tensions between the Albanians and the Serbs, biased speechmaking had been against certain unspoken ''rules'' in Yugoslavia. However, by the end of the year, he became the most powerful politician in Serbia (Andryszewski, 2000, p. 18). In 1991, Milosevic began his war in Bosnia for a ''Greater Serbia.'' By the time the Dayton Peace Agreement had been approved and signed, hundreds of thousands of Muslims and Croats had fallen victim to the program of ''ethnic cleansing,'' driven from their homes, tortured, raped, and murdered (Andryszewski, 2000, p. 20). Despite the declaration of peace, Milosevic's ambitions for a ''Greater Serbia'' had not been eliminated. His ambitions soon turned toward Kosovo.

Kosovo remained under the harsh rule of Serbia. In 1997, the Kosovo Liberation Army (KLA), a small guerrilla force, began to wage a war against Serbian authorities. Alone, the KLA's chances for a sweeping victory were slim. However, the worthy cause of self-defense justifies their actions. The occasional skirmishes between the KLA and Serbian authorities culminated in the Serbian massacre in Drenica where dozens of ethnic Albanian civilians were slaughtered (Andryszewski, 2000, p. 30). Despite NATO threats of airstrikes to end the fighting, the violence between the Albanians and Serbs continued to escalate. In January, 1999, Serbs massacred forty-five ethnic Albanians in the Kosovar village of Racak. NATO, acting as a peace-keeper gave the Serbs and Kosovar Albanians an ultimatum: make peace or face NATO military action. The Albanians were willing to make peace, but all agreements proved futile when Milosevic refused to sign (Andryszewski, 2000, p. 33).

Far from any kind of last resort, Milosevic, wielding the power of a legitimate authority, instigated a massive Serb military attack on Kosovo. Kosovar Albanians, both military and civilian, were his paramount targets. A campaign of ethnic cleansing, echoing that of Bosnia, was launched on the Kosovar Albanians. Homes were burned, women were raped, and men were slaughtered; mass graves, freshly dug, could be seen from the air (Andryszewski, 2000, p. 48). Milosevic justified his unjust actions through his call for a ''Greater Serbia.'' Again, the desire for a piece of land was put before the sanctity of human life.

When peace became impossible and violence continued, NATO was left with the last resort. As promised, NATO took military action to halt the Serbian offensive and its mass genocide of the Albanians. A reasonable chance for success was existent. Furthermore, there was the belief that the consequences of these aggressive actions would be better than the situation that would exist had these actions not been implemented. In March 1999, NATO airplanes and cruise missiles began bombing Serbian military targets. Ultimately, through the joint efforts of the KLA and NATO, Serbia withdrew from Kosovo seventy-eight days later and signed NATO peace agreements. By the time peace had been achieved, 900,000 Albanians had been removed from their homes in Kosovo (Andryszewski, 2000, p. 54). Another ten thousand lay dead—murdered by Serbs during their ethnic cleansing of Kosovo (Andryzsewski, 2000, p. 57).

Critics may argue that the decision to bomb Serbia may not have been the most effective course of action. Regrettably, serious mistakes were made and the bombings killed civilians, both Serb and Albanian. Furthermore, a bomb hit the Chinese embassy in Belgrade, killing three and wounding nearly two dozen (Andryszewski, 2000, p. 50). Despite these tragic events, had NATO not put pressure on Serbia to end its campaign of ethnic cleansing, the number of genocide victims would have only increased.

As demonstrated, one territory cannot serve two masters. The Anglo-Zulu and Kosovo Wars were waged because two parties tried to control one piece of land. Each party had reasons for taking part in the fight. Many factors come into play that do or do not justify these reasons. The Zulus and Albanians were justified by reaching the last resort and defense of their homeland. Though neither of these parties had any reasonable chance of victory, the justness of their cause is in no way lessened. NATO military action was justified in its attempts to check the violence. Britain and Milosevic, though legitimate authorities, valued land over human life. Their motives were unjust. Justice is blind, but will forever be weighed by our motives and actions.

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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 on September 22, 2000. A man looking to ''waste some faggots'' entered a gay bar in Roanoke, VA, and opened fire, killing Danny Overstreet, and injuring six others. Overstreet, sitting at a table closest to the gunman, dropped when a shot hit him in the chest. The 43-year-old gay man died within minutes, despite efforts to help him. The other six victims eventually recovered. A witness told police that the gunman—a vocal antigay advocate—had asked directions earlier in the evening to gay bars in the Roanoke area.

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.

SUPREME COURT AFFIRMATIVE ACTION DECISION

Mr. KENNEDY. Mr. President, on Monday, in a landmark decision, the Supreme Court made clear that colleges and universities can adopt admissions policies that take students' racial and ethnic background into account to achieve a diverse student body. The Court's decision is a resounding vindication for the fundamental principle that affirmative action can be used in education to promote opportunity for all, and encourage interaction among students of diverse backgrounds.

Our diversity is our greatest strength, and this decision recognizes the broad benefits of diversity in higher education. A diverse student body benefits all students at our colleges and universities and helps prepare students for our increasingly diverse workforce and our diverse society.

As the opinion of Justice O'Connor states, ''Major American businesses have made clear that the skills needed in today's increasingly global marketplace can only be developed through exposure to widely diverse people, cultures, ideas and viewpoints.'' High-ranking military leaders, too, have stated that affirmative action is necessary for promoting a ''qualified, racially diverse officer corps,'' to enable the Armed Forces to protect national security.

The Court's decision supports the paramount importance of education as a gateway to equal opportunity, reaffirming once again the Court's historic decision nearly 50 years ago in Brown v. Board of Education. Few areas are as vital to sustaining our democracy that education. Our institutions of higher education, like our public schools, are indispensable in broadening the minds of young adults, and training them for leadership.

As the Court stated in Brown, and emphasized again in Monday's opinion, ''Education is the very foundation of good citizenship.'' The Nation is becoming increasingly diverse, and it is important for all our institutions to reflect that rich diversity.

The Court stated: ''In order to cultivate a set of leaders with legitimacy in the eyes of the citizenry, it is necessary that the path to leadership be visibly open to talented and qualified individuals of every race and ethnicity. Access to education must be inclusive of talented and qualified individuals of every race and ethnicity, so that all members of our heterogeneous society may participate in the education institutions that provide the training and education necessary to succeed in America.''

The Supreme Court has made clear that a well-crafted affirmative action admissions program like that of the University of Michigan Law School is constitutional. It is flexible and allows for individualized review of each applicant, and it is not a quota. The Court also made clear that States do not have to promote diversity only by relying on percentage plan programs which guarantee college admission to all students above a certain class-rank in every high school graduating class in the State.

As the Court recognized, such programs do not work for graduate and professional schools. In fact, percentage plans can prevent colleges and universities from making the individualized assessment of applicants that is necessary to assemble a diverse student body.

Our country has made extraordinary progress over the past half century toward equality of opportunity in all aspects of our society, and affirmative action has been an indispensable part of that success. But we all know that we have to do more to make the promise of Brown a reality. Even with affirmative action, vast inequities remain in access to higher education especially for African-Americans and Latinos.

We know that civil rights is still the unfinished business in America. Half a century after Brown, our schools remain starkly divided along racial and ethnic lines, and minority children are too often relegated to inadequate schools. We have to do more to see that minority children are not forced to think of an institution like the University of Michigan as an impossible dream. This decision by the Supreme Court is another major step by the Court to make that dream possible, and it is difficult to believe that either this Congress or this President would approve a Supreme Court nominee who would reverse that decision.

Mr. FEINGOLD. Mr. President, it has been nearly 50 years since the Supreme Court ruled segregation in schools unconstitutional in Brown v. Board of Education of Topeka, Kansas. Then-Chief Justice Earl Warren said: ''We conclude that in the field of public education the doctrine of 'separate but equal' has no place. Separate educational facilities are inherently unequal.''

This week, the tenet of equality that lies at the foundation of the Brown decision was reaffirmed and strengthened. In fact, it is becoming more and

more infused into our Nation's increasingly diverse identity.

This week, the U.S. Supreme Court reaffirmed the principle that diversity is a compelling national interest and that race can be a factor in higher education admissions decisions. The Court upheld the admissions policy at the University of Michigan Law School in Grutter v. Bollinger.

Justice Sandra Day O'Connor, on behalf of the 5-to-4 majority and citing Brown, wrote: ''This Court has long recognized that 'education . . . is the very foundation of good citizenship.''

Justice O'Connor and the Supreme Court found the use of race in the Michigan Law School admissions policy consistent with the aspirations of the 1954 Supreme Court in deciding Brown. O'Connor stated for the Court:

> In order to cultivate a set of leaders with legitimacy in the eyes of the citizenry, it is necessary that the path to leadership be visibly open to talented and qualified individuals of every race and ethnicity. All members of our heterogeneous society must have confidence in the openness and integrity of the educational institutions with which the law interacts . . . Access to legal education (and thus, the legal profession) must be inclusive of talented and qualified individuals of every race and ethnicity, so that all members of our heterogenous society may participate in the educational institutions that provide the training and education necessary to succeed in America.

The Court's decision keeps this country on a path toward the day when our children and our children's children will not be able to envision a pre-Brown v. Board America. In fact, Justice O'Connor cites the Brown opinion in writing the Grutter decision. Justice O'Connor's words reflect a powerful American value that is really a strength of our Nation—diversity. It is in the best interest of all Americans to seek diversity in all segments of our society, including educational institutions, the military, and the workplace. To fail to do so, in fact, would be to misrepresent our national identity.

I am heartened, by the large number of amicus briefs filed in support of affirmative action. These briefs showed the Court the deep importance of diversity to so many people and institutions across the Nation. I am pleased to have had the opportunity to join Senator KENNEDY and several of our colleagues in signing one such brief, urging the court to uphold the Bakke decision and support Michigan's admission policies.

One of the greatest strengths of our Nation is its guarantee of equal educational opportunities for all students. Our Nation's colleges and universities are the envy of the world for their rigorous courses of study and high-caliber professors, but also for their enriching environment of students from a range of racial, ethnic, and social and economic backgrounds representing every part of America, if not the world. I am proud that the Court has affirmed the importance of campus diversity and deemed it a constitutionally permissible governmental interest.

In the Grutter case, the Court decisively allowed race and ethnicity to be considered in combination with other factors in an admissions decision. I don't believe that the decision striking down the specific point system used in the undergraduate admissions policy will be a serious impediment to the implementation of race-sensitive admissions policies at colleges and universities.

In the 50 years since the walls of segregation began to crumble, we have traveled many miles on the road toward guaranteeing civil rights to all Americans. But this week's decision affirming diversity as a compelling national interest—and thus declaring affirmative action constitutional and viable—confirms our Nation's progress in ways unmeasurable by miles or years. The Court's decision is more than a victory. It is a milestone. It is a testament to the strength of Brown and our Constitution's equal protection guarantees.

HONORING AMERICAN AND KOREAN VETERANS OF THE KOREAN WAR

Ms. MURKOWSKI. Mr. President, today marks the 53rd anniversary of the official beginning of the Korean war.

Korea has often been called the forgotten war, but for the thousands of Alaskans who are veterans of that war it is hardly forgotten. The memory is with them daily.

The heroic American and Korean veterans of that war fought under the most adverse circumstances to free the people of the Republic of Korea from the yoke of Communism.

These veterans learned the hard way the lesson that is engraved on the Korean war Memorial here in Washington, ''Freedom is not free.''

While today marks the beginning of the Korean war, this anniversary does not mark the beginning of the war between freedom and Communism in that troubled country. From the moment that the Korean peninsula was divided in 1945, that battle had begun.

While Korea was one of the first examples of Imperial Japan's lust for land when it became a Japanese possession in the wake of the Russo-Japanese War at the beginning of the twentieth century, it was a side show in World War II. The U.S. had no plan for what to do with Korea when the war was over.

Although we had had U.S. representatives—governmental, business and missionary—in Korea from 1882 until the outbreak of the war, we made no plans for what would happen when at war's end, we might return to Korea.

The United States remained committed to the December 1945 decision of the Allied foreign ministers in Moscow that a trusteeship under four powers, including China, should be established with a view toward Korea's eventual independence. As a result, we were slow to draw-up long-range alternative plans for South Korea.

We had made no decisions on how to govern Korea, or to assist Korea in governing itself. We had not made plans for the defense of the country, nor for its economic development. We didn't even have a plan for how we might accept a Japanese surrender on the peninsula.

The most convenient way to deal with the surrender issue was to allow the Soviets to accept the surrender in the north and for U.S. forces to take the surrender in the south. Such a division of Korea, which to modern eyes, seems so normal on our maps, was totally foreign to the long history of Korea. Further, the division, which was drawn on a large-scale map in the Pentagon and had no rational basis on the actual terrain, did not represent any known political division of the peninsula. When it took place, it left freedom loving Koreans in the north and communist insurgents in the south.

The Korean war did not begin with the full scale invasion of the Republic of Korea on June 25, 1950. It had been underway as an insurgency in the south since, at least, 1946. One of the first tasks facing the United States was to train and replace existing Japanese police and security forces. The United States, with insufficient forces in-country to deal with the insurgency problem, acted quickly to stem the insurgency by creating a Korean defense force to combat it.

This Korean Constabulary, consisting of Korean veterans of the various armies who had fought World War II in the area, was led by U.S. officers and fought under U.S. orders. The Constabulary had an initial force of 2,000 men in 1946, but built up to approximately 26,000 over the next two years.

It was equipped with the very little military materiel left behind by U.S. forces as they withdrew. The young American officers, mostly reservists, with few regulars had little in the way of education, language or experience for their task, but they had good will and a devotion to duty which they infused in their Korean troops. In contrast, the army that the North Koreans were forming north of the divide was well equipped with Soviet equipment and led by well trained and well indoctrinated communist zealots.

While all out invasion would wait until 1950, substantial insurgency and guerrilla warfare was a constant theme in the southern half of the peninsula from 1946 to 1948. When the Republic of Korea was founded in August of 1948, the Korean Constabulary became the Korean Army and brought with it a level of devotion to country and duty which has been, since that time, the envy of most of the world's fighting forces.

Today is a time, therefore, not just to remember the heroic men and women who served from 1950 to 1953, but to honor the heroic Koreans and Americans who defended Korean freedom in the days before 1950.

CIVIL LIBERTIES IN HONG KONG

Mr. FEINGOLD. Mr. President, 8 months ago I took the floor in this Chamber to call attention to some disturbing trends with regard to democracy and civil liberties in Hong Kong. I said that Hong Kong's rulers, at the behest of Beijing, were set upon a path that risked destroying the spirit and vitality that make Hong Kong unique. I urged those who care about Hong Kong, and about freedom, to speak out and alert Hong Kong authorities to the error of their ways. Many did so.

Today, I regret to report, Hong Kong is one step closer to becoming just another Chinese city. Hong Kong's Legislative Council is expected to vote into law next month antisubversion legislation that would significantly erode the barriers that insulate Hong Kong's residents from the antidemocratic legal concepts and practices of the People's Republic of China.

As I said here last October, China's leaders pressured their hand-picked Chief Executive in Hong Kong, Tung Chee-Hwa, to introduce this legislation last year. Hong Kong authorities maintained that they had no choice but to comply, since Article 23 of the Basic Law that became Hong Kong's constitution after the territory reverted from British to Chinese control in 1997 required Hong Kong to adopt laws to protect national security. Many Hong Kong legal experts disagreed. But be that as it may, the same Basic Law says the territory will move toward electing its legislature and executive by universal suffrage. At present, only one-third of the legislators were chosen by direct popular vote, and only 800 of Hong Kong's 7 million residents were allowed to cast ballots in Tung Chee-Hwa's reelection as Chief Executive last year. The Government has yet to announce any plans to expand suffrage.

The sequence of these steps is important. Pushing through legislation curtailing civil liberties to comply with Article 23 before establishing a democratic legislature per Article 68 violates the most fundamental tenet of popular rule—that governmental authority is derived from the consent of the governed. The Hong Kong authorities invited public comments on the legislation, both in its initial outline form and later detailed drafts. But despite serious objections from journalists, lawyers, chambers of commerce, human rights activists, religious groups, and other interested parties, the bill on which the Legislative Council is expected to vote next month reflects only minor revisions from the Government's original draft. Without a legislature accountable to the citizenry, the people were free to speak their views, but the Government was free to ignore them.

As a result, most of the concerns I raised about the legislative proposal last October remain unaddressed:

Definitions of offenses such as ''subversion,'' ''sedition'' and ''secession'' are extremely vague, permitting security officials to prosecute people arbitrarily, as they do on the Mainland.

Merely ''handling'' publications the authorities consider to be ''seditious'' would be a criminal offense, as would ''intimidating'' the Government in Beijing or acting to ''disestablish'' the ''basic system'' of China—meaning the political monopoly of the Communist Party—or endangering China's ''stability.''

''Inciting'' subversion, even if only through speech, would be criminalized. In China, workers have been given long prison sentences for ''inciting subversion'' for simply demanding to be paid. Others have received 10-year terms for criticizing the Government on the Internet.

Hong Kong affiliates of organizations that Beijing decides threaten national security may be banned. This provision is likely to be used to ban Falun Gong, and conceivably it could be applied to the Roman Catholic Church if it does not renounce its ties to Rome. Hong Kong groups that monitor human rights and labor conditions in China have also been labeled ''hostile foreign elements'' by Mainland authorities and thus could be targeted.

Police will be permitted to enter and search private residences and seize property without a warrant.

Journalists and others could be prosecuted for the unauthorized disclosure of official secrets or information related to Hong Kong affairs that are the responsibility of the Central Government. Recall that for 5 months, Mainland authorities treated information about SARS as an official secret, and the world learned about the epidemic only after it spread to Hong Kong. Disclosing that information was clearly in the public's interest. But this bill does not allow a public interest defense, nor is there any counterbalancing right-to-know or freedom-of-information legislation. If this bill becomes law, how long will it take us to find out about China's next epidemic?

These proposed revisions to Hong Kong's laws, demanded by Beijing, run counter to China's commitment in the 1984 Sino-British Declaration to preserve Hong Kong's civil liberties for at least 50 years following the handover. They would significantly undermine such internationally recognized basic human rights as freedom of expression, freedom of association, and freedom of conscience, and potentially threaten freedom of religion and the right to due process as well.

Hong Kong's democratic politicians, activists, attorneys, journalists, and other professionals are understandably alarmed about this legislation. To hear some of them tell it, passage of this bill will mean the end of Hong Kong as we know it. In reality, I suspect most Hong Kong residents would wake up on July 10 to find life in their city essentially unchanged. The effects of this legislation will appear only gradually and incrementally. The first to feel the impact will probably be groups on the margins of Hong Kong society, such as Falun Gong practitioners. Perhaps most Hong Kongers will say nothing, because they are not Falun Gong practitioners. But over time, they will come to find themselves living in a poorer place, and the world will be poorer as a result.

If this legislation passes in its present form, it promises to make Hong Kong poorer in more ways than one. Last December, the American Chamber of Commerce in Hong Kong wrote the Government to express its concern about the bill's potential impact on the free flow of information, which it said was essential for the operation of Hong Kong's markets and for maintaining its competitiveness as a business location. The letter came a few weeks after a senior analyst at Bank of China International resigned after China's Premier criticized one of his reports. The British Chamber of Commerce warned Hong Kong could become ''a much less favorable location for international business'' if investors could not obtain free and unfettered information. Some analysts have suggested that investment on the Chinese Mainland could suffer as well, since foreign firms operating in China often rely on their Hong Kong offices for uncensored information about the Mainland.

Through the United States-Hong Kong Policy Act of 1992, Congress made support for human rights and democratization in Hong Kong a fundamental principle of United States foreign policy. As a concrete expression of support for Hong Kong's continued autonomy, the act stipulated that Hong Kong would continue to receive the same treatment under most United States laws after the handover as it had before. However, it allowed the President to suspend that provision on a case by case basis, whenever he determined that Hong Kong was no longer sufficiently autonomous to justify being treated differently from the rest of China under a particular law. This is not a decision the President should take lightly. However, if the proposed legislation compromises the independence of Hong Kong's judicial system or the integrity of its financial markets, as some analysts fear, the President would have no choice but to review specific United States statutes to evaluate whether separate treatment for Hong Kong can still be justified.

I hope we never get to that point. I hope that Hong Kong's freedom and its creativity can be preserved and that its people will be given more say in how they are governed, not less. For that reason, I urge those in the Hong Kong Government and Legislative Council who care about Hong Kong's future—and I am sure most of them do—to turn back from the course they are on before it is too late.

CBO COST ESTIMATE

Mr. SHELBY. Mr. President, I ask unanimous consent that the Congressional Budget Office cost estimate for S. 498, the Joseph A. De Laine Congressional Gold Medal bill, be printed in the RECORD.

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

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 19, 2003.

Hon. RICHARD C. SHELBY,
Chairman, Committee on Banking, Housing, and Urban Affairs, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed estimate for S. 498, a bill to authorize the President to posthumously award a gold medal on behalf of Congress to Joseph A. De Laine in recognition of his contributions to the nation.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Matthew Pickford.

Sincerely,

DOUGLAS HOLTZ-EAKIN,
Director.

Enclosure

S. 498—A bill to authorize the President to posthumously award a gold medal on behalf of Congress to Joseph A. De Laine in recognition of his contributions to the nation

S. 709 would authorize the President to award posthumously a gold medal to Joseph De Laine Jr. to honor Reverend Joseph Anthony De Laine on behalf of the Congress for his civil rights contributions to the nation. The legislation would authorize the U.S. Mint to spend up to $30,000 to produce the gold medal. To help recover the costs of the medal, S. 498 would authorize the Mint to strike and sell bronze duplicates of the medal at a price that covers production costs for both the medal and the duplicates.

Based on the costs of recent medals produced by the Mint, CBO estimates that the bill would not significantly increase direct spending from the U.S. Mint Public Enterprise Fund. We estimate that the gold medal would cost about $25,000 to produce in fiscal years 2003 and 2004, including around $5,000 for the cost of the gold and around $20,000 for the costs to design, engrave, and manufacture the medal. CBO expects that the Mint would recoup little of its costs by selling bronze duplicates to the public.

S. 498 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would not affect the budgets of state, local, or tribal governments.

The CBO staff contact for this estimate is Matthew Pickford. This estimate was approved by Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

TRIBUTE TO JANINE LOUISE JOHNSON

Mr. HARKIN. Mr. President, it is with great sadness that I pay tribute to Janine Johnson, who for over 12 years served the Senate, its Members and staff as an assistant counsel in the Office of Legislative Counsel. Janine died on May 29, 2003 at the far too young age of 37.

In reality, there is little my words can add to the memorial Janine herself built through her outstanding legal skills, extraordinary dedication and uncommon kindness and personal grace. She will be remembered for her positive impact on the laws she helped so much to enact and for the example and fond memories she has left her colleagues and friends.

Janine came to work in the Senate Office of Legislative Counsel with an already full set of accomplishments: first in her high school class of 333 in Winchester, Massachusetts; National Merit Scholar; cum laude graduate of both Harvard College and Harvard Law School; a federal circuit court clerkship with Judge Cecil F. Poole on the United States Court of Appeals for the Ninth Circuit; member of the Massachusetts Bar.

We are fortunate that Janine built on that record by bringing her excellent qualifications and talent to the Senate. Beginning in February of 1991, she drafted many bills and amendments for committees and individual members and their staffs. Her work, which was primarily in the areas of the environment, public works, agriculture, nutrition and natural resources, contributed to a long list of enacted legislation.

In addition to numerous environmental and public works laws, including the Water Resources Development Acts of 1996 and 2000, and the Transportation Equity Act for the 21st Century of 1998, Janine contributed greatly to writing the Federal Agriculture Improvement and Reform Act of 1996 and the Farm Security and Rural Investment Act of 2002. And though her efforts helped better our Nation, and even other parts of the world, only a very few people have any idea or appreciation of Janine's work.

That is just the way Janine would have it. She was a private person who did not seek the limelight. Instead, she quietly went about doing excellent work as the consummate professional she was. She was meticulous, detail-oriented and precise, as one would want someone drafting important legislation to be, with an uncanny ability to take concepts and ideas and shape them into exact language carefully crafted to fit into the federal statutory scheme. To cite an example, Janine was the lead legislative counsel in drafting the nutrition title of the 2002 farm bill. Especially in a bill as extensive and complex as the farm bill, it is the rule that drafting errors are to be expected. To this day, not one error has been found in the drafting of the 2002 farm bill's nutrition title.

Janine willingly put in the extra hours so often required to produce such high-quality work while meeting the demanding time constraints of the legislative process. She was a very patient and stabilizing force in what are frequently pressurized circumstances—someone who also took pride in cultivating and maintaining good relations with both sides of the aisle and all sides of the various issues she worked on.

In short, Janine Johnson exemplified the fine professional qualities that are characteristic of the Senate Office of Legislative Counsel. She distinguished herself by setting a high standard within an office known for its high standards.

Janine's death is a terrible loss, and yet as we consider her very substantial and lasting accomplishments and contributions—and more importantly the memories of her that live on—it is fitting to recall the words of John Donne:

Death be not proud, though some have called thee
Mighty and dreadfull, for, thou art not so,
For, those, whom thou think'st, thou dost overthrow,
Die not, poore death, nor yet canst thou kill me.

I offer my condolences and kind wishes to Janine's family, friends and colleagues as they mourn her passing.

CREATING AN ASSISTANT SECRETARY FOR MANUFACTURING IN THE DEPARTMENT OF COMMERCE

Mr. VOINOVICH. Mr. President, I rise today to ask my colleagues' support for legislation I have introduced creating the new position of Assistant Secretary for Manufacturing in the Department of Commerce.

In America we are blessed with ingenuity, gumption, and a can-do spirit that is recognized around the world. At the turn of the last century we helped lead the world into the Industrial age. American inventors gave electricity and air travel to the world.

As we enter the 21st century, American manufacturing has as much potential as it has ever had at any time in our Nation's history. Accomplishments in the high-tech industry have been rapidly integrated into manufacturing to make our factories and our workers more productive, reduce costs, and save time.

At the same time, substantial new trade, training, energy, labor, and foreign competition challenges have arisen. Helping our manufacturing interests deal with these challenges is something that private sector organizations such as the National Association Manufacturers have done well for years. It only stands to reason that we focus resources in the Government sector in support of manufacturing as well.

I am concerned about the slow economic recovery and our Nation's declining position in the global marketplace, particularly for manufacturing, which is the backbone of our economy, both in Ohio and the Nation. There is a genuine panic by the manufacturing community over their future and the jobs created from manufacturing. They feel they are under siege from environmental regulations, rising health care costs, litigation, escalating natural gas costs, and the prospect of dramatically higher electricity costs if energy reform legislation is not passed.

First, health care costs continue to rise. Nationwide, we have seen double-digit increases in health care premiums over the last 2 years alone. In

Ohio, the business community tells me they are seeing 20 to 50 percent increases in their health care costs. These increases raise labor costs, decreasing capital that otherwise would be available to make investments, and, ultimately, negatively impact our global competitiveness. In addition, these costs are being passed on to employees, limiting their take-home pay and increasing the number of uninsured.

Second, high natural gas prices are also having a detrimental effect on industry in Ohio and across the Nation. Many industries cannot compete internationally because of these high prices. Over the last 10 years, the average price for natural gas has been less than $3.00 per million cubic feet (Mcf). This year, companies in Ohio have been paying almost $10.00 per Mcf, more than a threefold increase. These price spikes are felt the hardest by Ohio's agriculture, chemical, and manufacturing industries. In order to be competitive, we cannot afford to hamper American companies in this manner.

Additionally, I have heard from companies in both the manufacturing and the chemical sectors that they cannot survive with these high prices. In particular, two chemical companies in Ohio have informed me that they are considering moving their operations not only out of Ohio, but outside of the United States because of these high costs. At the same time, suppliers of these companies are considering temporary shutdowns because they cannot afford to operate. Ohio's companies have not been able to budget and plan sufficiently because these prices have been so unpredictable this year.

As natural gas prices continue to rise, the President's National Energy Policy Task Force projects that over 1,300 new power plants will need to be built to satisfy America's energy needs over the next 20 years. As a result of the emissions limits and regulatory uncertainty triggered by the Clean Air Act, the Department of Energy currently predicts that over 90 percent of these new plants will be powered by natural gas. Further, analysis by EIA and the EPA shows that a large percentage of coal-fired plants are likely to be replaced by natural gas-fired plants in the near future.

Third, manufacturers need reliable transportation infrastructure to bring in supplies and ship out their products. We are a ''just in time'' economy and we are falling behind in our national investment in highways and bridges. According to the U.S. Department of Transportation, for each $1 billion of Federal spending on highway construction, 47,500 jobs are created annually. Furthermore, the Department estimates that every dollar invested in our highways yields $5.70 in economic benefits due to reduced delays, improved safety and reduced vehicle operating cost. Clearly, transportation investment in needed ''ready-to-go'' projects could go a long way in getting the economy back on track.

Finally, manufacturing companies are distressed by the surge in foreign competition, particularly from China. As a matter of fact, if a vote were taken today among Ohio manufacturers, many would oppose normal trade relations with China.

These are only a few of the challenges facing American manufacturers. Their profitability and survivability is impacted by virtually every policy and/or agency within the Federal Government. Moreover, the fact that there has been limited coordination of Government policies and agencies that impact manufacturing has contributed to a prolonged, steady decline of what I believe is the most critical sector of our economy.

According to USA Today, U.S. manufacturers laid off 95,000 workers in April—the 33rd consecutive month of decline and the largest drop in 15 months. Since July 2000, manufacturing has lost 2.6 million jobs. My own State of Ohio has lost 154,500 manufacturing jobs, over a 15-percent decline. New orders for manufactured goods in April decreased by $9.4 billion, or 2.9 percent, to $320 billion. This was the largest percent decline since November 2001. Shipments decreased by $7.1 billion or 2.2 percent to $320.6 billion. This was the largest percent decline since February 2002.

According to the National Association of Manufacturers, ''If the U.S. manufacturing base continues to shrink at its present rate and the critical mass is lost, the manufacturing innovation process will shift to other global centers. Once that happens, a decline in U.S. living standards in the future is virtually assured.''

Unfortunately, up to now, there has been no senior level policymaker responsible for examining prospective and existing Government policies to determine their potential impact on manufacturing. This is more than an unfortunate oversight; it is a potential economic disaster. Government policies are often developed without regard to their impact on manufacturing. Too many Government decisionmakers view manufacturing as a ''dying sector'' that is better transferred overseas so Americans can focus on the more profitable service sector. What these people fail to realize is that manufacturing is the foundation of the service sector.

There is no retail industry without manufactured products to sell. There is no transportation industry without manufactured products to transport. There is no repair industry without manufactured products to repair. Even services such as accounting, financial management, banking, and information technology sell their services to manufacturers and could not remain profitable without a vibrant manufacturing sector.

Manufacturing growth spawns more additional economic activity and jobs than any other economic sector. Every $1 of final demand for manufactured goods generates an additional 67 cents in other manufactured products, and 76 cents in products and services from nonmanufacturing sectors.

In fact, manufacturers are responsible for almost two-thirds of all private sector Research & Development—$127 billion in 2002. In addition, spillovers from R&D benefit other manufacturing and nonmanufacturing firms.

Manufacturing productivity gains are historically higher than those of any other economic sector. For example, over the past two decades, manufacturing averaged twice the annual productivity gains of the rest of the private sector. These gains enable Americans to do more with less, increase our ability to compete, and facilitate higher wages for all employees.

Manufacturing salaries and benefits average $54,000, which is higher than the average for the total private sector. Two factors in particular attract workers to manufacturing: one, higher pay and benefits, and, two, opportunities for advanced education and training.

Manufacturing has been an important contributor to regional economic growth and tax receipts at all levels of government. During the 1990s, manufacturing corporations paid 30 to 34 percent of all corporate taxes collected by State and local governments, as well as Social Security and payroll taxes, excise taxes, import and tariff duties, environmental taxes and license taxes.

Furthermore, manufacturing is a secure foundation for future economic prosperity. Capital investments in factories and equipment tend to anchor businesses more securely to a community, a State or a nation. When a corporation owns property in a community, they are more likely to be an active participant in helping improve the quality of life, stability, and economic vitality of that community.

Our competitors recognize this and are moving rapidly to claim the manufacturing preeminence that once characterized the U.S. economy. While America's industrial leadership is being squeezed by rising health care costs, runaway litigation, excessive regulation and some of the highest taxes on investment in the industrialized world, our foreign competitors are taking a larger market share with less expensive products that make it difficult to raise prices. The result is a dramatic decline in manufacturing cashflow that forces firms to cut back on R&D and capital investment, and to reduce employment. The U.S. manufacturing base is receding—and with it the all-important innovation that is the seedbed of our industrial strength and competitive edge.

Unfortunately, while many countries support their manufacturing sector with favorable government policies, tax incentives, and even financial subsidies, the United States does not even coordinate government initiatives that

might impact our own manufacturers. Within the U.S. Government, however, we do have Cabinet level Departments to represent the interests of agriculture, transportation, and energy. These three sectors combined do not generate as much economic activity, nor employ as many individuals as manufacturing. Nevertheless, there is no senior level policymaker anywhere in the Federal Government whose sole responsibility is the health and growth of manufacturing. Is it any wonder we are losing market share to foreign competition?

The bill I am introducing today will help rectify this unfortunate situation. It will establish an Assistant Secretary in the Commerce Department who will: one, represent and advocate for the interests of the manufacturing sector; two, aid in the development of policies that promote the expansion of the manufacturing sector; three, review policies that may adversely impact the manufacturing sector; and, four, assist the manufacturing sector in other ways as the Secretary of Commerce shall prescribe.

The new Assistant Secretary of Commerce for Manufacturing will also submit to Congress an annual report that contains: one, an overview of the state of the manufacturing sector in the United States; two, forecast of the future state of the manufacturing sector in the United States; and, three, an analysis of current and significant laws, regulations, and policies that adversely impact the manufacturing sector in the United States.

It is a small step forward but an important one. I look forward to working with my colleagues to enact this important legislation.

CONTROL OF STATE AND LOCAL POLITICAL INSTITUTIONS

Mr. ALEXANDER. Mr. President, I recently had the opportunity to read a book cowritten by a friend and law school classmate of mine, Professor Ross Sandler. The book, ''Democracy by Decree,'' cowritten by Professor David Schoenbrod, is a fascinating discussion of an issue that has bedeviled our democracy since the 1960's: the control of State and local political institutions by the Federal courts.

When I served as Governor of Tennessee, I had the opportunity to attend many meetings with my fellow Governors. I learned that at that time, the prisons in virtually every State were under the control not of the Governor but of the Federal courts, whose decrees governed almost all aspects of prison management. Many of these decrees had lasted for years and years, and most would continue in force past the time I left the Governor's mansion.

Under our Federal system, the enforcement of criminal laws had been left to the States. With all of these decrees in force, however, instead of elected officials controlling a central aspect of law enforcement, a small group of lawyers and judges in each State could and would dictate penal policy by controlling the decrees. Nearly all these cases started out with the salutary purpose of protecting the constitutional rights of prison inmates to be free of prison brutality. They ended up going much further than the Constitution required or even permitted. Federal judges in some States were deciding how hot the coffee had to be in the prison commissary or how often the windows had to be washed. Judicial decrees of this nature had lasted so long that no one quite knew how to terminate them, and prison officials even got used to them. Not only had prison officials become comfortable with judicial management, they sometimes even colluded with litigants to force elected officials to provide a greater percentage of government resources to the penal system, even when the Constitution did not so require.

When the situation of judicial abuse over the management of prisons came to the attention of Congress, this body responded effectively by enacting the Prison Litigation Reform Act, codified at section 3626 of title 18 of the U.S. Code. This law, largely developed by Chairman HATCH, Senator SPECTER, former Senator Abraham, and others, limits the period of time Federal judges could impose decrees managing State and local prisons. Under the act, a judicial decree governing prison conditions cannot remain in effect for more than 2 years, unless the issuing court reviews the conditions at the prison and affirmatively determines that the decree is still needed to remedy a current violation of law or the Constitution. The burden of proving the need for the continuation of the decree remains, as in the original suit, with the plaintiffs. The 2-year time limit applies equally to consent decrees and to decrees entered after trial.

I believe the Prison Litigation Reform Act has been effective at restoring control of State and local penal facilities to the democratic branches of the States. According to Professor Sandler, many of the 20 and 25-year-old decrees governing prison conditions have been terminated or modified. This very fact demonstrates that the constitutional shortcomings that had initially prompted many of the lawsuits had been fixed, but there was no effective mechanism for allowing political actors to resume control over these institutions. At the same time, however, there has been no evident impact on the ability of the Federal courts to protect prison inmates from current or ongoing violations of the law or the Constitution.

What the Prison Litigation Reform Act accomplished so successfully and in a carefully balanced way should serve as a model for Congress to emulate in other areas of Federal law. Federal courts, prodded by activists and plaintiffs' lawyers, have taken control through negotiated consent decrees of multiple State and local social programs. The same problems that bedeviled Governors, State legislators, and prison administrators before the Prison Litigation Reform Act now confronts those democratically responsible actors who seek to manage foster care, special education, mental health services, Food Stamps, and welfare programs. In many States and local communities, any number of these programs is under direct judicial supervision. As was the case with prison decrees, many of the orders governing these myriad social programs have been in place for many years, binding elected officials to obligations imposed for a different set of circumstances, with no requirement that the court review the underlying facts to determine if continued judicial oversight is warranted or appropriate.

As a former law clerk to one of this Nation's most eminent Federal judges, I know that judicial oversight can often be a crucial tool, sometimes the only tool, with which to vindicate people's constitutional or legal rights. I know that Federal judges did not seek to usurp the prerogatives of Governors, mayors, and legislators. Over time and often incrementally, however, they did so.

Judges, in fact, were and are often reluctant to intrude into the operations of government programs. When they seek to encourage a negotiated resolution, however, they empower plaintiffs' lawyers and government lawyers to negotiate and decide the outcome. Often, the parties to the negotiation find that they can make common cause, particularly in finding non-democratic means for improving programs and prying more money and authority from Governors, mayors, and legislators. Working behind closed doors, and unaccountable to the people, the lawyers and the activists negotiate elaborate decrees of hundreds of pages, often encrusted with horse trades that often have little or nothing to do with the law or the alleged violations but a lot to do with long-term agendas of the parties to the negotiations. Only a small cadre of people is involved behind these closed doors. And at the end of the process, these self-interested negotiators present the judge with a decree that reflects the ''consent'' of all parties but bypasses the democratic process. These decrees are put into effect, and often no one ever reviews whether the legal bases on which they may be founded remain viable. Instead, they remain in effect for years and years, tying the hands of elected officials, even if there is no violation of law to remedy.

Building on the proven model of the Prison Litigation Reform Act, Congress can and should limit the harm that institutional reform decrees do to local democracy without precluding judges from vindicating legal and constitutional rights when necessary. Congress ought to consider legislation in different areas to limit judicial decrees in institutional reform cases to correcting only actually proven systemic

violations of federal law or the Constitution. Further, Congress ought to allow courts to consider and make modifications of consent decrees in institutional reform cases any time a public official with an interest in the case has a good and compelling reason to seek changes. Finally, Congress should compel termination of decrees after a fixed time, unless plaintiffs demonstrate that current violations of law necessitating the continuation of the decree exist.

Reform by Congress of the general procedures governing judicial decrees in cases seeking reform of State and local government institutions along the lines suggested by Professor Sandler in his book will strengthen our State and local democratic institutions while ensuring the continued protection of constitutional and legal rights. I hope to look for opportunities to pursue and effectuate some of the proposals I have outlined above as the Senate considers relevant authorizing legislation. I hope many of my colleagues will join me in this effort.

ADDITIONAL STATEMENTS

IN HONOR OF THE NATIONAL UNDERGROUND RAILROAD FAMILY REUNION FESTIVAL AND ITS SPONSORS

• Mr. CORZINE. Mr. President, I rise to pay tribute to the Harriet Tubman Historical Society and the National Underground Railroad Family Reunion Festival. The William Still Underground Railroad Foundation, Inc. sponsors this national festival. Celebrating the rich history of those that sought their freedom and the freedom of others by following the North Star, the festival reunites families from throughout the country—particularly descendants of the many men and women who bravely constituted the Underground Railroad.

Descendants of William Still, who is considered by many to be the father of the Underground Railroad, have gathered to preserve their family's legacy for the past 133 years. They unite in celebration and in honor of Still and other pioneering gentlemen and gentlewomen who fought against the oppressive forces of slavery. William Still was a freeborn black who became a prominent abolitionist, writer, and businessman. Working tirelessly to free the enslaved and to destroy the very institution of slavery, William Still led perhaps the most dramatic system of protest our young Nation had ever seen.

As the birthplace of William Still and other notable abolitionists, New Jersey played a significant role in the success of the Underground Railroad. Offering an excellent cover of dense forests and heavy wilderness, our State provided various routes for Underground conductors. After crossing the Delaware River under the cloak of darkness, escaping slaves would travel from Camden to Burlington, and then on to Bordentown. Runaways also came to Bordentown through the towns of Swedesboro and Woodbury. This path to freedom then ran north through the woodlands of Princeton and on to New Brunswick, a hub in the railroad that also received fugitives traveling from Trenton. Conductors then bore their travelers across the Raritan River—a perilous but pivotal crossing. From Rahway these exhausted and terrified slaves and their devoted guides traveled to Jersey City and into New York. These newly emancipated men, women, and children then continued their journey north, to Canada and to freedom. The Underground Railroad carried the hopes and dreams of hundreds of thousands. Many Americans risked their own lives and the lives of their loved ones in order to defend the beliefs that all are created equal and that liberty is a universal right.

Families and communities throughout New Jersey were vital to the liberation of countless slaves. The National Family Reunion Festival, sponsored by the Still family, seeks to provide a forum for generations, not only to preserve their due sense of pride, but to pass on the stories of their forebears' bravery to younger generations. The Still family boasts a proud American heritage that dates back 360 years. Fittingly, the Stills have spearheaded this year's 3-day festival. It is the first of its kind—a unique blend of history and culture, the past and the present, a commemoration of the historical fight against the enslavement of men and women and finally a celebration of the unity we seek and strive to create in our Nation every day. The National Underground Railroad Family Reunion Festival will bring together descendants of conductors, abolitionists, stationmasters, and fugitives along with those who joyously recognize the incredible courage with which the railroad ran and the invaluable justice for which it ran.

Mr. President, I invite you and my colleagues to join me in commending The William Still Underground Railroad Foundation, Inc. and the Harriet Tubman Historical Society for their spectacular efforts that honor the valorous deeds of abolitionists and keep the history and legacies of our great Nation alive.•

THE CENTENNIAL CELEBRATION OF COWETA, OKLAHOMA.

• Mr. NICKLES. Mr. President, I am pleased to inform my colleagues in the Senate today that the city of Coweta, in my home State of Oklahoma, is celebrating the centennial of its founding.

Coweta has a rich and proud history. From its beginning as a Native American settlement town to being one of the fastest growing cities in one of the fastest growing counties in Oklahoma, Coweta is truly a great place to live, work, and raise a family. It is a place where values like faith, family, and community are lived daily by its residents. The spirit and character of Oklahoma are alive and well in Coweta.

It is my honor and privilege of help recognize and celebrate this occasion. Generations of residents have made Coweta a renewable place during its first 100 hundred years. Current and future generations will continue to make Coweta a special place for many years to come.

Congratulations to Coweta for celebrating this centennial.•

TRIBUTE TO STEPHEN CABELL

• Mr. BUNNING. Mr. President, I rise today to honor and pay tribute to Mr. Stephen Cabell of Owensboro, KY. Earlier this year, Stephen was named a Presidential Scholar in the Arts.

The Presidential Scholars in the Arts Program is administered by the U.S. Department of Education to honor some of our Nation's most artistic and creative high school seniors. Each year, the National Foundation for Advancement in the Arts recommends a small number of exceptionally gifted students to this program. This year, only 16 students from across the country were named a Presidential Scholar in the Arts. This honor rewards individuals who excel in various disciplines of the arts, including music, theater, dance, and visual arts. Stephen was awarded this honor in recognition of his musical composition genius.

Stephen Cabell was born in Owensboro, KY. During his freshman year of high school he was accepted into the Interlochen Arts Academy in Michigan, a prestigious high school known for its contribution to the fine arts. While attending Interlochen, he studied horn, piano, and music composition. Stephen continues his love of music during his free time, when he tutors students in music theory, researches composers, and collects musical scores. He is the son of Steve and Mary Cabell of Owensboro, who I know are very proud of Stephen and his talent and commitment to music and perfection.

Since he was 8 years old, Stephen has been composing musical pieces. During his career he has won numerous awards. Stephen is a recipient of the Morton Gould Young Composers Award from the American Society of Composers, Authors, and Publishers, ASCAP, as well as the Neil Robert Memorial Scholarship from the Interlochen Arts Academy. Groups such as the Owensboro Symphony Orchestra, Imani Winds, and the Interlochen Academy regularly perform his music. Most recently, Stephen performed one of his pieces at the John F. Kennedy Center for the Performing Arts in an event designed to showcase the talents of all 16 Presidential Scholars. In the fall, Stephen plans to study composition at the Curtis Institute of Music.

Stephen Cabell has repeatedly proven his genius in the field of musical composition. I would like to congratulate him again on being named a Presidential Scholar in the Arts, a tremendous honor indeed. I thank the Senate for allowing me to recognize Stephen and his accomplishments. He is a true source of pride for Kentucky.●

TRIBUTE TO DANNY PIPER

● Mr. HARKIN. Mr. President, I want to put into the CONGRESSIONAL RECORD a statement I made last year shortly after we lost a great friend of mine and a true American success story, Danny Piper.

Danny Piper came into my life 13 years ago. I was the Chairman of the Disability Policy Subcommittee here in the Senate, and was the sponsor of the Americans with Disabilities Act. We were having a series of hearings leading up to the hopeful passage of this bill. Danny became the first person with Downs Syndrome to testify before a congressional committee. I can't remember exactly how this came about, but I am sure that Marietta Lane, Paul Marchand, and Bobby Silverstein had something to do with finding Danny and getting him and Sylvia and Larry to Washington.

I can remeber that day like it was yesterday. Danny was cool, composed, and very confident as a witness. I spoke with him later, and asked if appearing before the Senate was like being in his high school play. ''Not so bad,'' Danny replied.

I followed Danny from then on. I was so proud when he got his high school certificate, then got his first job. In fact, I spent one of my ''workdays'' at the store with Danny. He showed me the ropes.'' He showed me the correct way to stock shelves. He made sure I knew how to load the cardboard box machine so I wouldn't get hurt. We went to lunch together, and it was a day I will always cherish.

Evey once in a while I would run into Dan in one place or another. He always hailed me as ''Hi, big guy.'' Once, I was visiting a school in Ankeny during the summer, and I was to meet with some teachers and administrators. To my surprise, when I entered the room, there stood Dan. So he gave me his usual, ''Hi, big guy'' routine. One of the older persons there said, ''This is Senator HARKIN.'' Dan just sort of shrugged, and said, ''Yeah, yeah, I know . . . big guy''. This memory still makes me smile.

Dan was always a part of all my campaigns, always there for my announcements and always there for the victory parties. But perhaps my most cherished moment with Dan was this spring. Dan set another first, I believe, when he introduced me at my announcement for reelection before a bank of TV cameras and a couple of hundred people. Sylvia told me how hard he practiced for this, and I could tell. He was poised, but a little nervous as he forgot to introduce my wife, Ruth. I told Dan it was no big deal, I still forget to do that sometimes myself. But he gave that introduction without missing a beat. He had it down pat. I was so proud and honored that Dan would do that for me.

Sylvia and Larry, their family were pioneers in every sense of the word. Long before it was even grudgingly accepted, they made sure Dan was fully integrated in with his peers in school, made sure he was not ''sent away'' like my brother was so many years ago, to an institution where everyone was ''just like him.'' Dan was a pioneer, also, challenging a system that wanted to deny him his individuality, deny him his personal hopes and dreams, deny him his independence, deny him his human right to meet challenges and set goals for himself.

When we visited Dan in the hospital, I was so certain that he was going to make it. He had that same positive upbeat attitude I have always known. He was looking forward to helping me again this fall, as he had always helped me.

Well, Dan, a tragic accident has meant that you will not be with us physically. But the most powerful thing about you, Dan, was your spirit, and that will always be with us who were touched by your life. Your spirit commands us to lead on, break down barriers that separate us, provide that ladder or ramp of opportunity for all. We will enact MICASSA into law, Dan, and your example of overcoming challenges and meeting goals compels us not to fall in this endeavor.

Thank you, Dan, for all the help you gave us during your brief life. You helped us to be more understanding, more generous and more caring toward one another. That is a great legacy. In whatever lies ahead, you will be often on my mind, and always in my heart.●

RON MICHAELSON: 29 YEARS AT THE ILLINOIS STATE BOARD OF ELECTIONS

● Mr. DURBIN. Mr. President, I rise today to pay tribute to my friend Dr. Ronald D. Michaelson. Ron Michaelson will retire in June after 29 years of outstanding service to Illinois as the executive director of the Illinois State Board of Elections. I want to salute his dedication to public service and briefly share his story with you today.

Dr. Michaelson grew up in Chicago. He received a bachelor of arts degree from Wheaton College in 1963, a master of arts degree in political science from Northwestern University in 1965, and a Ph.D. in government from Southern Illinois University in 1970.

Dr. Michaelson went on to devote his life to public service. He began his professional career working in State government as an assistant to former Illinois Governor Richard Ogilvie. He then spent several years teaching at Sangamon State University. His interest in the political arena remained, however, and in 1974 he returned to that arena to head the newly created State board of elections. The board was formed to interpret election laws and coordinate procedures for holding elections, and Dr. Michaelson became the board's first and so far only executive director.

Dr. Michaelson's drive and ambition helped him administer and supervise the agency in a fair and bipartisan manner. He devoted himself and his 65 staff members to creating one of the most respected campaign disclosure systems in the Nation—one that requires candidates to report disclosure statements electronically, making them easily accessible to those interested in a candidate's campaign donations. Dr. Michaelson's success in creating a fair and effective system of campaign disclosure in the tough political environment of Illinois provided a heartening and instructive example for the cause of political openness nationwide.

In addition to his teaching and his work in government, Dr. Michaelson has authored numerous articles that have been published in leading state and national journals. He is the past national chairman of the Council on Governmental Ethics Laws and speaks frequently at conferences in the areas of election administration and campaign finance. He currently serves as an appointee to the advisory committee of the Federal Election Commission and teaches as an adjunct professor of public affairs at the University of Illinois at Springfield.

Dr. Michaelson's dedication to public service will continue beyond his retirement this month. He intends to assist the State board of elections on a part-time basis with the implementation of the recently enacted Help America Vote Act.

In a time of considerable cynicism about public officials, Ron Michaelson's career stands as a shining example of the finest tradition of honorable service to the public: an example of integrity, fairness, hard work, and high standards. I am truly pleased to honor Dr. Michaelson on his retirement from the Illinois State Board of Elections and to thank him for his service to the state of Illinois and for the example he has set in the course of that service. I know my fellow Senators will join me in congratulating Dr. Michaelson on his remarkable career.●

TRIBUTE TO REBECCA WILLIAMS

● Mr. BUNNING. Mr. President, I rise today to honor and pay tribute to Ms. Rebecca Williams of Henderson, KY. Rebecca was recently awarded a James Madison Memorial fellowship.

The James Madison fellowship, in its 12th year of competition, supports the further study of American history by college graduates who aspire to become teachers of American history, American government, and social studies in

the Nation's secondary schools. Named in honor of the fourth President of the United States, the fellowship will fund up to $24,000 of Ms. William's course of study toward a master's degree.

The award recognizes promising and distinguished teachers and encourages the strengthening of their knowledge of the origins and development of American government and history. Ultimately, the award acknowledges educators who will provide outstanding tutelage to students across the country.

Ms. Williams is a teacher at Bryan Station High School in Lexington, KY. She is one of 56 recipients of the fellowship, selected from applicants from across the United States. Ms. Williams has distinguished herself as an exceptional and aspiring educator. Her dedication to the field of American history and to the education of Kentucky's youth is remarkable.

Ms. Williams is a tribute to Kentucky, and I am proud of her achievements. I thank the Senate for allowing me to recognize Ms. Williams's wonderful accomplishments. She is Kentucky at its finest.●

TRIBUTE TO THE EDUCATION ASSOCIATION OF McCRACKEN COUNTY

● Mr. BUNNING. Mr. President, I rise to honor and pay tribute to the McCracken County Education Association for the high ideals which they have taught through example to the children of their county school system. The McCracken County Education Association of McCracken County, KY, generously took the initiative not only to raise $10,089 and donate it to Habitat for Humanity but also to give their time and effort in the construction of a home in Paducah.

The initiative involved all 12 of McCracken County's public schools and the children that attend them. Each teacher was asked to raise $35 from their own classroom while the central office and each school contributed $350. The ways in which the money was raised are just as admirable for their originality and civic mindedness as they are for their charity. One teacher added a brick to a miniature house structure for every dollar her students contributed, while one school of only 350 students held a bake sale and raised approximately $5,000. Overall and throughout, the raising of funds was marked with a spirit of cooperation and team spirit. On June 6 the funds were presented to Habitat for Humanity of Paducah/McCracken County and on the 14th the teachers, administrators, and staff of McCracken County Education Association assembled at 1920 Broad St. in Paducah, KY, to donate time and labor in the construction of a house.

The altruism and generosity of the McCracken County Education Association ought to be highly commended and imitated by all who have seen its shining example. Such interest in the well-being of our neighbors combines the virtues of justice and compassion and enriches the society in which it exists.

While it is true that the McCracken County Education Association's concern for their neighbors and for a society in which all have shelter is truly virtuous, it is also true that the work they did was just as, if not more, valuable for the reason that they are the educators of America's future. The children whom the McCracken County Education Association included in this fundraiser event learned more than just what books might have taught them in school. They learned that an active interest in the well-being of others is important. They learned that though they are children who are still in the process of learning, their voices will be heard if they work together with order and with the good of society at heart. It is not only these children who stand to learn something from this notable example of generosity and civic responsibility but all of us here today.

My Senate colleagues and all others would do well to imitate the concern and initiative of the McCracken County Education Association. I thank the Senate for allowing me to laud the praises of the McCracken County Education Association.●

BIRTHDAY TRIBUTE FOR MR. WILLARD ELDREDGE

● Mr. CRAPO. Mr. President, I would like to take a moment to extend a heartfelt birthday greeting to Mr. Willard Eldredge who turns 80 years old today. On July 5, his friends and family will gather in Idaho Falls to honor this great man on the occasion of his birthday. Mr. Eldredge has touched many lives over the years, and I am one of the fortunate ones to have benefited from his influence. You see, I was involved in Boy Scouts, and eventually became an Eagle Scout. Mr. Eldredge was a Scout pack leader of mine many years ago. He taught me and other young men the values, work ethic, and commitment that it took to succeed in Scouts and in life. He served as a role model for me, and taught me lessons about honor, duty, honesty, and patriotism that I have carried with me throughout my life. It is now my honor to wish my former mentor a wonderful, and very happy 80th birthday.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGE FROM THE HOUSE

At 2:52 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 923. An act to amend the Small Business Investment Act of 1958 to allow certain premier certified lenders to elect to maintain an alternative loss reserve.

H.R. 1416. An act to make technical corrections to the Homeland Security Act of 2002.

H.R. 1460. An act to amend title 38, United States Code, to improve education and entrepreneurship benefits, housing, and certain other benefits for veterans, and for other purposes.

H.R. 1772. An act to improve small business advocacy, and for other purposes.

H.R. 2555. An act making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2004, and for other purposes.

MEASURES REFERRED

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

H.R. 923. An act to amend the Small Business Investment Act of 1958 to allow certain premier certified lenders to elect to maintain an alternative loss reserve; to the Committee on Small Business and Entrepreneurship.

H.R. 1416. An act to make technical corrections to the Homeland Security Act of 2002; to the Committee on Governmental Affairs.

H.R. 1460. An act to amend title 38, United States Code, to improve education and entrepreneurship benefits, housing, and certain other benefits for veterans, and for other purposes.

H.R. 1772. An act to improve small business advocacy, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H.R. 2555. An act making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2004, and for other purposes; to the Committee on Appropriations.

MEASURES PLACED ON THE CALENDAR

The following bill was read the second time, and placed on the calendar:

S. 1323. A bill to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months.

MEASURE HELD AT THE DESK

The following resolution was ordered held at the desk by unanimous consent:

S. Res. 186. A Resolution commending August Hiebert for his Service to the Alaska Communications Industry.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with

accompanying papers, reports, and documents, and were referred as indicated:

EC–2899. A communication from the Chairman, Navy Sea Cadet Corps, transmitting, pursuant to law, the 2002 Audit and Annual Report; to the Committee on the Judiciary.

EC–2900. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Flufenacet acetamid; Pesticide Tolerance'' (FRL7313–9) received on June 24, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–2901. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Extension of Tolerances for Emergency Exemptions (Multiple Chemicals'' (FRL7311–5) received on June 24, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–2902. A communication from the Director, Regulations Management, Veterans Benefits Administration, Department of Veterans' Affairs, transmitting, pursuant to law, the report of a rule entitled ''Accelerated Payments Under the Montgomery GI Bill—Active Duty Program'' (RIN2900–AL22) received on June 24, 2002; to the Committee on Veterans' Affairs.

EC–2903. A communication from the Under Secretary for Health, Department of Veterans' Affairs, transmitting, pursuant to law, the 2002 Annual Report entitled ''VA Research: Discovery, Innovation, Leadership''; to the Committee on Veterans' Affairs.

EC–2904. A communication from the White House Liaison, Department of Health and Human Services, transmitting, pursuant to law, the report of vacancy and the designation of acting officer for the position of Assistant Secretary for Legislation; to the Committee on Health, Education, Labor, and Pensions.

EC–2905. A communication from the White House Liaison, Department of Health and Human Services, transmitting, pursuant to law, the report of vacancy and the designation of acting officer for the position of Inspector General; to the Committee on Health, Education, Labor, and Pensions.

EC–2906. A communication from the Director, Regulations Policy and Management, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Regulations on Aluminum in Large and Small Volume Parenterals Used in Total Parenteral Nutrition; Delay of Effective Date'' (Doc. No. 02N–0241) received on June 24, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2907. A communication from the Director, Regulations Policy and Management, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Labeling for Oral and Rectal Over-the-Counter Drug Products Containing Aspirin and Nonaspirin Salicylates; Reye's Syndrome Warning'' (RIN0910–AA01) received on June 24, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2908. A communication from the Director, Regulations Policy and Management, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Ingrown Toenail Relief Drug Products for Over-the-Counter Human Use'' (RIN0910–AA01) received on June 24, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2909. A communication from the Director, Regulations Policy and Management, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Antidiarrheal Drug Products for Over-the-Counter Human Use; Final Monograph'' (RIN0910–AA01) received on June 24, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2910. A communication from the Director, Regulations Policy and Management, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Public Information Regulations'' (Doc. No. 99N–2637) received on June 24, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2911. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Suspension of Community Eligibility'' (Doc. No. FEMA–7809) received on June 24, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2912. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Changes in Flood Elevation Determinations'' (44 CFR Part 65) received on June 24, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2913. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Final Flood Elevation Determinations'' (44 CFR Part 67) received on June 24, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2914. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Final Flood Elevation Determinations'' (44 CFR Part 67) received on June 24, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2915. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Changes in Flood Elevation Determinations'' (Doc. No. FEMA–B–7436) received on June 24, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2916. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Changes in Flood Elevation Determinations'' (Doc. No. FEMA–B–7539) received on June 24, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2917. A communication from the Chairman of the Board of Governors of the Federal Reserve System, transmitting, pursuant to law, the Annual Report on the Profitability of the Credit Card Operations of Depository Institutions for 2002; to the Committee on Banking, Housing, and Urban Affairs.

EC–2918. A communication from the General Counsel, Department of Housing and Urban Development, transmitting, pursuant to law, the report of a nomination confirmed for the position of Assistant Secretary for Congressional and Intergovernmental Relations; to the Committee on Banking, Housing, and Urban Affairs.

EC–2919. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed manufacturing license agreement for the manufacture of significant military equipment abroad to Canada; to the Committee on Foreign Relations.

EC–2920. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense articles or defense services sold commercially under contract in the amount of $100,000,000 or more to Japan; to the Committee on Foreign Relations.

EC–2921. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense articles or defense services sold commercially under contract in the amount of $100,000,000 or more to Japan; to the Committee on Foreign Relations.

EC–2922. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed technical assistance agreement for the export of defense articles or defense services sold commercially under contract in the amount of $50,000,000 or more to Israel; to the Committee on Foreign Relations.

EC–2923. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $100,000,000 or more to Japan; to the Committee on Foreign Relations.

EC–2924. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed manufacturing license agreement for the manufacture of significant military equipment abroad and the export of defense articles or defense services in the amount of $50,000,000 or more to South Korea; to the Committee on Foreign Relations.

EC–2925. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense services, technical data and defense articles sold commercially under a contract in the amount of $50,000,000 or more to South Korea; to the Committee on Foreign Relations.

EC–2926. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $100,000,000 or more to Japan; to the Committee on Foreign Relations.

EC–2927. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $100,000,000 or more to Belgium, Canada, Denmark, France, Germany, Ireland, Italy, Norway and the United Kingdom; to the Committee on Foreign Relations.

EC–2928. A communication from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting, pursuant to law, the report of the text of agreements and background statements of international agreements other than treaties; to the Committee on Foreign Relations.

EC–2929. A communication from the Under Secretary of Defense, Acquisition, Technology and Logistics, transmitting, pursuant

to law, a report concerning the amount of funds for information technology and software used to support Department of Defense weapon systems; to the Committee on Armed Services.

EC–2930. A communication from the Director, Strategic and Tactical Systems, Office of Under Secretary of Defense, Acquisition, Technology and Logistics, transmitting, pursuant to law, the report of funds for four new Foreign Comparative Testing projects; to the Committee on Armed Services.

EC–2931. A communication from the Director, Admissions Liaison, Department of the Air Force, transmitting, the report of separation action; to the Committee on Armed Services.

EC–2932. A communication from the Director, Admissions Liaison, Department of the Air Force, transmitting, the report of separation action; to the Committee on Armed Services.

EC–2933. A communication from the Under Secretary of Defense, Acquisition, Technology and Logistics, transmitting, pursuant to law, the Annual Report on the Department of Defense Mentor-Protege Program; to the Committee on Armed Services.

EC–2934. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Federally Enforceable State Operating Permit Program; Allegheny County, Pennsylvania'' (FRL7511–7) received on June 24, 2003; to the Committee on Environment and Public Works.

EC–2935. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; State of Colorado; Credible Evidence'' (FRL7512–7) received on June 24, 2003; to the Committee on Environment and Public Works.

EC–2936. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Utah; SIP Renumbering'' (FRL7501–5) received on June 24, 2003; to the Committee on Environment and Public Works.

EC–2937. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plans and Designation of Areas for Quality Planning Purposes 1-Hour Ozone Standard for San Diego, California'' (FRL7515–4) received on June 24, 2003; to the Committee on Environment and Public Works.

EC–2938. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Finding of Substantial Inadequacy of Implementation Plan; Call for California State Implementation Plan Revision'' (FRL7518–4) received on June 24, 2003; to the Committee on Environment and Public Works.

EC–2939. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Interim Final Determination that the State of California has Corrected Deficiencies and Stay and Deferral of Sanctions; San Joaquin Valley Ozone Nonattainment Area'' (FRL7517–9) received on June 24, 2003; to the Committee on Environment and Public Works.

EC–2940. A communication from the Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of the Drinking Water State Revolving Fund Program; to the Committee on Environment and Public Works.

EC–2941. A communication from the Comptroller General of the United States, General Accounting Office, transmitting, pursuant to law, a report on the forum to develop a more comprehensive key national indicator system; to the Committee on Governmental Affairs.

EC–2942. A communication from the Administrator, General Service Administration, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2943. A communication from the Chairman, National Science Board, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2944. A communication from the Chairman, Federal Maritime Commission, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2945. A communication from the Secretary of Veterans Affairs, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2946. A communication from the Chair, Equal Employment Opportunity Commission, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2947. A communication from the Chief Executive Officer, Corporation for National and Community Service, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2948. A communication from the Chairman, Congressional Award, transmitting, pursuant to law, the fiscal year 2002 report to Congress; to the Committee on Governmental Affairs.

EC–2949. A communication from the CFO and Plan Administrator, First South Farm Credit Retirement Committee, transmitting, pursuant to law, the Annual Pension Plan Report for calendar year 2002; to the Committee on Governmental Affairs.

EC–2950. A communication from the District of Columbia Auditor, transmitting, a report entitled ''The Department of Mental Health Failed to Implement A Vocational Rehabilitation Program for the District's Mental Health Consumers''; to the Committee on Governmental Affairs.

EC–2951. A communication from the Assistant Administrator, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Atlantic Highly Migratory Species; incidental Catch Requirements of Bluefin Tuna'' (RIN0648–AO75) received on June 24, 2003; to the Committee on Governmental Affairs.

EC–2952. A communication from the Deputy Associate Administrator, Office of Acquisition Policy, General Service Administration, transmitting, pursuant to law, the report of a rule entitled ''Federal Acquisition Regulation'' (FAC 2001–14) received on June 24, 2003; to the Committee on Governmental Affairs.

EC–2953. A communication from the General Counsel of the Department of Commerce, transmitting, a draft of proposed legislation entitled ''Fishery Conservation and Management Amendments of 2003''; to the Committee on Commerce, Science, and Transportation.

EC–2954. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: SOCATA Group AEROSPATIALE Models MD 892A–150, MS 892E–150, MS 893A, MS 893E, MS 894A, MS 894E, Rallye 150ST Airplanes'' ((RIN2120–AA64)(2003–0245)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2955. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Hartzell Propeller Inc. Model HC–C2Y (KR) 1BF/F8477–4 Propellers'' ((RIN2120–AA64)(2003–0242)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2956. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Dornier Model 328 100 and 300 Series Airplanes'' ((RIN2120–AA64)(2003–0243)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2957. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: McDonnell Douglas Model MD 90 Airplanes'' ((RIN2120–AA64)(2003–0240)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2958. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Fokker Odel F28 Mark 0070 and 0100 Series Airplanes'' ((RIN2120–AA64)(2003–0241)) received on June 19 , 2003; to the Committee on Commerce, Science, and Transportation .

EC–2959. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class E Airspace; Moundridge, KS; Correction'' ((RIN2120–AA66)(2003–0102)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2960. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class E Airspace; Cabelier, ND'' ((RIN2120–AA66)(2003–0101)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. SHELBY, from the Committee on Banking, Housing, and Urban Affairs, without amendment:

S. 1334. An original bill to facilitate check truncation by authorizing substitute checks, to foster innovation in the check collection system without mandating receipt of checks in electronic form, and to improve the overall efficiency of the Nation's payments system, and for other purposes (Rept. No. 108-79).

By Mr. SHELBY, from the Committee on Banking, Housing, and Urban Affairs, with an amendment:

S. 498. A bill to authorize the President to posthumously award a gold medal on behalf of Congress to Joseph A. De Laine in recognition of his contributions to the Nation.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of committees were submitted:

By Mr. GREGG for the Committee on Health, Education, Labor, and Pensions.

*David Hall, of Massachusetts, to be a Member of the Board of Directors of the Legal Services Corporation for a term expiring July 13, 2005.

*Lilian R. BeVier, of Virginia, to be a Member of the Board of Directors of the Legal Services Corporation for a term expiring July 13, 2004.

Mr. GREGG. Mr. President, for the Committee on Health, Education, Labor, and Pensions I report favorably the following nomination list which was printed in the RECORD on the date indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that this nomination lie at the Secretary's desk for the information of Senators.

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

*Public Health Service nominations beginning Thomas D. Matte and ending Ronald R. Pinheiro, which nominations were received by the Senate and appeared in the Congressional Record on June 3, 2003.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

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. VOINOVICH:

S. 1326. A bill to establish the position of Assistant Secretary of Commerce for Manufacturing in the Department of Commerce; to the Committee on Commerce, Science, and Transportation.

By Mr. CORZINE:

S. 1327. A bill to reduce unsolicited commercial electronic mail and to protect children from sexually oriented advertisements; to the Committee on Commerce, Science, and Transportation.

By Mr. HATCH (for himself and Mrs. CLINTON):

S. 1328. A bill to provide for an evaluation by the Institute of Medicine of the National Academy of Sciences of leading health care performance measures and options to implement policies that align performance with payment under the medicare program under title XVIII of the Social Security Act; to the Committee on Finance.

By Mr. LOTT (for himself and Mr. KERRY):

S. 1329. A bill to amend title 49, United States Code, to require the Secretary of Transportation to carry out a grant program to provide financial assistance for local rail line relocations projects; to the Committee on Commerce, Science, and Transportation.

By Ms. MURKOWSKI:

S. 1330. A bill to establish the Kenai Mountains-Turnagain Arm National Heritage Area in the State of Alaska, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SANTORUM (for himself, Mr. CONRAD, and Mr. BREAUX):

S. 1331. A bill to clarify the treatment of tax attributes under section 108 of the Internal Revenue Code of 1986 for taxpayers which file consolidated returns; to the Committee on Finance.

By Mr. HATCH:

S. 1332. A bill to amend title XVIII of the Social Security Act to provide regulatory relief, appeals process reforms, contracting flexibility, and education improvements under the Medicare program, and for other purposes; to the Committee on Finance.

By Mr. GRASSLEY (for himself, Mr. BINGAMAN, Mr. BUNNING, Mr. DASCHLE, Mr. ROCKEFELLER, Mr. BAUCUS, Ms. SNOWE, Mr. THOMAS, Mr. SMITH, Mr. CONRAD, Mr. GRAHAM of Florida, Mr. KERRY, Mr. BREAUX, Mrs. LINCOLN, and Mr. JEFFORDS):

S. 1333. A bill to amend the Internal Revenue Code of 1986 to provide for the treatment of certain expenses of rural letter carriers; to the Committee on Finance.

By Mr. SHELBY:

S. 1334. An original bill to facilitate check truncation by authorizing substitute checks, to foster innovation in the check collection system without mandating receipt of checks in electronic form, and to improve the overall efficiency of the Nation's payments system, and for other purposes; from the Committee on Banking, Housing, and Urban Affairs; placed on the calendar.

By Mr. GRASSLEY (for himself, Mr. GRAHAM of Florida, Ms. MIKULSKI, and Mr. BREAUX):

S. 1335. A bill to amend the Internal Revenue Code of 1986 to allow individuals a deduction for qualified long-term care insurance premiums, use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long-term care needs; to the Committee on Finance.

By Mr. BROWNBACK (for himself and Mr. KENNEDY):

S. 1336. A bill to allow North Koreans to apply for refugee status or asylum; to the Committee on the Judiciary.

By Mr. SMITH:

S. 1337. A bill to establish an incentive program to promote effective safety belt laws and increase safety belt use; to the Committee on Commerce, Science, and Transportation.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

By Mr. ENSIGN (for Mr. CAMPBELL (for himself, Mr. ENSIGN, Mr. KYL, Mr. BURNS, Mr. ALLARD, Mr. CRAPO, and Mr. CRAIG)):

S. Res. 183. A resolution commemorating 50 years of adjudication under the McCarran Amendment of rights to the use of water; to the Committee on Energy and Natural Resources.

By Mr. KYL (for himself, Ms. MIKULSKI, Mr. BROWNBACK, Mr. MCCAIN, and Mr. ALLEN):

S. Res. 184. A resolution calling on the Government of the People's Republic of China immediately and unconditionally to release Dr. Yang Jianli, and for other purposes; to the Committee on Foreign Relations.

By Ms. MURKOWSKI (for herself, Mr. STEVENS, and Mr. INOUYE):

S. Res. 185. A resolution expressing the sense of the Senate with respect to raising awareness and encouraging education about safety on the Internet and supporting the goals and ideals of National Internet Safety Month; considered and agreed to.

By Mr. STEVENS (for himself and Ms. MURKOWSKI):

S. Res. 186. A resolution commending August Hiebert for his service to the Alaska Communications Industry; ordered held at the desk.

ADDITIONAL COSPONSORS

S. 470

At the request of Mr. SARBANES, the name of the Senator from Missouri (Mr. TALENT) was added as a cosponsor of S. 470, a bill to extend the authority for the construction of a memorial to Martin Luther King, Jr.

S. 501

At the request of Mr. GRASSLEY, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 501, a bill to provide a grant program for gifted and talented students, and for other purposes.

S. 517

At the request of Mr. DAYTON, his name was added as a cosponsor of S. 517, a bill to amend title 38, United States Code, to provide improved benefits for veterans who are former prisoners of war.

S. 518

At the request of Ms. COLLINS, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 518, a bill to increase the supply of pancreatic islet cells for research, to provide better coordination of Federal efforts and information on islet cell transplantation, and to collect the data necessary to move islet cell transplantation from an experimental procedure to a standard therapy.

S. 595

At the request of Mr. BREAUX, the name of the Senator from Florida (Mr. GRAHAM) was added as a cosponsor of S. 595, a bill to amend the Internal Revenue Code of 1986 to repeal the required use of certain principal repayments on mortgage subsidy bond financings to redeem bonds, to modify the purchase price limitation under mortgage subsidy bond rules based on median family income, and for other purposes.

S. 610

At the request of Mr. VOINOVICH, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 610, a bill to amend the provisions of title 5, United States Code, to provide for workforce flexibilities and certain Federal personnel provisions relating to the National Aeronautics and Space Administration, and for other purposes.

S. 640

At the request of Mr. LEAHY, the name of the Senator from New Jersey (Mr. CORZINE) was added as a cosponsor of S. 640, a bill to amend subchapter III of chapter 83 and chapter 84 of title 5, United States Code, to include Federal

prosecutors within the definition of a law enforcement officer, and for other purposes.

S. 664

At the request of Mr. BAUCUS, the name of the Senator from Florida (Mr. GRAHAM) was added as a cosponsor of S. 664, a bill to amend the Internal Revenue Code of 1986 to permanently extend the research credit, to increase the rates of the alternative incremental credit, and to provide an alternative simplified credit for qualified research expenses.

S. 678

At the request of Mr. AKAKA, the names of the Senator from Nebraska (Mr. HAGEL) and the Senator from Ohio (Mr. VOINOVICH) were added as cosponsors of S. 678, a bill to amend chapter 10 of title 39, United States Code, to include postmasters and postmasters organizations in the process for the development and planning of certain policies, schedules, and programs, and for other purposes.

S. 752

At the request of Mr. BINGAMAN, the name of the Senator from Oklahoma (Mr. INHOFE) was added as a cosponsor of S. 752, a bill to amend the Internal Revenue Code of 1986 to treat distributions from publicly traded partnerships as qualifying income of regulated investment companies, and for other purposes.

S. 765

At the request of Mr. VOINOVICH, the name of the Senator from Tennessee (Mr. ALEXANDER) was added as a cosponsor of S. 765, a bill to amend the Ethics in Government Act of 1978 (5 U.S.C. App.) to streamline the financial disclosure process for executive branch employees.

S. 811

At the request of Mr. ALLARD, the name of the Senator from Colorado (Mr. CAMPBELL) was added as a cosponsor of S. 811, a bill to support certain housing proposals in the fiscal year 2003 budget for the Federal Government, including the downpayment assistance initiative under the HOME Investment Partnership Act, and for other purposes.

S. 854

At the request of Mr. COLEMAN, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. 854, a bill to authorize a comprehensive program of support for victims of torture, and for other purposes.

S. 875

At the request of Mr. KERRY, the names of the Senator from Vermont (Mr. JEFFORDS) and the Senator from Colorado (Mr. CAMPBELL) were added as cosponsors of S. 875, a bill to amend the Internal Revenue Code of 1986 to allow an income tax credit for the provision of homeownership and community development, and for other purposes.

S. 888

At the request of Mr. GREGG, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 888, a bill to reauthorize the Museum and Library Services Act, and for other purposes.

S. 939

At the request of Mr. HAGEL, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 939, a bill to amend part B of the Individuals with Disabilities Education Act to provide full Federal funding of such part, to provide an exception to the local maintenance of effort requirements, and for other purposes.

S. 973

At the request of Mr. NICKLES, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 973, a bill to amend the Internal Revenue Code of 1986 to provide a shorter recovery period for the depreciation of certain restaurant buildings.

S. 1032

At the request of Mr. SARBANES, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1032, a bill to provide for alternative transportation in certain federally owned or managed areas that are open to the general public.

S. 1046

At the request of Mr. HOLLINGS, the name of the Senator from Maryland (Mr. SARBANES) was added as a cosponsor of S. 1046, a bill to amend the Communications Act of 1934 to preserve localism, to foster and promote the diversity of television programming, to foster and promote competition, and to prevent excessive concentration of ownership of the nation's television broadcast stations.

S. 1091

At the request of Mr. DURBIN, the names of the Senator from Michigan (Ms. STABENOW) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of S. 1091, a bill to provide funding for student loan repayment for public attorneys.

S. 1109

At the request of Mr. TALENT, the name of the Senator from Minnesota (Mr. COLEMAN) was added as a cosponsor of S. 1109, a bill to provide $50,000,000,000 in new transportation infrastructure funding through Federal bonding to empower States and local governments to complete significant infrastructure projects across all modes of transportation, including roads, rail, transit, aviation, and water, and for other purposes.

S. 1129

At the request of Mrs. FEINSTEIN, the name of the Senator from New Mexico (Mr. BINGAMAN) was added as a cosponsor of S. 1129, a bill to provide for the protection of unaccompanied alien children, and for other purposes.

S. 1195

At the request of Mr. DAYTON, his name was added as a cosponsor of S. 1195, a bill to amend title XIX of the Social Security Act to clarify that inpatient drug prices charged to certain public hospitals are included in the best price exemptions for the medicaid drug rebate program.

S. 1201

At the request of Mr. GRAHAM of South Carolina, the name of the Senator from Indiana (Mr. LUGAR) was added as a cosponsor of S. 1201, a bill to promote healthy lifestyles and prevent unhealthy, risky behaviors among teenage youth.

S. 1218

At the request of Mr. HOLLINGS, the names of the Senator from New Jersey (Mr. LAUTENBERG), the Senator from Washington (Ms. CANTWELL) and the Senator from Florida (Mr. NELSON) were added as cosponsors of S. 1218, a bill to provide for Presidential support and coordination of interagency ocean science programs and development and coordination of a comprehensive and integrated United States research and monitoring program.

S. 1248

At the request of Mr. GREGG, the name of the Senator from Kansas (Mr. ROBERTS) was added as a cosponsor of S. 1248, a bill to reauthorize the Individuals with Disabilities Education Act, and for other purposes.

S. 1252

At the request of Mr. DAYTON, the name of the Senator from Hawaii (Mr. INOUYE) was added as a cosponsor of S. 1252, a bill to provide benefits to domestic partners of Federal employees.

S. 1289

At the request of Mr. GRAHAM of Florida, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 1289, a bill to name the Department of Veterans Affairs Medical Center in Minneapolis, Minnesota, after Paul Wellstone.

S. 1293

At the request of Mr. HATCH, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 1293, a bill to criminalize the sending of predatory and abusive e-mail.

S. 1303

At the request of Mr. BROWNBACK, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1303, a bill to amend title XVIII of the Social Security Act and otherwise revise the Medicare Program to reform the method of paying for covered drugs, drug administration services, and chemotherapy support services.

S. 1315

At the request of Mr. CRAIG, the name of the Senator from Missouri (Mr. TALENT) was added as a cosponsor of S. 1315, a bill to amend the Federal Land Policy and Management Act of 1976 to provide owners of non-Federal lands with a reliable method of receiving compensation for damages resulting from the spread of wildfire from nearby forested National Forest System lands or Bureau of Land Management lands, when those forested Federal lands are not maintained in the

forest health status known as condition class 1.

S. 1325

At the request of Mr. BURNS, the name of the Senator from Kansas (Mr. BROWNBACK) was added as a cosponsor of S. 1325, a bill to amend the National Highway System Designation Act of 1995 to modify the applicability of requirements concerning hours of service to operators of commercial motor vehicles transporting agricultural commodities and farm supplies.

S. CON. RES. 25

At the request of Mr. VOINOVICH, the names of the Senator from Minnesota (Mr. COLEMAN) and the Senator from New York (Mrs. CLINTON) were added as cosponsors of S. Con. Res. 25, a concurrent resolution recognizing and honoring America's Jewish community on the occasion of its 350th anniversary, supporting the designation of an ''American Jewish History Month'', and for other purposes.

S. CON. RES. 40

At the request of Mrs. CLINTON, the names of the Senator from Oregon (Mr. SMITH), the Senator from Texas (Mrs. HUTCHISON), the Senator from North Dakota (Mr. CONRAD), the Senator from North Dakota (Mr. DORGAN), the Senator from Minnesota (Mr. DAYTON) and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of S. Con. Res. 40, a concurrent resolution designating August 7, 2003, as ''National Purple Heart Recognition Day''.

S. RES. 160

At the request of Mr. AKAKA, the name of the Senator from Hawaii (Mr. INOUYE) was added as a cosponsor of S. Res. 160, a resolution to express the sense of the Senate that the federal Government should actively pursue a unified approach to strengthen and promote the national policy on aquaculture.

AMENDMENT NO. 936

At the request of Mr. NELSON of Florida, the name of the Senator from Florida (Mr. GRAHAM) was added as a cosponsor of amendment No. 936 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 938

At the request of Mr. NELSON of Florida, the name of the Senator from Louisiana (Mr. BREAUX) was added as a cosponsor of amendment No. 938 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 956

At the request of Mr. REID, his name was added as a cosponsor of amendment No. 956 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 967

At the request of Mr. HARKIN, the names of the Senator from North Dakota (Mr. DORGAN), the Senator from New York (Mr. SCHUMER), the Senator from Washington (Mrs. MURRAY), the Senator from Maryland (Ms. MIKULSKI) and the Senator from Oregon (Mr. SMITH) were added as cosponsors of amendment No. 967 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 972

At the request of Mr. BINGAMAN, his name was added as a cosponsor of amendment No. 972 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 972

At the request of Mr. SMITH, his name was added as a cosponsor of amendment No. 972 proposed to S. 1, supra.

AMENDMENT NO. 972

At the request of Mr. HOLLINGS, his name was added as a cosponsor of amendment No. 972 proposed to S. 1, supra.

AMENDMENT NO. 972

At the request of Mr. HATCH, his name was added as a cosponsor of amendment No. 972 proposed to S. 1, supra.

AMENDMENT NO. 972

At the request of Mr. BOND, his name was added as a cosponsor of amendment No. 972 proposed to S. 1, supra.

AMENDMENT NO. 991

At the request of Mr. HARKIN, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of amendment No. 991 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 994

At the request of Mr. DURBIN, the names of the Senator from Louisiana (Ms. LANDRIEU) and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of amendment No. 994 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 994

At the request of Mr. SARBANES, his name was added as a cosponsor of amendment No. 994 proposed to S. 1, supra.

AMENDMENT NO. 994

At the request of Ms. MIKULSKI, her name was added as a cosponsor of amendment No. 994 proposed to S. 1, supra.

AMENDMENT NO. 1000

At the request of Mrs. CLINTON, the names of the Senator from Connecticut (Mr. LIEBERMAN) and the Senator from Florida (Mr. GRAHAM) were added as cosponsors of amendment No. 1000 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 1003

At the request of Mr. BROWNBACK, the names of the Senator from Alaska (Mr. STEVENS) and the Senator from Alaska (Ms. MURKOWSKI) were added as cosponsors of amendment No. 1003 intended to be proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 1021

At the request of Mr. CONRAD, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of amendment No. 1021 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 1022

At the request of Mr. BROWNBACK, the name of the Senator from Virginia (Mr. ALLEN) was added as a cosponsor of amendment No. 1022 intended to be proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 1024

At the request of Mr. ENSIGN, the names of the Senator from Maryland (Ms. MIKULSKI) and the Senator from Minnesota (Mr. DAYTON) were added as cosponsors of amendment No. 1024 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 1040

At the request of Mr. SCHUMER, the names of the Senator from Pennsylvania (Mr. SANTORUM) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors of amendment No. 1040 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. VOINOVICH:

S. 1326. A bill to establish the position of Assistant Secretary of Commerce for Manufacturing in the Department of Commerce; to the Committee on Commerce, Science, and Transportation.

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

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

S. 1326

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

SECTION 1. ASSISTANT SECRETARY OF COMMERCE FOR MANUFACTURING.

(a) ESTABLISHMENT.—There is in the Department of Commerce the position of Assistant Secretary of Commerce for Manufacturing. The Assistant Secretary shall be appointed by the President by and with the advice and consent of the Senate.

(b) DUTIES.—The Assistant Secretary of Commerce for Manufacturing shall—

(1) represent and advocate for the interests of the manufacturing sector;

(2) aid in the development of policies that promote the expansion of the manufacturing sector;

(3) review policies that may adversely impact the manufacturing sector; and

(4) perform such other duties as the Secretary of Commerce shall prescribe.

(c) REPORTING REQUIREMENTS.—The Assistant Secretary of Commerce for Manufacturing shall submit to Congress an annual report that contains the following:

(1) An overview of the state of the manufacturing sector in the United States.

(2) A forecast of the future state of the manufacturing sector in the United States.

(3) An analysis of current and significant laws, regulations, and policies that adversely impact the manufacturing sector in the United States.

(d) COMPENSATION.—Section 5314 of title 5, United States Code, relating to Level IV of the Executive Schedule, is amended by inserting before ''and Assistant'' in the item relating to the Assistant Secretaries of Commerce the following: ''Assistant Secretary of Commerce for Manufacturing,''.

By Mr. CORZINE:

S. 1327. A bill to reduce unsolicited commercial electronic mail and to protect children from sexually oriented advertisements; to the Committee on Commerce, Science, and Transportation.

Mr. CORZINE. Mr. President, today I am introducing legislation, the Restrict and Eliminate the Delivery of Unsolicited Commercial Electronic Mail, REDUCE, Spam Act, to curb the influx of unwanted junk e-mail, or ''spam,'' that is clogging our inboxes and wasting the time and money of American consumers and businesses.

The flood of spam is growing so fast that it will soon account for more than half of all e-mail sent in the United States. Spam already accounts for nearly 40 percent of e-mail traffic, and costs U.S. businesses $10 billion annually in lost productivity and additional equipment, software and manpower costs necessary to manage this burden. Microsoft Inc. estimates that more than 80 percent of the more than 2.5 billion e-mail messages sent each day to Hotmail users are spam. And data suggests that the problem is only growing.

The problem of spam goes well beyond inconvenience and cost. The Federal Trade Commission examined a random sample of 1000 spam messages and, in a report issued on April 30, 2003, found staggering evidence of fraud. According to the report, 33 percent of the messages sampled contained false routing information; 22 percent contained false information in the subject line; 40 percent contained false statements in the text; and a full 66 percent contained false information of some sort. Most alarmingly, in the case of spam touting business or investment opportunities, 96 percent contained some sort of fraudulent information.

In addition, pornographic spam is a growing problem for parents trying to shield their children from such images. The FTC report found that 17 percent of spam advertising pornographic websites included adult images in the body of the message. This is not acceptable when our children are using email more and more each day.

Unfortunately, it is very difficult to track down those who send spam. Often, spammers use multiple e-mail addresses or disguise routing information to avoid being identified. Finding spammers can take not just real expertise, but persistence, time, energy and commitment.

To attack the problem of spam, my proposal adopts a two-prong approach championed by the leading thinker about cyberlaw, Professor Lawrence Lessig of Stanford Law School. Congresswoman ZOE LOFGREN also has introduced similar legislation in the House of Representatives. The approach is simple: first, anyone sending bulk unsolicited commercial e-mail would have to include on each e-mail a simple prefix—either ADV: or ADV:ADLT. Second, anyone who finds a spam-source who has failed to properly label unsolicited commercial e-mail would be eligible for a monetary reward from the FTC.

The first part of this proposal would enable Internet Service Providers, ISPs, employers and individual users to filter spam from business and personal email. This would give people the ability to tell their Internet service provider to block ADV e-mail, or they could automatically filter such e-mail into a spam folder on their own computer. This approach would enable far more effective filtering than currently possible.

The second part of my proposal would require the FTC to pay a bounty to anyone who tracks down a spammer who has failed properly to label unsolicited commercial e-mail. The proposal would invite anyone across the world who uses the Internet to hunt down these law-violating spammers. The FTC would then fine them and pay a portion of that fine as a reward to the bounty hunter who found them. The FTC could use the remainder of the fine to track down and prosecute other spammers.

Creating incentives for private individuals to help track down spammers is likely to substantially strengthen the enforcement of anti-spam laws. And with proper enforcement, spammers would soon learn that neglecting to label spam does not pay. In the end, that will mean that more spammers will label their spam or give up and stop spamming altogether. Either way, we will have fixed, or at least started to fix, the problem.

Professor Lessig is so convinced that this approach will substantially reduce spam that he has pledged to resign from his job at Stanford if it does not. While I will not hold him to that warranty, I do share his enthusiasm about this innovative approach, which is likely to be much more effective than relying exclusively on government investigators to identify spammers.

Having said that, I recognize that any domestic anti-spam legislation potentially is subject to evasion by spammers who relocate overseas in order to continue sending spam. To respond to that possibility, my bill also orders the Administration to study the possibility of an international agreement to reduce spam. This is an issue that affects us globally, and, in my view, we should consider a coordinated response.

In addition to these primary provisions, my bill would require marketers to establish a valid return e-mail address to which an e-mail recipient can write to ''opt-out'' of receiving further e-mails, and would prohibit marketers from sending any further e-mails after a person opts-out. The bill also would prohibit spam with false or misleading routing information or deceptive subject headings, and would authorize the Federal Trade Commission to collect civil fines against marketers who violate these requirements. Furthermore, my proposal would give Internet Service Providers the right to bring civil actions against marketers who violate these requirements and disrupt their networks, and, finally, the proposal would establish criminal penalties for fraudulent spam.

I know that the Commerce Committee recently ordered reported legislation to deal with the problem of spam, and I am hopeful that bill will come before the full Senate before long. When it does, it is my intention to work with my colleagues to see if some of the concepts in the REDUCE Spam Act, such as the establishment of individual rewards for bounty hunters, and a report on a possible international agreement on spam, can be incorporated into the broader package, to ensure that any legislation sent to the President will actually be effective in reducing spam.

I ask unanimous consent that the text of the legislation be printed in the

RECORD at this point, along with a related article by Professor Lawrence Lessig.

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

S. 1327

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 ''Restrict and Eliminate the Delivery of Unsolicited Commercial Electronic Mail or Spam Act of 2003'' or the ''REDUCE Spam Act of 2003''.

SEC. 2. DEFINITIONS.

In this Act:

(1) COMMERCIAL ELECTRONIC MAIL MESSAGE.—

(A) IN GENERAL.—The term ''commercial electronic mail message'' means any electronic mail message the primary purpose of which is the commercial advertisement or promotion of a commercial product or service (including content on an Internet website operated for a commercial purpose).

(B) REFERENCE TO COMPANY OR WEBSITE.—The inclusion of a reference to a commercial entity or a link to the website of a commercial entity in an electronic mail message does not, by itself, cause such message to be treated as a commercial electronic mail message for purposes of this Act if the contents or circumstances of the message indicate a primary purpose other than commercial advertisement or promotion of a commercial product or service.

(2) COMMISSION.—The term ''Commission'' means the Federal Trade Commission.

(3) ELECTRONIC MAIL ADDRESS.—

(A) IN GENERAL.—The term ''electronic mail address'' means a destination (commonly expressed as a string of characters) to which an electronic mail message can be sent or delivered.

(B) INCLUSION.—In the case of the Internet, the term ''electronic mail address'' may include an electronic mail address consisting of a user name or mailbox (commonly referred to as the ''local part'') and a reference to an Internet domain (commonly referred to as the ''domain part'').

(4) FTC ACT.—The term ''FTC Act'' means the Federal Trade Commission Act (15 U.S.C. 41 et seq.).

(5) HEADER INFORMATION.—The term ''header information'' means the source, destination, and routing information attached to an electronic mail message, including the originating domain name and originating electronic mail address.

(6) INITIATE.—The term ''initiate'', when used with respect to a commercial electronic mail message, means to originate such message or to procure the transmission of such message, either directly or through an agent, but shall not include actions that constitute routine conveyance of such message by a provider of Internet access service. For purposes of this Act, more than 1 person may be considered to have initiated the same commercial electronic mail message.

(7) INTERNET.—The term ''Internet'' has the meaning given that term in section 231(e)(3) of the Communications Act of 1934 (47 U.S.C. 231(e)(3)).

(8) INTERNET ACCESS SERVICE.—The term ''Internet access service'' has the meaning given that term in section 231(e)(4) of the Communications Act of 1934 (47 U.S.C. 231(e)(4)).

(9) PRE-EXISTING BUSINESS RELATIONSHIP.—

(A) IN GENERAL.—The term ''pre-existing business relationship'', when used with respect to a commercial electronic mail message, means that either—

(i) within the 5-year period ending upon receipt of a commercial electronic mail message, there has been a business transaction between the sender and the recipient, including a transaction involving the provision, free of charge, of information, goods, or services requested by the recipient and the recipient was, at the time of such transaction or thereafter, provided a clear and conspicuous notice of an opportunity not to receive further commercial electronic mail messages from the sender and has not exercised such opportunity; or

(ii) the recipient has given the sender permission to initiate commercial electronic mail messages to the electronic mail address of the recipient and has not subsequently revoked such permission.

(B) APPLICABILITY.—If a sender operates through separate lines of business or divisions and holds itself out to the recipient as that particular line of business or division, then such line of business or division shall be treated as the sender for purposes of subparagraph (A).

(10) RECIPIENT.—The term ''recipient'', when used with respect to a commercial electronic mail message, means the addressee of such message.

(11) SENDER.—The term ''sender'', when used with respect to a commercial electronic mail message, means the person who initiates such message. The term ''sender'' does not include a provider of Internet access service whose role with respect to electronic mail messages is limited to handling, transmitting, retransmitting, or relaying such messages.

(12) UNSOLICITED COMMERCIAL ELECTRONIC MAIL MESSAGE.—The term ''unsolicited commercial electronic mail message'' means any commercial electronic mail message that—

(A) is not a transactional or relationship message; and

(B) is sent to a recipient without the recipient's prior affirmative or implied consent.

SEC. 3. COMMERCIAL ELECTRONIC MAIL CONTAINING FRAUDULENT HEADER OR ROUTING INFORMATION.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''§ 1351. Unsolicited commercial electronic mail containing fraudulent header information

''(a) Any person who initiates the transmission of any unsolicited commercial electronic mail message, with knowledge and intent that the message contains or is accompanied by header information that is false or materially misleading, shall be fined or imprisoned for not more than 1 year, or both, under this title.

''(b) For purposes of this section, the terms 'unsolicited commercial electronic mail message' and 'header information' have the meanings given such terms in section 2 of the REDUCE Spam Act of 2003.''.

(b) CONFORMING AMENDMENT.—The chapter analysis at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1351. Unsolicited commercial electronic mail.''.

SEC. 4. REQUIREMENTS FOR UNSOLICITED COMMERCIAL ELECTRONIC MAIL.

(a) SUBJECT LINE REQUIREMENTS.—It shall be unlawful for any person to initiate the transmission of an unsolicited commercial electronic mail message to an electronic mail address within the United States, unless the subject line includes—

(1) except in the case of an unsolicited commercial electronic mail message described in paragraph (2)—

(A) an identification that complies with the standards adopted by the Internet Engineering Task Force for identification of unsolicited commercial electronic mail messages; or

(B) in the case of the absence of such standards, ''ADV:'' as the first four characters; or

(2) in the case of an unsolicited commercial electronic mail message that contains material that may only be viewed, purchased, rented, leased, or held in possession by an individual 18 years of age and older—

(A) an identification that complies with the standards adopted by the Internet Engineering Task Force for identification of adult-oriented unsolicited commercial electronic mail messages; or

(B) in the case of the absence of such standards, ''ADV:ADLT'' as the first eight characters.

(b) RETURN ADDRESS REQUIREMENTS.—

(1) ESTABLISHMENT.—It shall be unlawful for any person to initiate the transmission of an unsolicited commercial electronic mail message to an electronic mail address within the United States, unless the sender establishes a valid sender-operated return electronic mail address where the recipient may notify the sender not to send any further commercial electronic mail messages.

(2) INCLUDED STATEMENT.—All unsolicited commercial electronic mail messages subject to this subsection shall include a statement informing the recipient of the valid return electronic mail address referred to in paragraph (1).

(3) PROHIBITION OF SENDING AFTER OBJECTION.—Upon notification or confirmation by a recipient of the recipient's request not to receive any further unsolicited commercial electronic mail messages, it shall be unlawful for a person, or anyone acting on that person's behalf, to send any unsolicited commercial electronic mail message to that recipient. Such a request shall be deemed to terminate a pre-existing business relationship for purposes of determining whether subsequent messages are unsolicited commercial electronic mail messages.

(c) HEADER AND SUBJECT HEADING REQUIREMENTS.—

(1) FALSE OR MISLEADING HEADER INFORMATION.—It shall be unlawful for any person to initiate the transmission of an unsolicited commercial electronic mail message that such person knows, or reasonably should know, contains or is accompanied by header information that is false or materially misleading.

(2) DECEPTIVE SUBJECT HEADINGS.—It shall be unlawful for any person to initiate the transmission of an unsolicited commercial electronic mail message with a subject heading that such person knows, or reasonably should know, is likely to mislead a recipient, acting reasonably under the circumstances, about a material fact regarding the contents or subject matter of the message.

(d) AFFIRMATIVE DEFENSE.—A person who violates subsection (a) or (b) shall not be liable if—

(1)(A) the person has established and implemented, with due care, reasonable practices and procedures to effectively prevent such violations; and

(B) the violation occurred despite good faith efforts to maintain compliance with such practices and procedures; or

(2) within the 2-day period ending upon the initiation of the transmission of the unsolicited commercial electronic mail message in violation of subsection (a) or (b), such person initiated the transmission of such message, or one substantially similar to it, to less than 1,000 electronic mail addresses.

SEC. 5. ENFORCEMENT.

(a) IN GENERAL.—Section 4 shall be enforced by the Commission under the FTC

Act. For purposes of such Commission enforcement, a violation of this Act shall be treated as a violation of a rule under section 18 (15 U.S.C. 57a) of the FTC Act prohibiting an unfair or deceptive act or practice.

(b) RULEMAKING.—Not later than 30 days after the date of enactment of this Act, the Commission shall institute a rulemaking proceeding concerning enforcement of this Act. The rules adopted by the Commission shall prevent violations of section 4 in the same manner, by the same means, and with the same jurisdiction, powers, and duties as though all applicable terms and provisions of the FTC Act were incorporated into and made a part of this section, except that the rules shall also include—

(1) procedures to minimize the burden of submitting a complaint to the Commission concerning a violation of section 4, including procedures to allow the electronic submission of complaints to the Commission;

(2) civil penalties for violations of section 4 in an amount sufficient to effectively deter future violations, a description of the type of evidence needed to collect such penalties, and procedures to collect such penalties if the Commission determines that a violation of section 4 has occurred;

(3) procedures for the Commission to grant a reward of not less than 20 percent of the total civil penalty collected to the first person that—

(A) identifies the person in violation of section 4; and

(B) supplies information that leads to the successful collection of a civil penalty by the Commission;

(4) a provision that enables the Commission to keep the remainder of the civil penalty collected and use the funds toward the prosecution of further claims, including for necessary staff or resources; and

(5) civil penalties for knowingly submitting a false complaint to the Commission.

(c) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Commission shall conclude the rulemaking proceeding initiated under subsection (b) and shall prescribe implementing regulations.

SEC. 6. PRIVATE RIGHT OF ACTION.

(a) ACTION AUTHORIZED.—A recipient of an unsolicited commercial electronic mail message, or a provider of Internet access service, adversely affected by a violation of section 4 may bring a civil action in any district court of the United States with jurisdiction over the defendant to—

(1) enjoin further violation by the defendant; or

(2) recover damages in an amount equal to—

(A) actual monetary loss incurred by the recipient or provider of Internet access service as a result of such violation; or

(B) at the discretion of the court, the amount determined under subsection (b).

(b) STATUTORY DAMAGES.—

(1) IN GENERAL.—For purposes of subsection (a)(2)(B), the amount determined under this subsection is the amount calculated by multiplying the number of willful, knowing, or negligent violations by an amount, in the discretion of the court, of up to $10.

(2) PER-VIOLATION PENALTY.—In determining the per-violation penalty under this subsection, the court shall take into account the degree of culpability, any history of prior such conduct, ability to pay, the extent of economic gain resulting from the violation, and such other matters as justice may require.

(c) ATTORNEY FEES.—In any action brought pursuant to subsection (a), the court may, in its discretion, require an undertaking for the payment of the costs of such action, and assess reasonable costs, including reasonable attorneys' fees, against any party.

SEC. 7. INTERNET ACCESS SERVICE PROVIDERS.

Nothing in this Act shall be construed—

(1) to enlarge or diminish the application of chapter 121 of title 18, relating to when a provider of Internet access service may disclose customer communications or records;

(2) to require a provider of Internet access service to block, transmit, route, relay, handle, or store certain types of electronic mail messages;

(3) to prevent or limit, in any way, a provider of Internet access service from adopting a policy regarding commercial electronic mail messages, including a policy of declining to transmit certain types of commercial electronic mail messages, or from enforcing such policy through technical means, through contract, or pursuant to any other provision of Federal, State, or local criminal or civil law; or

(4) to render lawful any such policy that is unlawful under any other provision of law.

SEC. 8. EFFECT ON OTHER LAWS.

Nothing in this Act shall be construed to impair the enforcement of section 223 or 231 of the Communications Act of 1934 (47 U.S.C. 223 or 231), chapter 71 (relating to obscenity) or 110 (relating to sexual exploitation of children) of title 18, United States Code, or any other Federal criminal statute.

SEC. 9. FTC STUDY.

Not later than 24 months after the date of enactment of this Act, the Commission, in consultation with appropriate agencies, shall submit a report to Congress that provides a detailed analysis of the effectiveness and enforcement of the provisions of this Act and the need, if any, for Congress to modify such provisions.

SEC. 10. STUDY OF POSSIBLE INTERNATIONAL AGREEMENT.

Not later than 6 months after the date of enactment of this Act, the President shall—

(1) conduct a study in consultation with the Internet Engineering Task Force on the possibility of an international agreement to reduce spam; and

(2) issue a report to Congress setting forth the findings of the study required by paragraph (1).

SEC. 11. EFFECTIVE DATE.

The provisions of this Act shall take effect 180 days after the date of enactment of this Act, except that subsections (b) and (c) of section 5 shall take effect upon the date of enactment of this Act.

[From the Philadelphia Inquirer, May 4, 2003]

HOW TO UNSPAM THE INTERNET

(By Lawrence Lessig)

The Internet is choking on spam. Billions of unsolicited commercial messages—constituting almost 50 percent of all e-mail traffic—fill the in-boxes of increasingly impatient Internet users. These messages offer to sell everything from human growth hormones to pornography. And increasingly the offers to sell pornography are themselves pornographic.

So far, Congress has done nothing about this burden on the Internet. Many states have passed laws that have tried. Virginia just passed the most extreme of these laws, making it a felony to send spam with a fraudulent return address. Other states are considering the same.

Yet all of these regulations suffer from a similar flaw: Spamsters know the laws will never be enforced. The cost of bringing a lawsuit is extraordinarily high. Most of us have better things to do than sue spamsters. Thus, despite a patchwork of regulation that in theory should be restricting spam, the practice of spam continues to increase at an astonishing rate.

But last week, U.S. Rep. Zoe Lofgren (D., Calif.) introduced a bill that, if properly implemented by the Federal Trade Commission, would actually work. I am so confident she is right that I've offered to resign my job if her proposal does not significantly reduce the burden of spam.

The Restrict and Eliminate Delivery of Unsolicited Commercial E-mail (REDUCE) Spam Act has two important parts. First, anyone sending bulk unsolicited commercial e-mail must include on each e-mail a simple tag—either ADV: or ADV:ADLT. Second, anyone who finds a spamster who fails properly to label unsolicited commercial e-mail will be paid a bounty by the FTC.

The first part of the proposal would enable simple filters to block unwanted spam. Users could tell their Internet service provider to block ADV e-mail, or they could automatically filter such e-mail into a spam folder on their own computer. These simple filters would replace the extraordinarily sophisticated filters companies have been developing to identify and block spam.

These complex filters, though ingenious, are necessarily one step behind. Spamsters will always find a way to trick them. The filters will be changed to respond, but the spamsters will in turn change their spam to find a way around the filters. Thus the filters will never block all spam, but they will always block a certain number of messages that are not spam.

But part one of the Lofgren legislation would never work if it weren't for part two: A spamster bounty. Lofgren's proposal would require the FTC to pay a bounty to anyone who tracks down a spamster who has failed properly to label unsolicited commercial e-mail. This proposal would invite savvy 18-year-olds from across the world to hunt down these law-violating spamsters. The FTC would then fine them, after paying a reward to the bounty hunter who found them.

The bounty would assure that the spam law was enforced. Properly enforced, the law would teach most spamsters that failing to label spam doesn't pay. The spamsters in turn would decide either to label their spam or give up and get a real job. Either way, the burden of spam would be reduced.

No doubt no solution would eliminate 100 percent of spam. Much is foreign; American laws would not easily reach those spamsters. But the question lawmakers should ask is what is the smallest, least burdensome regulation that would have the most significant effect. If Lofgren's proposal were passed, the vast majority of spamsters would have to change their ways. Technologists could then target their filters on the spamsters that remain.

What about free speech? Don't spamsters have First Amendments rights?

Of course they do. And many of the laws proposed right now go too far in censoring speech. Threatening a felony for a bad return address, as the Virginia law does, is a dangerous precedent. Laws that ban spam altogether are much worse.

But Lofgren's proposal simply requires a proper label so consumers can choose whether they want to receive the speech or not. And most important, by reducing the clutter of unsolicited and unwanted spam, the law would improve the opportunity for other speech—including political speech—to get through.

More fundamentally, free speech is threatened just as much by bad filters as by bad laws. A well-crafted law—narrow in its scope, and moderate in its regulation—can in turn eliminate the demand for bad filters. Lofgren's proposal would have just this effect. Congress should act to follow Lofgren's lead. In Internet time, not Washington time.

By Mr. HATCH (for himself and Mrs. CLINTON):

S. 1328. A bill to provide for an evaluation by the Institute of Medicine of the National Academy of Sciences of leading health care performance measures and options to implement policies that align performance with payment under the Medicare program under title XVIII of the Social Security Act; to the Committee on Finance.

Mr. HATCH. Mr. President, I rise today to address an issue of importance to all Americans, the quality and safety of health care in the United States.

Numerous studies have identified serious shortcomings in the quality and safety of health care. However, addressing these shortcomings and improving health care outcomes in a complex health care system requires long-range strategies and specific goals.

The Medicare program, as one of the largest purchasers of health care, is ideally situated to take a leadership role in encouraging quality improvement. Currently, however, Medicare's payment methods and regulations provide few incentives to pursue innovative quality improvement strategies and to reward those who achieve exemplary performance.

Traditional Medicare pays most physicians according to a fee schedule and pays hospitals according to a DRG-based payment system. Medicare+Choice plans are paid a capitated rate and, in turn, pay physicians using a range of approaches, from salary to capitation to fee-for-service, none of which directly reward enhanced quality.

Attempts to adjust Medicare payments to reward performance improvements in safety and quality have been hampered, in part, by the lack of measures and data for assessing performance. Although the Centers for Medicare and Medicaid Services recently began an initiative to develop voluntary consensus performance measures for 10 clinical conditions for hospitals, standardized measures of quality for hospitals and providers do not otherwise exist.

As the Senate considers a new Medicare prescription drug benefit and additional measures to reform the Medicare program, it is more important than ever that we consider also measures to ensure that these new benefits are provided as safely and effectively as possible.

That is why I am today introducing a bill charging the Institute of Medicine with performing a study to evaluate leading health care performance measures and options to implement policies that align performance with payment in Medicare.

We have learned much about health care quality in the last several years. The Institute of Medicine, in its studies entitled ''To Err Is Human,'' and ''Crossing the Quality Chasm,'' has identified the health care safety and quality shortcomings that exist and the need for improvement. In a recent study performed at the request of Congress, ''Leadership by Example,'' the Institute of Medicine identified the leadership role that Government can take in improving health care quality in government sponsored health care programs and those in the private sector.

The bill that I am introducing today, and the study that will result, represents the next step toward improving health care quality and safety in the United States. It is an important step and one that we must take in order to ensure that Medicare beneficiaries receive the highest quality health care services available. I urge my colleagues to join me in supporting this legislation.

Mrs. CLINTON. Mr. President, I am pleased to join my friend from Utah, Senator HATCH, today in introducing a bill that will commission a study from IOM to identify performance measures and payment incentives that reward high quality providers in Medicare.

Currently Medicare pays the same amount for good care as it does for poor quality care. It's easy to assume that the dollars that go to Medicare all yield high quality care, but the evidence is otherwise.

Take heart disease, the leading cause of death in the U.S. Cholesterol management after a heart attack can mean the difference between disability and an active lifestyle. Yet we don't have adequate data that show us whether most Medicare beneficiaries are getting this clinically appropriate care. And the only data that we do have, from NCQA, The State of Health Care Quality 2002, tells us that in 2001 almost one-quarter, 23 percent, of Medicare beneficiaries in health plans did not have their cholesterol managed after a heart attack.

In New York, between 14 and 22 percent of diabetic beneficiaries in health plans did not get a blood sugar control test in 2001.

When Medicare and Medicare enrollees pay the same amount to providers that give excellent care as it does to those who provide mediocre care, that may unintentionally create incentives for providers to skimp or cut corners on quality. We debate endlessly over ways to control costs in Medicare, but we have not taken one of the simple steps that will, almost certainly, drive quality up and assure that we are getting good value for the dollars we spend.

Medicare should be a leader in national efforts to improve quality. Medicare, with its $250 billion of purchasing power, 40 million enrollees, programs data, and professional experience can bring more resources to bear on these quality problems than any other purchaser.

The study we are proposing today would be the first step down this path. It would cost relatively little but yield great rewards as a guide to how to measure and pay for quality in the future. The study would develop measures to assess quality, including outcome measures. It would tell us what payment incentives have worked in the private sector. And it would identify approaches to use incentives to improve quality that can be implemented across all of Medicare.

So I am pleased that we are making this effort today, and hope that it is just the first step of many more that we will take down the path of improving Medicare for patients and consumers.

By Ms. MURKOWSKI:

S. 1330. A bill to establish the Kenai Mountains-Turnagain Arm National Heritage Area in the State of Alaska, and for other purposes; to the Committee on Energy and Natural Resources.

Ms. MURKOWSKI. Mr. President, the Kenai Mountains-Turnagain Arm National Heritage Area is one of the best examples for preserving the heritage of one of this Nation's first pioneer areas. This legislation will create a national heritage corridor that covers an area from Seward to Anchorage.

This national heritage corridor will protect the natural and cultural resources of a well established region. The Kenai Mountains-Turnagain Arm National Heritage Area will follow along a corridor that was established by pioneering Alaskans. This route will partially follow two nationally recognized treasures—the Iditarod Trail and the Seward Highway National Scenic Byway. It will honor Native traders, gold rush stampeders and the route of the Alaska Railroad. One of the biggest gold discoveries along this route was the Bear Creek gold find near Hope in 1895. The route of the Alaska Railroad was finished in 1923.

Unlike many others, this national heritage corridor will not be managed by the Federal Government, but instead, by a group of local community leaders. The preservation of historic areas depends largely upon the community and its support, and clearly, no one entity can provide the adequate management, protection and preservation for these extensive resources. In fact, over the past five years, a group of local community leaders has been working hard for this national heritage designation. They have been successful in garnering support from communities throughout this entire route. These local folks have extensive knowledge of the resources; they are personally acquainted with the area; they understand the ruggedness and the beauty of the land, and certainly appreciate the potential economic value this designation would bring to the area.

The preservation of history and heritage depends upon the mutual support and assistance from public and private groups. This national heritage designation has been a vision of many people from Seward to Anchorage, and comprises lands in the Kenai Mountains and the upper Turnagain Arm region. An 11-member board will be established and charged with seeing the vision become a reality. This non-profit board

will be tasked with coordinating and supporting the protection of trail resources; interpreting the trail, and identifying the cultural landscapes of the Kenai Mountains-Turnagain Arm historic transportation corridor. A plan will also be developed for the management of the heritage corridor, and will complement existing Federal, State, borough and local plans. To ensure even greater support of this designation, there will be opportunities provided to the public for their full participation as the plan is being developed.

The purposes of designating this national treasure are to: Enable all people to envision and experience the heritage and impacts of transportation routes used first by indigenous people, followed by pioneers to the Nation's first frontier;

Encourage economic viability in the affected communities.

This national heritage corridor is significant for a whole host of reasons: Allow citizens to help preserve the heritage of the pioneers; protect and honor the history of Native traders, gold seekers and pioneers; decisions and management will be made by local citizens; support of several historical associations, the cities of Seward, Girdwood, Hope and Anchorage; an 11-member non-profit local board will plan and operate the heritage corridor; increase public awareness and appreciation for the natural, historical and cultural resources, and modern resource development of the heritage corridor; restore historic buildings and structures that are located within the boundaries of the heritage corridor; and, no additional lands will be acquired by the Federal Government or by the local management group.

Rarely ever do we have such an opportunity when whole communities, Federal, State and local governments agree on and support such a national designation. Through adequate funding from the Department of the Interior, interpretation signs and technical assistance to conduct local planning will help to preserve and protect natural, historical, landscape and cultural resource values for current and future generations of the Kenai Mountains-Turnagain Arm National Heritage Area.

And, finally, with the passage of this bill, visitors to the area can enjoy the shore lines of Turnagain Arm and watch the world's second largest tidal range move 30 foot tides in and out. A traveler through the mountain passes of the heritage area can view evidence of retreating glaciers and avalanches. Visitors will be amazed at the abundant wildlife that make their home in the area. The history of early settlers will be preserved for current and future generations.

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

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

S. 1330

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 ''Kenai Mountains-Turnagain Arm National Heritage Area Act''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds that—

(1) The Kenai Mountains-Turnagain Arm transportation corridor is a major gateway to Alaska and includes a range of transportation routes used first by indigenous people who were followed by pioneers who settled the Nation's last frontier;

(2) the natural history and scenic splendor of the region are equally outstanding; vistas of nature's power include evidence of earthquake subsidence, recent avalanches, retreating glaciers and tidal action along Turnagain Arm, which has the world's second greatest tidal range;

(3) the cultural landscape formed by indigenous people and then by settlement, transportation and modern resource development in this rugged and often treacherous natural setting stands as powerful testimony to the human fortitude, perseverance, and resourcefulness that is America's proudest heritage from the people who settled the frontier;

(4) there is a national interest in recognizing, preserving, promoting, and interpreting these resources;

(5) the Kenai Mountains-Turnagain Arm region is geographically and culturally cohesive because it is defined by a corridor of historic routes—trail, water, railroad, and roadways through a distinct landscape of mountains, lakes, and fjords;

(6) national significance of separate elements of the region include, but are not limited to, the Iditarod National Historic Trail, the Seward Highway National Scenic Byway, and the Alaska Railroad National Scenic Railroad;

(7) national heritage area designation provides for the interpretation of these routes, as well as the national historic districts and numerous historic routes in the region as part of the whole picture of human history in the wider transportation corridor including early Native trade routes, connections by waterway, mining trail, and other routes;

(8) national heritage area designation also provides communities within the region with the motivation and means for ''grass roots'' regional coordination and partnerships with each other and with borough, State, and Federal agencies; and

(9) national heritage area designation is supported by the Kenai Peninsula Historical Association, the Seward Historical Commission, the Seward City Council, the Hope and Sunrise Historical Society, the Hope Chamber of Commerce, the Alaska Association for Historic Preservation, the Cooper Landing Community Club, the Alaska Wilderness Recreation and Tourism Association, Anchorage Historic Properties, the Anchorage Convention and Visitors Bureau, the Cook Inlet Historical Society, the Moose Pass Sportsman's Club, the Alaska Historical Commission, the Girdwood Board of Supervisors, the Kenai River Special Management Area Advisory Board, the Bird/Indian Community Council, the Kenai Peninsula Borough Trails Commission, the Alaska Division of Parks and Recreation, the Kenai Peninsula Borough, the Kenai Peninsula Tourism Marketing Council, and the Anchorage Municipal Assembly.

(b) PURPOSES.—The purposes of this Act are—

(1) to recognize, preserve, and interpret the historic and modern resource development and cultural landscapes of the Kenai Mountains-Turnagain Arm historic transportation corridor, and to promote and facilitate the public enjoyment of these resources; and

(2) to foster, through financial and technical assistance, the development of cooperative planning and partnership among the communities and borough, State, and Federal Government entities.

SEC. 3. DEFINITIONS.

In this Act:

(1) HERITAGE AREA.—The term ''Heritage Area'' means the Kenai Mountains-Turnagain Arm National Heritage Area established by section 4(a) of this Act.

(2) MANAGEMENT ENTITY.—The term ''management entity'' means the 11 member Board of Directors of the Kenai Mountains-Turnagain Arm National Heritage Corridor Communities Association.

(3) MANAGEMENT PLAN.—The term ''management plan'' means the management plan for the Heritage Area.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of the Interior.

SEC. 4. KENAI MOUNTAINS-TURNAGAIN ARM NATIONAL HERITAGE AREA.

(a) ESTABLISHMENT.—There is established the Kenai Mountains-Turnagain Arm National Heritage Area.

(b) BOUNDARIES.—The Heritage Area shall comprise the lands in the Kenai Mountains and upper Turnagain Arm region generally depicted on the map entitled ''Kenai Peninsula/Turnagain Arm National Heritage Corridor'', numbered ''Map #KMTA–1, and dated ''August 1999''. The map shall be on file and available for public inspection in the offices of the Alaska Regional Office of the National Park Service and in the offices of the Alaska State Heritage Preservation Officer.

SEC. 5. MANAGEMENT ENTITY.

(a) The Secretary shall enter into a cooperative agreement with the management entity, to carry out the purposes of this Act. The cooperative agreement shall include information relating to the objectives and management of the Heritage Area, including the following:

(1) A discussion of the goals and objectives of the Heritage Area;

(2) An explanation of the proposed approach to conservation and interpretation of the Heritage Area;

(3) A general outline of the protection measures, to which the management entity commits.

(b) Nothing in this Act authorizes the management entity to assume any management authorities or responsibilities on Federal lands.

(c) Representatives of other organizations shall be invited and encouraged to participate with the management entity and in the development and implementation of the management plan, including but not limited to: The State Division of Parks and Outdoor Recreation; the State Division of Mining, Land and Water; the Forest Service; the State Historic Preservation Office; the Kenai Peninsula Borough; the Municipality of Anchorage; the Alaska Railroad; the Alaska Department of Transportation; and the National Park Service.

(d) Representation of ex-officio members in the non-profit corporation shall be established under the bylaws of the management entity.

SEC. 6. AUTHORITIES AND DUTIES OF MANAGEMENT ENTITY.

(a) MANAGEMENT PLAN.—

(1) IN GENERAL.—Not later than 3 years after the Secretary enters into a cooperative agreement with the management entity, the management entity shall develop a management plan for the Heritage Area, taking into consideration existing Federal, State, borough, and local plans.

(2) CONTENTS.—The management plan shall include, but not be limited to—

(A) comprehensive recommendations for conservation, funding, management, and development of the Heritage Area;

(B) a description of agreements on actions to be carried out by Government and private organizations to protect the resources of the Heritage Area;

(C) a list of specific and potential sources of funding to protect, manage, and develop the Heritage Area;

(D) an inventory of the resources contained in the Heritage Area; and

(E) a description of the role and participation of other Federal, State, and local agencies that have jurisdiction on lands within the Heritage Area.

(b) PRIORITIES.—The management entity shall give priority to the implementation of actions, goals, and policies set forth in the cooperative agreement with the Secretary and the heritage plan, including assisting communities within the region in—

(1) carrying out programs which recognize important resource values in the Heritage Area;

(2) encouraging economic viability in the affected communities;

(3) establishing and maintaining interpretive exhibits in the Heritage Area;

(4) improving and interpreting heritage trails;

(5) increasing public awareness and appreciation for the natural, historical, and cultural resources and modern resource development of the Heritage Area;

(6) restoring historic buildings and structures that are located within the boundaries of the Heritage Area; and

(7) ensuring that clear, consistent, and appropriate signs identifying public access points and sites of interest are placed throughout the Heritage Area.

(c) PUBLIC MEETINGS.—The management entity shall conduct 2 or more public meetings each year regarding the initiation and implementation of the management plan for the Heritage Area. The management entity shall place a notice of each such meeting in a newspaper of general circulation in the Heritage Area and shall make the minutes of the meeting available to the public.

SEC. 7. DUTIES OF THE SECRETARY.

(a) The Secretary, in consultation with the Governor of Alaska, or his designee, is authorized to enter into a cooperative agreement with the management entity. The cooperative agreement shall be prepared with public participation.

(b) In accordance with the terms and conditions of the cooperative agreement and upon the request of the management entity, and subject to the availability of funds, the Secretary may provide administrative, technical, financial, design, development, and operations assistance to carry out the purposes of this Act.

SEC. 8. SAVINGS PROVISIONS.

(a) REGULATORY AUTHORITY.—Nothing in this Act shall be construed to grant powers of zoning or management of land use to the management entity of the Heritage Area.

(b) EFFECT ON AUTHORITY OF GOVERNMENTS.—Nothing in this Act shall be construed to modify, enlarge, or diminish any authority of the Federal, State, or local governments to manage or regulate any use of land as provided for by law or regulation.

(c) EFFECT ON BUSINESS.—Nothing in this Act shall be construed to obstruct or limit business activity on private development or resource development activities.

SEC. 9. PROHIBITION ON THE ACQUISITION OR REAL PROPERTY.

The management entity may not use funds appropriated to carry out the purposes of this Act to acquire real property or interest in real property.

SEC. 10. AUTHORIZATION OF APPROPRIATIONS.

(a) FIRST YEAR.—For the first year $350,000 is authorized to be appropriated to carry out the purposes of this Act, and is made available upon the Secretary and the management entity completing a cooperative agreement.

(b) IN GENERAL.—There is authorized to be appropriated not more than $1,000,000 to carry out the purposes of this Act for any fiscal year after the first year. Not more than $10,000,000, in the aggregate, may be appropriated for the Heritage Area.

(c) MATCHING FUNDS.—Federal funding provided under this Act shall be matched at least 25 percent by other funds or in-kind services.

(d) SUNSET PROVISION.—The Secretary may not make any grant or provide any assistance under this Act beyond 15 years from the date that the Secretary and management entity complete a cooperative agreement.

By Mr. SANTORUM (for himself, Mr. CONRAD, and Mr. BREAUX):

S. 1331. A bill to clarify the treatment of tax attributes under section 108 of the Internal Revenue Code of 1986 for taxpayers which file consolidated returns; to the Committee on Finance.

Mr. SANTORUM. Mr. President, today I am introducing a bill along with Senator CONRAD that would close a gaping loophole in the Internal Revenue Code. This loophole involves the treatment of companies whose debt is cancelled in a bankruptcy proceeding. Under existing law, these companies are not required to immediately pay tax on their income from debt cancellation. The are, however, required to reduce their net operating losses, NOLs, and other tax attributes. These attribute reductions have the effect of allowing bankrupt companies to defer, but not permanently avoid, paying tax on income from debt cancellation.

It has come to my attention that MCI/WorldCom and certain other bankrupt companies are attempting to circumvent these rules. In plain English, MCI/WorldCom—the group of corporations that has perpetrated the greatest business fraud—is trying to relieve itself of $35 billion of debt and yet emerge from bankruptcy with an NOL that is estimated to range from $10 to $15 billion. Such an NOL will, post-bankruptcy, eliminate federal income tax of $3.5 billion to $5.25 billion on MCI/WorldCom's first $10 to $15 billion of income.

Plainly, if this tax loophole is not eliminated, MCI/WorldCom will not pay taxes for the foreseeable future. By attempting to utilize this loophole, MCI/WorldCom is demonstrating that it is not, in fact, a new company—instead, it is the same reckless company that we have come to know. The legislation I am introducing today will assure that MCI/WorldCom doesn't get away with this outrageous behavior. It will also prevent other companies from imitating this approach.

Such results would be bad tax policy for two reasons. First, they would clearly be contrary to the policy objectives that Congress intended to achieve when it enacted the current tax attribute reduction rules. Second, equivalent taxpayers would be treated differently under Section 108 based on their corporate structure and borrowing practices—factors that, form a tax policy standpoint, do not justify any difference in treatment.

Based on rulings and court cases, I believe this bill reflects the current tax position of the Treasury Department with respect to NOLs. Although it is also clear that aggressive taxpayers and their lawyers have utilized this tax loophole. The approach to this provision is contrary to United Dominion Industries, Inc. v. United States, 532 U.S. 822 (2001). Although not dealing directly with Section 108, the case is clear that the only NOL of a consolidated group is the group's entire NOL. I am introducing this bill with an effective date of today to provide notice to MCI/WorldCom, and all similarly situated taxpayers, that this Congress will not stand for this.

I encourage my colleagues to support closing this loophole to avoid such abuse in the future. I ask unanimous consent to have the Business Week story from May 12, 2003, ''Why This Tax Loophole For Losers Should End,'' and the text of the bill be printed in the RECORD.

S. 1331

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

SECTION 1. CLARIFICATION OF THE TREATMENT OF TAX ATTRIBUTES.

(a) IN GENERAL.—Section 108(b) of the Internal Revenue Code of 1986 (relating to reduction of tax attributes) is amended by adding at the end the following new paragraph:

''(6) AFFILIATED GROUPS.—If the taxpayer is a member of an affiliated group of corporations which files a consolidated return under section 1501, the tax attributes described in paragraph (1) shall be the aggregate tax attributes of such group. The Secretary shall prescribe such regulations as may be necessary under section 1502 to carry out the purposes of this paragraph.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges of indebtedness occurring after June 25, 2003, except that discharges of indebtedness under any plan of reorganization in a case under title 11, United States Code, shall be deemed to occur on the date such plan is confirmed.

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

[From Business Week, May 12, 2003]

(By David Henry)

WHY THIS TAX LOOPHOLE FOR LOSERS SHOULD END

Is there no end to the ugly superlatives that fallen telecom giant WorldCom Inc. is amassing? First, its top execs reigned over the greatest alleged accounting fraud in history. Then, the company filed the largest corporate bankruptcy. Now, it is lining up to collect what could be one of the biggest single corporate tax breaks of all time.

To the fury of its competitors, WorldCom is angling to snare a $2.5 billion benefit from Uncle Sam. How? By exploiting a provision in the Internal Revenue Service code so it

can hanging onto previous losses of at least $6.6 billion and enjoy years of tax-free earnings. What's more, the ploy would protect new management against any takeover for at least two years. And, WorldCom could use the losses to offset even income it picks up by taking over other companies. ''WorldCom is in an enviable position,'' says Robert Willens, tax accounting analyst at Lehman Brothers Inc. ''It will have a copious tax losses and can be a powerful acquirer.''

WorldCom's new owners—the holders of its $41 billion of dad debt—are driving a truck through a loophole that needs to be closed pronto. It was left open by Congress when the lawmakers overhauled IRS rules to stamp out a notorious trade in corporate tax losses. At one time, owners of loss-making businesses could sell their companies along with their accumulated tax loss—often their only asssit—to profitable companies. Now, tax losses are snuffed out when company ownership changes hands.

So, WorldCom is going through hoops to avoid that fate. Pending a final vote by creditors later this year, the company is changing its bylaws to prohibit anyone from building anyone from building a stake of more than 4.75 percent in the company. They have to keep bidders at bay for at least two years, otherwise the IRS would argue that control of WorldCom has changed hands and that the tax losses—which, assuming a 38 percent tax rate, could give a $2.5 billion boost to earnings—should be wiped out. ''It is the perfect poison pill,'' says Carl M. Jenks, tax expert at law firm Jones Day.

The perverse tactic is increasingly popular. The former Williams Communication Group put a similar 5 percent ownership limit in place last fall when it became WilTil Communications Group Inc. after a bankruptcy reorganization. The bankruptcy judge overseeing UAL Corp. agreed on Feb. 24 to a similar restriction on UAL securities in order to preserve its $4 billion of tax losses. ''We will generally recommend that any company with net operating losses worth anything adopt these restrictions,'' says Douglas W. Killip, a tax lawyer at Akin Gump Strauss Hauer & Field.

For WorldCom's rivals, the tax break is salt on a wound. William P. Barr, a former U.S. attorney general and now general counsel of Verizon Communications, fumes that WorldCom is trying to ''compound its fraud by escaping the payment of taxes.'' WorldCom's bankruptcy reorganization will eliminate the cost of servicing some $30 billion of debt. That, the company projects, will help it to make $2 billion before taxes next year. By using the tax losses, it will be able to keep about $780 million in cash it would otherwise owe the government. In fact, it won't be liable for any tax at least until the accumulated losses are worked through. And, because it racked up the $6.6 billion in losses just through 2001, WorldCom could have billions more to play with once the numbers for 2002 are finally worked out.

What's more, the poison pill is likely to deter any company from buying WorldCom and dumping some of the obsolete assets still clogging and telecom industry. That will slow and recovery in capital spending and hurt WorldCom's competitors. ''It is bad when business decisions are motivated by tax reasons and not based on sound economics,'' says Anthony Sabino, bankruptcy law professor at St. John's University.

Rivals are likely to push the IRS to find a way to stop WorldCom from utilizing the losses, observers say. But their chances of success are slim because the IRS never issued regulations that could have nullified the ploy. And the courts generally rule against the agency when it attempts to write rules retroactively, Willens says.

Still, it's time to close the stable door before any more horses bolt. Besides, Uncle Sam could use the money right now.

By Mr. HATCH:

S. 1332. A bill to amend title XVIII of the Social Security Act to provide regulatory relief, appeals process reforms, contracting flexibility, and education improvements under the Medicare program, and for other purposes; to the Committee on Finance.

Mr. HATCH. Mr. President, there is no question that our need to improve the Medicare program by adding prescription drug coverage for beneficiaries is extremely important, as this debate indicates.

But, our discussions would not be complete if we neglected another major Medicare improvement which is also long overdue, and that is the need to improve the climate in which providers strive to provide high quality services to patients.

Medicare's anticipated regulations—three times longer than the U.S. tax code—prevent providers from delivering health care efficiently and beneficiaries from receiving the care they need.

Complex Federal regulations and reams of paperwork require physicians to spend hours each day filling out government forms rather than caring for their patients. The array of Federal Medicare rules with which physicians must comply is overwhelming. Doctors are required to complete claims forms, advance beneficiary notices, certify medical necessity, file enrollment forms, and comply with code documentation guidelines. Indeed, these rules and mandates are not only extensive, they are constantly changing and they may be interpreted differently in different regions of the country.

The complexity of the rules and the variation in their interpretation has prompted outcries from all centers of our country. In fact, I have heard loud and clear from the physicians in my home State of Utah about the severity of the problem.

Leon Sorensen, Executive Vice President of the Utah Medical Association, recently wrote to me and said:

''The Utah Medical Association has long been concerned about the unnecessary burdens placed upon physicians by the voluminous regulations of Medicare. Not only does compliance with these regulations take physicians' time away from patients, but also the regulations contribute to the high cost of medical care while contributing little of value. They discourage physicians from participating fully in Medicare. They are often punitive in nature rather than an educational. They use tactics that would not be tolerated by businesses or government if applied to them.

An example is the practice of extrapolating a small sample of billing errors over the physician's entire practice, making the physician liable for payback of thousands of dollars of ''overpaid'' claims when demonstrated over billings may amount only to a few dollars. If this process were used by the IRS in a tax audit, the public outcry would be deafening.

Medicare also requires that alleged ''overpayments'' to physicians by repaid within 60 days, even if a physician chooses to appeal Medicare's allegations. When assessed a Medicare overpayment, the only way physicians can appeal is to subject their practices to another audit, using a ''statistically valid random sample.'' Statistical sample audits can shut down a physician's practice for days, preventing physicians from treating patients. Physicians are forced to settle with Medicare rather than be subjected to such unfair scrutiny.

Any defense against this kind of administrative abuse is extremely costly, time consuming and often ineffective.

Indeed, failure to follow Medicare's complex rules—or just the perception of such failure—can result in an audit of a physician's billing records, withholding of payments and crippling of a physician's practice.

And, physicians are not the only individuals affected by these rules. Medicare beneficiaries are affected—both directly and indirectly—by Medicare's onerous rules and burdensome paperwork. Both patients and providers are confused by obscure paperwork and apparently conflicting rules. Physicians have difficulty understanding how to bill for their services and beneficiaries find it difficult to understand the forms and billing information that they receive. Indeed, the administrative costs associated with managing this paperwork and the fear of harsh consequences in response to clerical errors has led some providers to consider whether they should continue to participate in the Medicare program.

The problem has not escaped the attention of the administration and addressing it is a priority for President Bush and it should be for Congress also. Secretary Thompson has said, ''Patients and providers alike are fed up with voluminous and complex paperwork. Rules are constantly changing. Complexity is overloading the system, criminalizing honest mistakes and driving doctors, nurses, and other health care professionals out of the program.''

Congress has considered legislation over the past few years to provide relief from this regulatory burden. Former Senator Frank Murkowski should be given great credit for drafting S. 452, the ''Medicare Education and Regulatory Fairness Act of 2001''—legislation that he introduced in the Senate on March 5, 2001 but which never came to a vote.

The legislation that I am introducing today, the ''Medicare Education Regulatory Reform and Contracting Improvement Act of 2003,'' MERCI, builds on that initiative. It will improve the Medicare program for beneficiaries and providers alike by clarifying regulations, rewarding quality and by enhancing services. I am introducing this legislation today because the need for Medicare regulatory reform remains. In fact, the need for Medicare regulatory reform has never been greater. In addition, the regulatory reform that I am proposing in MERCI fits hand in glove with the reforms that we have

proposed in S. 1, the ''Prescription Drug and Medicare Improvement Act of 2003.'' The reformed Medicare program must include reformed regulations if it is to provide efficient service to beneficiaries.

Let me take a moment to review a few of the important provisions in this bill. The educational provisions of the MERCI Act are designed to decrease Medicare billing and claims payment errors by improving education and training programs for Medicare providers. It includes also provisions that will improve communication between the Department of Health and Human Services and Medicare providers. Furthermore, the bill will improve communication with Medicare beneficiaries by providing for central toll-free telephone services to require free, appropriate referrals to individuals seeking information or assistance with Medicare.

The MERCI Act includes regulatory reform provisions that are designed to reduce waste, fraud and abuse in Medicare; provisions that are just and fair for beneficiaries, contractors, and providers. Among other things, the bill eliminates retroactive application of regulatory changes and expedites the appeals processes for beneficiaries, providers, and suppliers of Medicare services.

Finally, the MERCI Act will improve Medicare contracting; increasing competition, improving service and reducing costs by providing for a competitive bidding process for Medicare contractors that takes into account performance quality, price and other factors that are important to beneficiaries.

Medicare beneficiaries and Medicare providers have been suffering from burdensome and confusing regulations for too long. It is time that they received some mercy. The time for Medicare regulatory reform has come and the bill that I am introducing today provides that mercy. MERCI, the ''Medicare Education, Regulatory Reform and Contracting Improvement Act of 2003'' takes a common sense approach to providing relief for the Medicare beneficiaries and providers who have been suffering this burden for so long.

I believe that MERCI will improve the delivery of health care services to Medicare beneficiaries by enhancing the efficiency of the Medicare program for all concerned.

Finally, I would be remiss if I did not thank Chairman GRASSLEY and Senator BAUCUS for working with me to include the MERCI legislative language in S. 1, the ''Prescription Drug and Medicare Improvement Act of 2003.'' Senators GRASSLEY and BAUCUS have worked for many years to reform Medicare's complex regulations, as have I, and their agreement to include this language is appreciated greatly.

And so, it is with a great appreciation for my colleagues who have worked with me on this legislation and for those who have worked on similar legislation in the past, that I urge my colleagues in the Senate today to join me in addressing the needs of Medicare beneficiaries and providers by supporting this legislation.

By Mr. GRASSLEY (for himself, Mr. BINGAMAN, Mr. BUNNING, Mr. DASCHLE, Mr. ROCKEFELLER, Mr. BAUCUS, Ms. SNOWE, Mr. THOMAS, Mr. SMITH, Mr. CONRAD, Mr. GRAHAM of Florida, Mr. KERRY, Mr. BREAUX, Mrs. LINCOLN, and Mr. JEFFORDS):

S. 1333. A bill to amend the Internal Revenue Code of 1986 to provide for the treatment of certain expenses of rural letter carriers; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, the U.S. Postal Service provides a vital and important communication link for the Nation and the citizens of my home State of Iowa. Rural Letter Carriers play a special role and have a proud history as an important link in assuring the delivery of our mail. Rural letter carriers first delivered the mail with their own horses and buggies, later with their own motorcycles, and now in their own cars and trucks. They are responsible for maintenance and operation of their vehicles in all types of weather and road conditions. In the winter, snow and ice is their enemy, while in the spring, the melting snow and ice causes potholes and washboard roads. In spite of these quite adverse conditions, rural letter carriers daily drive over 3 million miles and serve 24 million American families on over 66,000 routes.

Although the mission of rural carriers has not changed since the horse and buggy days, the amount of mail they deliver has changed dramatically. As the Nation's mail volume has increased throughout the years, the Postal Service is now delivering more than 200 billion pieces of mail a year. The average carrier delivers about 2,300 pieces of mail a day to about 500 addresses.

Most recently, e-commerce has changed the type of mail rural letter carriers deliver. This fact was confirmed in a GAO study entitled ''U.S. Postal Service: Challenges to Sustaining Performance Improvements Remain Formidable on the Brink of the 21st Century,'' dated October 21, 1999. As this report explains, the Postal Service expects declines in its core business, which is essentially letter mail, in the coming years. The growth of e-mail on the Internet, electronic communications, and electronic commerce has the potential to substantially affect the Postal Service's mail volume.

First-Class mail has always been the bread and butter of the Postal Service's revenue, but the amount of revenue from First-Class letters is declining. E-commerce is providing the Postal Service with another opportunity to increase another part of its business. That is because what individuals and companies order over the Internet must be delivered, sometimes by the Postal Service and often by rural letter carriers. Currently, the Postal Service had about 33 percent of the parcel business. Rural letter carriers are now delivering larger volumes of business mail, parcels, and priority mail packages. But, more parcel business means more cargo capacity is necessary in postal delivery vehicles, especially in those owned and operated by rural letter carriers.

When delivering greeting cards or bills, or packages ordered over the Internet, rural letter carriers use vehicles they currently purchase, operate and maintain. In exchange, they receive a reimbursement from the Postal Service. This reimbursement is called an Equipment Maintenance Allowance, EMA. Congress recognizes that providing a personal vehicle to delivery the U.S. Mail is not typical vehicle use. So, when a rural letter carrier is ready to sell such a vehicle, it's going to have little trade-in value because of the typically high mileage, extraordinary wear and tear, and the fact that it is probably right-hand drive. Therefore, Congress intended to exempt the EMA allowance from taxation in 1988 through a specific provision for rural mail carriers in the Technical and Miscellaneous Revenue Act of 1988.

That provision allowed an employee of the U.S. Postal Service who was involved in the collection and delivery of mail on a rural route, to compute their business use mileage deduction as 150 percent of the standard mileage rate for all business use mileage. As an alternative, rural letter carrier taxpayers could elect to utilize the actual expense method, business portion of actual operation and maintenance of the vehicle, plus depreciation. If EMA exceeded the allowable vehicle expense deductions, the excess was subject to tax. If EMA fell short of the allowable vehicle expenses, a deduction was allowed only to the extent that the sum of the shortfall and all other miscellaneous itemized deductions exceeded two percent of the taxpayer's adjusted gross income.

The Taxpayer Relief Act of 1997 further simplified the tax returns of rural letter carriers. That Act permitted the EMA income and expenses ''to wash,'' so that neither income nor expenses would have to be reported on a rural letter carrier's return. That simplified taxes for approximately 120,000 taxpayers, but the provision eliminated the option of filing the actual expense method for employee business vehicle expenses. The lack of this option, combined with the dramatic changes the Internet is having on the mail, specifically on rural letter carriers and their vehicles, is a problem I believe Congress must address.

The mail mix is changing and already Postal Service management has, understandably, encouraged rural letter carriers to purchase larger right-hand

drive vehicles, such as Sports Utility Vehicles, SUVs, to handle the increase in parcel loads. Large SUVs are much more expensive than traditional vehicles. So without the ability to use the actual expense method and depreciation, rural letter carriers must use their salaries to cover vehicle expenses. Additionally, the Postal Service has placed 11,000 postal vehicles on rural routes, which means those carriers receive no EMA.

These developments have created a situation that is contrary to the historical Congressional intent of using reimbursement to fund the government service of delivering mail, and also has created an inequitable tax situation for rural letter carriers. If actual business expenses exceed the EMA, a deduction for those expenses should be allowed. To correct this inequity, I am introducing a bill today that reinstates the ability of a rural letter carrier to choose between using the actual expense method for computing the deduction allowable for business use of a vehicle, or using the current practice of deducting the reimbursed EMA expenses.

Rural letter carriers perform a necessary and valuable service and face may changes and challenges in this new Internet era. We must make sure that these public servants receive fair and equitable tax treatment as they perform their essential role in fulfilling the Postal Service's mandate of binding the Nation together.

I urge my colleagues to join Senators BINGAMAN, DASCHLE, BUNNING, ROCKEFELLER, SNOWE, THOMAS, SMITH of Oregon, CONRAD, GRAHAM of Florida, KERRY, BREAUX, LINCOLN and myself in sponsoring this legislation.

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

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

S. 1333

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

SECTION 1. CERTAIN EXPENSES OF RURAL LETTER CARRIERS.

(a) IN GENERAL.—Section 162(o) of the Internal Revenue Code of 1986 (relating to treatment of certain reimbursed expenses of rural mail carriers) is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) SPECIAL RULE WHERE EXPENSES EXCEED REIMBURSEMENTS.—Notwithstanding paragraph (1)(A), if the expenses incurred by an employee for the use of a vehicle in performing services described in paragraph (1) exceed the qualified reimbursements for such expenses, such excess shall be taken into account in computing the miscellaneous itemized deductions of the employee under section 67.''.

(b) CONFORMING AMENDMENT.—The heading for section 162(o) of the Internal Revenue Code of 1986 is amended by striking ''REIMBURSED''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2003.

Mr. BINGAMAN. Mr. President, I join Senator GRASSLEY, the chairman of the Finance Committee, and several of our colleagues in introducing legislation that will allow rural letter carriers to deduct their actual expenses when they use their own vehicle to deliver the mail. This Tax Code correction will reduce the out-of-pocket costs currently incurred by our Nation's rural letter carriers, giving them comparable tax treatment enjoyed by others using their vehicles in their line of business.

For many years, rural letter carriers were allowed to calculate their deductible expenses by using either a special formula or keeping track of their costs. In 1997, Congress simplified the tax treatment for letter carriers, but disallowed them the ability to use the actual expense method—business portion of actual operation and maintenance of the vehicle, plus depreciation—for calculating their costs. Unfortunately, this has resulted in many letter carriers being unable to account for their real expenses when using their own vehicle to deliver the mail. This problem is worse in more rugged parts of our country where road conditions and severe weather can require letter carriers to use an SUV or four-wheel-drive vehicle that are more expensive to maintain. This legislation will ensure that these mail carriers are fully reimbursed for the costs associated with the operation of their vehicles.

Although the Internet has made the world seem smaller, purchased goods must still be delivered. The benefits of Internet purchases in remote locations is limited if the purchased item cannot be delivered. For this reason, in rural States, such as New Mexico, these letter carriers play an important role in delivering the majority of the State's mail and parcels. On a daily basis across the Nation, rural letter carriers drive over 3 million miles delivering mail and parcels to over 30 million families. We need to be sure that we have not created a tax impediment for these dedicated individuals. I look forward to working with the chairman and my colleagues to get this legislation passed this year.

I ask unanimous consent that the text of the bill be printed in the RECORD immediately following the statement of Senator GRASSLEY on the introduction of this legislation.

By Mr. GRASSLEY (for himself, Mr. GRAHAM of Florida, Ms. MIKULSKI, and Mr. BREAUX):

S. 1335. A bill to amend the Internal Revenue Code of 1986 to allow individuals a deduction for qualified long-term care insurance premiums, use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long-term care needs; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, I rise today to introduce the Long-Term Care and Retirement Security Act. This legislation, which I sponsored in the 106th and 107th Congress with my distinguished colleague from Florida, Senator BOB GRAHAM, would ease the tremendous cost of long-term care.

The bill that Senator GRAHAM and I are re-introducing today would allow individuals a tax deduction for the cost of long-term care insurance premiums. Increasingly, Americans are interested in private long-term care insurance to pay for nursing home stays, assisted living, home health aides, and other services. However, most people find the policies unaffordable. The younger the person, the lower the insurance premium, yet most people aren't ready to buy a policy until retirement. A deduction would encourage more people to buy long-term insurance.

Our proposal would also give individuals or their care givers a $3,000 tax credit to help cover their long-term care expenses. This would apply to those who have been certified by a doctor as needing help with at least three activities of daily living, such as eating, bathing, or dressing. This credit would help care givers pay for medical supplies, nursing care and any other expenses incurred while caring for family members with disabilities.

One family that would benefit from this legislation is the Gardner family of Waterloo, IA. Ruth Gardner is a 70-year-old mother of nine who suffers from a degenerative tissue disorder, Scleroderma, atrial fibrillation, congestive heart failure and is a breast cancer survivor. For the last 3 years her nine children, their spouses and numerous grandchildren have worked tirelessly to fulfill Ms. Gardner's wish of spending her last months with dignity and respect at home.

While Ms. Gardner's wish may seem small, the task of managing her care is not. Each week family members meet to organize their schedules in an effort to provide over 20 hours of daily care for Ms. Gardner. Working relentlessly, and at a considerable cost, the Gardner family manages to provide around-the-clock care while balancing both work and their family lives. All this effort comes at a great cost, both emotionally and financially. The Gardners have been able to locate some funding to help support the care for Ms. Gardner; however, the family continues to bear considerable costs. These costs include weekly nursing visits that cost $102 per visit, emergency response service at $30 a month, daily hospice service at $32 an hour and not to mention the hours and hours of personal time donated by the family.

The Long-Term Care and Retirement Security Act would help the 22 million family caregivers like the Gardners. A $3,000 tax credit would help to pay for Ms. Gardner's monthly hospice care, weekly nurse visits or help to hire a nurse to cover some of the time that the family currently donates. This legislation would also help the increasing number of families placed in the difficult situation by allowing them to purchase long-term care insurance. Had this legislation been enacted earlier, long-term care insurance would

have been an affordable option for Ms. Gardner, alleviating the difficult situation that her family currently faces.

As it has in the past, the bill that Senator GRAHAM and I are introducing today has been endorsed by both the AARP and the Health Insurance Association of America. A companion bill sponsored by Representatives NANCY JOHNSON, Karen Thurman and EARL POMEROY is pending in the House of Representatives.

An aging nation has no time to waste in preparing for long-term care, and the need to help people afford long-term care is more pressing than ever. I look forward to working with Senator GRAHAM and our colleagues in the Senate to get our bill passed into law as soon as possible.

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

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

S. 1335

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 ''Long-Term Care and Retirement Security Act of 2003''.

SEC. 2. TREATMENT OF PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 223 as section 224 and by inserting after section 222 the following new section:

''SEC. 223. PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction an amount equal to the applicable percentage of the amount of eligible long-term care premiums (as defined in section 213(d)(10)) paid during the taxable year for coverage for the taxpayer and the taxpayer's spouse and dependents under a qualified long-term care insurance contract (as defined in section 7702B(b)).

''(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a)—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the applicable percentage shall be determined in accordance with the following table based on the number of years of continuous coverage (as of the close of the taxable year) of the individual under any qualified long-term care insurance contracts (as defined in section 7702B(b)):

''If the number of years of continuous coverage is—	**The applicable percentage is—**
Less than 1	60
At least 1 but less than 2	70
At least 2 but less than 3	80
At least 3 but less than 4	90
At least 4	100.

''(2) SPECIAL RULES FOR INDIVIDUALS WHO HAVE ATTAINED AGE 55.—In the case of an individual who has attained age 55 as of the close of the taxable year, the following table shall be substituted for the table in paragraph (1):

''If the number of years of continuous coverage is—	**The applicable percentage is—**
Less than 1	70
At least 1 but less than 2	85
At least 2	100.

''(3) ONLY COVERAGE AFTER 2003 TAKEN INTO ACCOUNT.—Only coverage for periods after December 31, 2003, shall be taken into account under this subsection.

''(4) CONTINUOUS COVERAGE.—An individual shall not fail to be treated as having continuous coverage if the aggregate breaks in coverage during any 1-year period are less than 60 days.

''(c) COORDINATION WITH OTHER DEDUCTIONS.—Any amount paid by a taxpayer for any qualified long-term care insurance contract to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 162(l) or 213(a).''.

(b) LONG-TERM CARE INSURANCE PERMITTED TO BE OFFERED UNDER CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.—

(1) CAFETERIA PLANS.—Section 125(f) of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by inserting before the period at the end '', except that such term shall include the payment of premiums for any qualified long-term care insurance contract (as defined in section 7702B) to the extent the amount of such payment does not exceed the eligible long-term care premiums (as defined in section 213(d)(10)) for such contract''.

(2) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 of such Code (relating to contributions by an employer to accident and health plans) is amended by striking subsection (c).

(c) CONFORMING AMENDMENTS.—

(1) Section 62(a) of the Internal Revenue Code of 1986 is amended by inserting after paragraph (18) the following new paragraph:

''(19) PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.—The deduction allowed by section 223.''.

(2) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

''Sec. 223. Premiums on qualified long-term care insurance contracts.

''Sec. 224. Cross reference.''.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2003.

(2) CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.—The amendments made by subsection (b) shall apply to taxable years beginning after December 31, 2004.

SEC. 3. CREDIT FOR TAXPAYERS WITH LONG-TERM CARE NEEDS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is amended by inserting after section 25B the following new section:

''SEC. 25C. CREDIT FOR TAXPAYERS WITH LONG-TERM CARE NEEDS.

''(a) ALLOWANCE OF CREDIT.—

''(1) IN GENERAL.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable credit amount multiplied by the number of applicable individuals with respect to whom the taxpayer is an eligible caregiver for the taxable year.

''(2) APPLICABLE CREDIT AMOUNT.—For purposes of paragraph (1), the applicable credit amount shall be determined in accordance with the following table:

''For taxable years beginning in calendar year—	**The applicable credit amount is—**
2004	$1,000
2005	1,500
2006	2,000
2007	2,500
2008 or thereafter	3,000.

''(b) LIMITATION BASED ON ADJUSTED GROSS INCOME.—

''(1) IN GENERAL.—The amount of the credit allowable under subsection (a) shall be reduced (but not below zero) by $100 for each $1,000 (or fraction thereof) by which the taxpayer's modified adjusted gross income exceeds the threshold amount. For purposes of the preceding sentence, the term 'modified adjusted gross income' means adjusted gross income increased by any amount excluded from gross income under section 911, 931, or 933.

''(2) THRESHOLD AMOUNT.—For purposes of paragraph (1), the term 'threshold amount' means—

''(A) $150,000 in the case of a joint return, and

''(B) $75,000 in any other case.

''(3) INDEXING.—In the case of any taxable year beginning in a calendar year after 2004, each dollar amount contained in paragraph (2) shall be increased by an amount equal to the product of—

''(A) such dollar amount, and

''(B) the medical care cost adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins, determined by substituting '2003' for '1996' in subclause (II) thereof.

If any increase determined under the preceding sentence is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

''(c) DEFINITIONS.—For purposes of this section—

''(1) APPLICABLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'applicable individual' means, with respect to any taxable year, any individual who has been certified, before the due date for filing the return of tax for the taxable year (without extensions), by a physician (as defined in section 1861(r)(1) of the Social Security Act) as being an individual with long-term care needs described in subparagraph (B) for a period—

''(i) which is at least 180 consecutive days, and

''(ii) a portion of which occurs within the taxable year.

Notwithstanding the preceding sentence, a certification shall not be treated as valid unless it is made within the 39½ month period ending on such due date (or such other period as the Secretary prescribes).

''(B) INDIVIDUALS WITH LONG-TERM CARE NEEDS.—An individual is described in this subparagraph if the individual meets any of the following requirements:

''(i) The individual is at least 6 years of age and—

''(I) is unable to perform (without substantial assistance from another individual) at least 3 activities of daily living (as defined in section 7702B(c)(2)(B)) due to a loss of functional capacity, or

''(II) requires substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment and is unable to perform, without reminding or cuing assistance, at least 1 activity of daily living (as so defined), or to the extent provided in regulations prescribed by the Secretary (in consultation with the Secretary of Health and Human Services), is unable to engage in age appropriate activities.

''(ii) The individual is at least 2 but not 6 years of age and is unable due to a loss of functional capacity to perform (without substantial assistance from another individual) at least 2 of the following activities: eating, transferring, or mobility.

''(iii) The individual is under 2 years of age and requires specific durable medical equipment by reason of a severe health condition or requires a skilled practitioner trained to address the individual's condition to be available if the individual's parents or guardians are absent.

''(2) ELIGIBLE CAREGIVER.—

''(A) IN GENERAL.—A taxpayer shall be treated as an eligible caregiver for any taxable year with respect to the following individuals:

''(i) The taxpayer.

''(ii) The taxpayer's spouse.

''(iii) An individual with respect to whom the taxpayer is allowed a deduction under section 151(c) for the taxable year.

''(iv) An individual who would be described in clause (iii) for the taxable year if section 151(c)(1)(A) were applied by substituting for the exemption amount an amount equal to the sum of the exemption amount, the standard deduction under section 63(c)(2)(C), and any additional standard deduction under section 63(c)(3) which would be applicable to the individual if clause (iii) applied.

''(v) An individual who would be described in clause (iii) for the taxable year if—

''(I) the requirements of clause (iv) are met with respect to the individual, and

''(II) the requirements of subparagraph (B) are met with respect to the individual in lieu of the support test of section 152(a).

''(B) RESIDENCY TEST.—The requirements of this subparagraph are met if an individual has as his principal place of abode the home of the taxpayer and—

''(i) in the case of an individual who is an ancestor or descendant of the taxpayer or the taxpayer's spouse, is a member of the taxpayer's household for over half the taxable year, or

''(ii) in the case of any other individual, is a member of the taxpayer's household for the entire taxable year.

''(C) SPECIAL RULES WHERE MORE THAN 1 ELIGIBLE CAREGIVER.—

''(i) IN GENERAL.—If more than 1 individual is an eligible caregiver with respect to the same applicable individual for taxable years ending with or within the same calendar year, a taxpayer shall be treated as the eligible caregiver if each such individual (other than the taxpayer) files a written declaration (in such form and manner as the Secretary may prescribe) that such individual will not claim such applicable individual for the credit under this section.

''(ii) NO AGREEMENT.—If each individual required under clause (i) to file a written declaration under clause (i) does not do so, the individual with the highest modified adjusted gross income (as defined in section 32(c)(5)) shall be treated as the eligible caregiver.

''(iii) MARRIED INDIVIDUALS FILING SEPARATELY.—In the case of married individuals filing separately, the determination under this subparagraph as to whether the husband or wife is the eligible caregiver shall be made under the rules of clause (ii) (whether or not one of them has filed a written declaration under clause (i)).

''(d) IDENTIFICATION REQUIREMENT.—No credit shall be allowed under this section to a taxpayer with respect to any applicable individual unless the taxpayer includes the name and taxpayer identification number of such individual, and the identification number of the physician certifying such individual, on the return of tax for the taxable year.

''(e) TAXABLE YEAR MUST BE FULL TAXABLE YEAR.—Except in the case of a taxable year closed by reason of the death of the taxpayer, no credit shall be allowable under this section in the case of a taxable year covering a period of less than 12 months.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 6213(g)(2) of the Internal Revenue Code of 1986 is amended by striking ''and'' at the end of subparagraph (L), by striking the period at the end of subparagraph (M) and inserting '', and'', and by inserting after subparagraph (M) the following new subparagraph:

''(N) an omission of a correct TIN or physician identification required under section 25C(d) (relating to credit for taxpayers with long-term care needs) to be included on a return.''.

(2) The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 25B the following new item:

''Sec. 25C. Credit for taxpayers with long-term care needs.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2003.

SEC. 4. ADDITIONAL CONSUMER PROTECTIONS FOR LONG-TERM CARE INSURANCE.

(a) ADDITIONAL PROTECTIONS APPLICABLE TO LONG-TERM CARE INSURANCE.—Subparagraphs (A) and (B) of section 7702B(g)(2) of the Internal Revenue Code of 1986 (relating to requirements of model regulation and Act) are amended to read as follows:

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any contract if such contract meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 6A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 6A.

''(II) Section 6B (relating to prohibitions on limitations and exclusions).

''(III) Section 6C (relating to extension of benefits).

''(IV) Section 6D (relating to continuation or conversion of coverage).

''(V) Section 6E (relating to discontinuance and replacement of policies).

''(VI) Section 7 (relating to unintentional lapse).

''(VII) Section 8 (relating to disclosure), other than section 8F thereof.

''(VIII) Section 11 (relating to prohibitions against post-claims underwriting).

''(IX) Section 12 (relating to minimum standards).

''(X) Section 13 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

''(XI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

''(XII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Section 6C (relating to preexisting conditions).

''(II) Section 6D (relating to prior hospitalization).

''(III) The provisions of section 8 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of September 2000).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

''(iii) DETERMINATION.—For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.''.

(b) EXCISE TAX.—Paragraph (1) of section 4980C(c) of the Internal Revenue Code of 1986 (relating to requirements of model provisions) is amended to read as follows:

''(1) REQUIREMENTS OF MODEL PROVISIONS.—

''(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

''(i) Section 9 (relating to required disclosure of rating practices to consumer).

''(ii) Section 14 (relating to application forms and replacement coverage).

''(iii) Section 15 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

''(iv) Section 22 (relating to filing requirements for marketing).

''(v) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C, except that—

''(I) in addition to such requirements, no person shall, in selling or offering to sell a qualified long-term care insurance contract, misrepresent a material fact; and

''(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

''(vi) Section 24 (relating to suitability).

''(vii) Section 29 (relating to standard format outline of coverage).

''(viii) Section 30 (relating to requirement to deliver shopper's guide).

The requirements referred to in clause (vi) shall not include those portions of the personal worksheet described in Appendix B relating to consumer protection requirements not imposed by section 4980C or 7702B.

''(B) MODEL ACT.—The following requirements of the model Act must be met:

''(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

''(ii) Section 6G (relating to outline of coverage).

''(iii) Section 6H (relating to requirements for certificates under group plans).

''(iv) Section 6I (relating to policy summary).

''(v) Section 6J (relating to monthly reports on accelerated death benefits).

''(vi) Section 7 (relating to incontestability period).

''(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(g)(2)(B).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to policies issued more than 1 year after the date of the enactment of this Act.

Mr. GRAHAM of Florida. Mr. President, there has been a renewed interest in health issues, particularly the plight

of the uninsured. That issue presents lawmakers with significant challenges, particularly finding the right mixes of programs to provide health care coverage to the vastly different populations that make up this group.

There is an equally daunting health care issue facing our country, but it is one that has received far less attention. That issue is the increasing need for long-term care. Over 13 million people in the United States need help with basic activities of daily living such as eating, getting in and out of bed, getting around inside, dressing, bathing and using the toilet. While many Americans believe that long-term care is an issue primarily affecting seniors, the reality is that 5.2 million adults between the ages of 18 to 64 and over 450,000 children need long-term care services. These numbers are expected to double as the baby boom generation begins to retire.

Most long-term is provided at home or in the community by informal caregivers. However, in situations where individuals must enter nursing homes or other institutional facilities, costs are paid largely out-of-pocket. Such a financing structure jeopardizes the retirement security of many Americans who have worked hard their entire lives.

In order to help families address their long-term care needs, Senator GRASSLEY and I are re-introducing the ''Long-Term Care and Retirement Security Act.'' This legislation provides two important tools to help Americans and their families meet their immediate and future long-term care needs—an above-the-line income tax deduction for the purchase of long-term care insurance and a caregiver tax credit.

First, the bill provides an above-the-line deduction for long-term care premiums to make long-term care insurance more affordable for a greater number of Americans. Today, such premiums are deductible, but the availability of the deduction is severely limited. First, the current deduction is available only for the thirty percent of taxpayers who itemize their deductions. That leaves the remaining seventy percent of taxpayers with absolutely no benefit. Second, the deduction is limited to an amount, which in addition to other medical expenses exceeds 7.5 percent of the taxpayers adjusted gross income. This AGI limit further decreases the utilization of the current deduction.

The Graham-Grassley legislation removes these restrictions and makes the deduction for long-term care premiums available to all taxpayers.

In order to provide sufficient incentives for families to maintain long-term care coverage, the deduction allowed under this bill increases the longer the policy is maintained. The deduction starts at 60 percent for premiums paid during the first year of coverage and gradually increases each year thereafter until the deduction reaches 100 percent after at least 4 years of continuous coverage. This schedule is accelerated for those age 55 or older. For them, the deduction starts at 70 percent for the first year and increases to 100 percent with at least two years of continuous coverage.

Second, the bill provides an income tax credit for taxpayers with long-term care needs. The credit is phased in over 4 years, starting at $1,000 for 2003 and eventually reaching $3,000. To target assistance to those most in need, the credit phases out for married couples with income above $150,000, $75,000 for single taxpayers.

In addition to the deduction and tax credit, our bill allows employers to offer long-term care insurance under cafeteria plans and include long-term care services as reimbursable costs under flexible spending arrangements. The bill also updates the requirements that long-term care policies must meet in order to qualify for the income tax deduction. These updated requirements reflect the most recent model regulations and code issued by the National Association of Insurance Commissioners.

I urge my colleagues to join Senator GRASSLEY and me in cosponsoring this legislation.

By Mr. BROWNBACK (for himself and Mr. KENNEDY):

S. 1336. A bill to allow North Koreans to apply for refugee status or asylum; to the Committee on the Judiciary.

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

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

S. 1336

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

SECTION 1. PURPOSE.

The purpose of this Act is to ensure that North Koreans are not barred from eligibility for refugee status or asylum in the United States on account of any legal right to citizenship they may enjoy under the Constitution of the Republic of Korea. This Act is not intended in any way to prejudice whatever rights to citizenship North Koreans may enjoy under the Constitution of the Republic of Korea.

SEC. 2. TREATMENT OF NATIONALS OF THE DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA.

For purposes of eligibility for refugee status under section 207 of the Immigration and Nationality Act (8 U.S.C. 1157), or for asylum under section 208 of such Act (8 U.S.C. 1158), a national of the Democratic People's Republic of Korea shall not be considered a national of the Republic of Korea.

By Mr. SMITH:

S. 1337. A bill to establish an incentive program to promote effective safety belt laws and increase safety belt use; to the Committee on Commerce, Science, and Transportation.

Mr. SMITH of Oregon. Mr. President, I rise today to introduce the Safe, Efficient, Automobile Travel to Better Ensure Lives in Transit, SEAT BELT, Act of 2003.

This bill will establish an incentive grant program that rewards States that have enacted or will enact primary seat belt laws. The bill also gives a premium to those States that increase seat belt usage.

According to the National Highway Traffic Safety Administration, NHTSA, motor vehicle crashes are responsible for 95 percent of all transportation-related deaths and 99 percent of all transportation-related injuries. It is estimated that in 2002, 42,850 people were killed in vehicle crashes and roughly 3 million more were injured. Motor vehicle crashes are ranked as the leading cause of death for Americans ages 1 to 34.

In addition to the thousands of transportation-related deaths and injuries, the economic costs associated with vehicle crashes constitute a serious public health problem and significant fiscal burden to the Nation. The total annual economic cost to the U.S. economy of all motor vehicle crashes is an astonishing $230.6 billion, or 2.3 percent of the U.S. gross domestic product. This translates into an average of $820 for every person living in the United States.

Increasing seat belt usage is a guaranteed and proven way to lower the number of transportation-related deaths and costs associated with vehicle crashes. In 2002, 59 percent of vehicle occupants killed were not restrained by seat belts or child safety seats. Safety experts agree that the best short-term and most immediate way to reduce traffic crash fatalities and serious injuries is to increase seat belt use.

Experience in the United States and other countries has shown that sound laws coupled with high-visibility enforcement are the keys to high seat belt use. Currently, the effectiveness of most State seat belt laws is reduced by secondary enforcement provisions that preclude law enforcement from stopping an unbelted motorist unless another traffic law violation is also observed.

Primary enforcement seat belt laws are significantly correlated with higher seat belt usage levels. States with primary enforcement laws have an average of 80 percent belt usage, compared to just 69 percent in States having secondary enforcement laws. Currently, only 19 jurisdictions have primary seat belt laws. Nearly 4000 lives would be saved each year if seat belt use were to increase from the national average of 75 percent to 90 percent.

The SEAT BELT Act creates two grant programs to encourage seat belt use. The first grant program rewards States that have or will have primary seat belt enforcement. Forty percent of the available funds for this program will be applied to the first grant category.

Every State that enacts a primary seat belt law or currently has one will receive two times their Section 402 allotment. Those States that enact a primary seat belt law sooner will receive

their incentive grant sooner. Any funds not obligated by the end of FY 2008 will be made available to States qualified to receive funds under the second grant category.

The second grant program would reward States that increase their seat belt usage. Sixty percent of the available funds for this program will be applied to the second grant category. The Secretary of Transportation shall carry out this program which is designed to maximize the effectiveness of the awarded funds and the fairness of the distribution of such funds; increase the national seat belt usage rate as expeditiously as possible; reward States that maintain a seat belt usage rate above 85 percent, as determined by NHTSA; and reward States that demonstrate an increase in their seat belt usage rates.

The SEAT BELT Act will ensure that funds are distributed fairly by rewarding the 19 jurisdictions, including my home state of Oregon, which took an early lead to enact a primary seat belt law. The Act also provides sufficient financial incentives to persuade the States that have not enacted a primary seat belt law to do so. And lastly, the Act provides continuing incentives to States to encourage them to have high seat belt usage rates and rewards them for their persistence in striving towards higher usage rates.

I urge my colleagues to cosponsor this important legislation and ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1337

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 ''Safe, Efficient Automobile Travel to Better Ensure Lives in Transit (SEATBELT) Act of 2003''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) According to the National Highway Traffic Safety Administration (NHTSA), motor vehicle crashes are responsible for 95 percent of all transportation-related deaths and 99 percent of all transportation-related injuries.

(2) Motor vehicle crashes are the leading cause of death for Americans between the ages of 1 and 34.

(3) It is estimated that, in 2002, 42,850 people were killed and approximately 3,000,000 people were injured in vehicle crashes.

(4) NHTSA estimates that if safety belt use were to increase from 75 percent to 90 percent, nearly 4,000 lives would be saved each year.

SEC. 3. SAFETY BELT INCENTIVE GRANTS.

(a) REQUIREMENTS FOR GRANT PROGRAMS.—

(1) IN GENERAL.—Chapter 4 of title 23, United States Code, is amended by adding at the end the following new section:

''§ 412. Safety belt incentive grants

''(a) PRIMARY ENFORCEMENT SAFETY BELT USE LAW INCENTIVE GRANTS.—

''(1) ELIGIBILITY.—The Secretary shall make a grant to each State that, as determined by the Secretary, has in effect a primary enforcement safety belt use law.

''(2) AMOUNT OF GRANT.—The amount of a grant for which a State qualifies under this subsection shall equal the amount of funds allocated to the State under section 402 of this title for fiscal year 2003 multiplied by 2.

''(3) DISTRIBUTION OF FUNDS.—Funds awarded to a State under this subsection shall be distributed over a 2-year period.

''(4) FUNDS AVAILABLE FOR GRANT PROGRAM.—Forty percent of the funds made available to carry out the occupant protection programs under section 405 of this title in a fiscal year shall be available for grants under this subsection during such fiscal year.

''(5) DISPOSITION OF UNUSED FUNDS.—Any funds available for grants under this subsection that have not been awarded by the end of fiscal year 2008 shall be made available for the safety belt usage grant program under subsection (b).

''(b) SAFETY BELT USAGE AWARD GRANTS.—

''(1) IN GENERAL.—The Secretary shall carry out a program for making safety belt usage award grants to eligible States. The program shall be designed to—

''(A) maximize the effectiveness of the awarded funds and the fairness of the distribution of such funds;

''(B) increase the national seat belt usage rate as expeditiously as possible;

''(C) reward States that maintain a seat belt usage rate above 85 percent (as determined by the National Highway Traffic Safety Administration); and

''(D) reward States that demonstrate an increase in their seat belt usage rates.

''(2) FUNDS AVAILABLE FOR GRANT PROGRAM.—Sixty percent of the funds made available to carry out the occupant protection programs under section 405 of this title in a fiscal year shall be available for grants under this subsection during such fiscal year.

''(c) USE OF FUNDS.—Grants awarded under this section may be used to carry out activities under this title.

''(d) DEFINITIONS.—In this section:

''(1) PASSENGER MOTOR VEHICLE.—The term 'passenger motor vehicle' has the meaning given the term in section 405(f)(5) of this title.

''(2) PRIMARY ENFORCEMENT SAFETY BELT USE LAW.—The term 'primary enforcement safety belt use law' means a law that meets the criteria for such laws published by the Secretary in a rule relating to the grant program under this section.

''(3) SAFETY BELT.—The term 'safety belt' has the meaning given the term in section 405(f)(6) of this title.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of that chapter is amended by inserting after the item relating to section 411 the following new item:

''412. Safety belt incentive grants.''.

(b) INTERIM FINAL RULE.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Transportation shall publish an interim final rule listing the criteria for awarding grants pursuant to section 412 of title 23, United States Code, as added by subsection (a), including the criteria to be used by the Secretary in determining whether a law is a primary enforcement safety belt use law for purposes of such section.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 183—COMMEMORATING 50 YEARS OF ADJUDICATION UNDER THE MCCARRAN AMENDMENT OF RIGHTS TO THE USE OF WATER

Mr. ENSIGN (for Mr. CAMPBELL (for himself, Mr. ENSIGN, Mr. KYL, Mr. BURNS, Mr. ALLARD, Mr. CRAPO, and Mr. CRAIG)) submitted the following resolution; which was referred to the Committee on Energy and Natural Resources:

S. RES. 183

Whereas section 208 of the Department of Justice Appropriation Act, 1953 (commonly known as the McCarran Amendment) (43 U.S.C. 666) waived the sovereign immunity of the United States so that it could be joined in comprehensive State general adjudications of the rights to use water;

Whereas in United States v. District Court for Eagle County, 401 U.S. 520, 524 (1971), the Supreme Court confirmed that the McCarran Amendment was ''an all-inclusive statute concerning 'the adjudication of rights to the use of water of a river system' which . . . has no exceptions and . . . includes appropriative rights, riparian rights, and reserved rights'';

Whereas in Colorado River Water Conservation District v. United States, 424 U.S. 800, 819 (1976), the Supreme Court concluded that the concern over ''avoiding the generation of additional litigation through permitting inconsistent dispositions of property . . . Is heightened with respect to water rights, the relationships among which are highly interdependent'' and that the ''consent to jurisdiction given by the McCarran Amendment bespeaks a policy that recognizes the availability of comprehensive state systems for adjudication of water rights as the means of achieving these goals'';

Whereas since the passage of the McCarran Amendment, Federal and non-Federal users, along with numerous Western States, have invested millions of dollars in water right adjudications in those States to establish rights to the use of water that will determine priority of use during times of scarcity;

Whereas State water laws in the West have evolved to accommodate instream values such as recreation and environmental needs, while continuing to recognize and protect traditional consumptive uses for the West's cities and farms;

Whereas Federal claims for water have been recognized under both Federal and State laws within State general adjudications, thus enhancing the protection of Federal interests, as well as the certainty and reliability of non-Federal interests, in water in the West;

Whereas the significance of the McCarran Amendment, in providing States with the ability to determine the extent of federal claims to water resources, has become increasingly apparent as many of the Western States are experiencing a severe and sustained drought, where water supplies for all purposes are severely restricted; and

Whereas now more than ever there is a pressing need to recognize and support the availability of comprehensive systems for quantification of rights to use water in those Western States for all beneficial purposes: Now, therefore, be it

Resolved, that the Senate—

(1) reaffirms the policies and principles of the McCarran Amendment that have been recognized by Supreme Court decisions and recognizes that, as a matter of practice, the United States should adhere and defer to State water law; and

(2) commends Western States that maintain comprehensive systems for the quantification of rights to use water for all beneficial purposes, including environmental protection and enhancement.

Mr. CAMPBELL. Mr. President, I rise to submit a Resolution commemorating 50 years of adjudicating water rights under the McCarran Amendment and commending Western States' management of water.

Rather than simply go into the Resolution itself, I would like to put the Amendment in its proper historical context.

Unlike the Eastern United States, the history of the West, its settlement, and even its founding, is closely linked to the Federal Government. We should remember that Lewis and Clark and so many other courageous explorers who mapped the Western territories were funded by the United States government. We should also be mindful that much of what we know as the West was purchased or otherwise acquired by the United States Government including the Louisiana Purchase of 1803 and the 1848 Treaty of Guadalupe Hidalgo.

However, just because the Federal Government might have acquired the Western territories didn't mean that people wanted to move there. The West was a rough place, harsh land and harsher winters were enough to keep most folks back East. Again, the United States took action to promote Westward expansion by implementing laws like the Homestead Act to encourage people to relocate.

Eventually, the dream of discovering gold and mining precious metals was the catalyst that got people moving West, and eventual completion of the trans-continental railroad provided the means. Each Western territory developed into a distinct State, based on the makeup of its constituents, diverse as the Mormons of Utah to the Spanish and Mexican-Americans of New Mexico and to the Great Plains Indians and other Tribes.

No matter the reason why people moved West, they all needed water as precious and scarce a resource then as it is today. New industries and cities to sprout up that needed water to survive and a way to manage it.

Water law out West is as distinct from the East as are the histories of the two great regions of our Nation. In the West, water is a rare commodity, and is therefore regarded as a property right under the law sold apart from the land.

Since water was such a scarce resource, each State managed water based on its particular resources, geography, population, and municipal and industrial needs. Yet, Western States all recognized and favored water adjudication systems according to the doctrines of prior appropriation and beneficial use.

State management of water worked rather smoothly for decades. Then after World War II, during the new Deal's expansive programs, the Federal government sought to realign and trump the established States' interest in water to some degree. On one hand, the Federal Government believed it to be acting in its own interest since Uncle Sam owned much of the West. The United States still owns thirty-seven percent of my State of Colorado.

The United States rode roughshod over State interests, often completely ignoring private property rights and resisting cooperative agreements to manage water. The States fought Federal arm twisting as best as they could, but couldn't do much against the U.S. as sovereign. The Federal bullying got so bad that in 1951, a Readers Digest article criticized the U.S.'s strong arm tactics in the famous Santa Margarita water conflict stating that, ''the lack of moral sensitivity in our Government has put into jeopardy thousands of our small landowners; their property, homes, savings and their future.''

Thankfully, Senator PATRICK MCCARRAN of Nevada along with other likeminded Senators, successfully defended States' interests and got a very simply provision passed into law. In short, the law that we are celebrating today waives the United States' sovereign immunity so that it could be joined in general state adjudications of rights to use water.

Although a simple concept, the McCarran Amendment effectively leveled the playing field, requiring Uncle Sam to work within the State system he implicitly helped to establish.

The breadth of the McCarran Amendment has been defined by U.S. Supreme Court cases. The Court concluded that although the amendment itself might be short in length, its effect war far reaching. The High Court stated that McCarran was ''an all inclusive statute concerning the adjudication of 'the rights to the use of water of a river system' '' which ''has no exceptions'' and ''includes appropriat[ive] rights, riparian rights, and reserved rights.''

It is undeniable that the history of the West is linked to the Federal Government. Since the Federal Government maintains vast landholdings, the future of the West will also be linked to Uncle Sam. Similarly, the management of property and natural resources, of which water is both, has been and shall remain a State function.

The purpose of the McCarran Amendment was to prevent federal bullying of private and state interests in managing water, and to recognize water as a State resource. McCarran encourages the Federal Government to work together with the States.

I am submitting this resolution today at a time when much of the West is still under or will likely experience severe drought conditions. The Federal Government must remember the history of the McCarran amendment and look to the States in adjudicating water.

SENATE RESOLUTION 184—CALLING ON THE GOVERNMENT OF THE PEOPLE'S REPUBLIC OF CHINA IMMEDIATELY AND UNCONDITIONALLY TO RELEASE DR. YANG JIANLI, AND FOR OTHER PURPOSES

Mr. KYL (for himself, Ms. MIKULSKI, Mr. BROWNBACK, Mr. MCCAIN, and Mr. ALLEN) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 184

Whereas, according to the Department of State's 2002 Country Reports on Human Rights Practices in China, the Government of the People's Republic of China has ''continued to commit numerous and serious [human rights] abuses,'' including ''instances of . . . arbitrary arrest and detention, lengthy incommunicado detention, and denial of due process'';

Whereas according to the report, ''the country's criminal procedures were not in compliance with international standards,'' the ''lack of due process in the judicial system remained a serious problem,'' and ''authorities routinely violated legal protections in the cases of political dissidents'';

Whereas Dr. Yang Jianli, an internationally renowned scholar, pro-democracy activist, and president of the Foundation for China in the 21st Century, is an alien lawfully admitted for permanent residence in the United States who has been detained incommunicado by the Government of the People's Republic of China since April 26, 2002;

Whereas according to the United Nations Commission on Human Rights Resolution 1997/38 of April 11, 1997, ''prolonged incommunicado detention may . . . itself constitute a form of cruel, inhuman, or degrading treatment,'' which is prohibited by international law;

Whereas Dr. Yang Jianli has been deprived of his basic human rights by being denied access to legal counsel and contact with his wife and two children (who are United States citizens), and has also been denied his right to trial within a reasonable time or to release pending trial;

Whereas, on June 3, 2003, the United Nations Working Group on Arbitrary Detention expressed the opinion that ''[t]he non-observance of Mr. Yang Jianli's right to a fair trial is of such gravity as to give his deprivation of liberty an arbitrary character. Therefore, his arrest and detention is arbitrary being in contravention of Article 9 of the Universal Declaration of Human Rights and Article 9 of the International Covenant on Civil and Political Rights.''; and

Whereas the arbitrary imprisonment of United States citizens and permanent resident aliens by the Government of the People's Republic of China and the continuing violations by the Government of their fundamental human rights demands a forceful response by Congress and the President of the United States: Now, therefore, be it

Resolved,

SECTION 1. CONDEMNATION OF THE TREATMENT BY THE GOVERNMENT OF CHINA OF DR. YANG JIANLI.

The Senate—

(1) condemns and deplores the incommunicado detention of Dr. Yang Jianli, and calls for his immediate and unconditional release;

(2) condemns and deplores the lack of due process afforded to Dr. Yang; and

(3) strongly urges the Government of the People's Republic of China to consider the

implications for the broader relationship between the United States and the People's Republic of China of detaining permanent resident aliens of the United States without providing them access to legal counsel or family members.

SEC. 2. SENSE OF THE SENATE.

It is the sense of the Senate that the United States should—

(1) make the immediate release of Dr. Yang Jianli by the Government of the People's Republic of China a top priority of United States foreign policy;

(2) continue to make every effort to assist Dr. Yang Jianli and his family while discussions of his release are ongoing;

(3) ensure that the Government of the People's Republic of China understands that the detention of United States citizens and permanent resident aliens, and the infliction of human rights violations on these groups, is not in the interests of the Government of the People's Republic of China because it will reduce the opportunities for cooperation between the United States and the People's Republic of China;

(4) reiterate its deep concern regarding the continued imprisonment of Dr. Yang Jianli and other United States citizens and permanent resident aliens whose human rights are being violated; and

(5) engage in discussions with the Government of the People's Republic of China regarding the legal status and immediate humanitarian needs of these United States citizens and permanent resident aliens.

Mr. KYL. Mr. President, I rise today to submit a resolution calling on the government of the People's Republic of China to release Dr. Yang Jianli, an internationally renowned scholar and pro-democracy activist, who has been detained in China since April 2002 without access to legal counsel, contact with his family, or a trial. Dr. Yang, a U.S. permanent resident, is a mathematician and economist who lives in Massachusetts. He heads the Foundation for China in the 21st Century, a group that advocates democratization in China.

On June 3, the U.N.'s Working Group on Arbitrary Detention condemned China's detention of Dr. Yang, finding that the Chinese government has violated his rights as a citizen of China and as a resident of the U.S. The panel declared that, ''The nonobservance of Dr. Yang's right to a fair trial is of such gravity as to give his deprivation of liberty an arbitrary character. Therefore, his arrest and detention is arbitrary being in contravention of Article 9 of the Universal Declaration on Human Rights and Article 9 of the International Covenant on Civil and Political Rights.''

In recognition of the U.N. working group's conclusions, as well as the Chinese government's blatant rejection of them, the State Department officially called for Dr. Yang's release, stating, ''We are particularly disturbed now by China's public rejection of an accepted international process and the findings of the independent and impartial panel of jurists, so we are urging China to comply fully with international obligations that it has assumed, and we urge that Dr. Yang be released and allowed to return to his wife and children in Boston.''

The resolution that I am submitting with my colleagues goes hand-in-hand with the State Department's support for Dr. Yang. It expresses the sense of the Senate that the U.S. should: 1. make the immediate release of Dr. Yang Jianli a top foreign policy priority; 2. make clear to the Chinese government that the detention of U.S. citizens and permanent residents is not in its best interests; and 3. express the deep concern of the U.S. regarding the imprisonment of Dr. Yang and other U.S. citizens and permanent residents, as well as discuss their legal status and humanitarian needs.

I would like to note that a similar resolution—submitted by Representatives Cox and Frank—is expected to be considered today by the House of Representatives.

As I have stated repeatedly, if China wants to become a productive and respected member of the international community, it must begin to adhere to accepted norms of behavior. China's leaders seem to be oblivious to the understanding that all people deserve certain basic freedoms and that violation of such fundamental rights is an appropriate concern of the United States and the world at large. We should make clear that the Chinese government's continued detention of Yang Jianli and others—in violation of these international norms—will adversely impact our bilateral relations. Without such pressure, the behavior of China's leaders is unlikely to change, and the voices of those who have devoted their lives to the cause of freedom—like Yang Jianli—will continue to be silenced.

I hope that my colleagues in the Senate will join me in strongly supporting this resolution and in calling for Dr. Yang Jianli's release.

Ms. MIKULSKI. Mr. President, I rise to join Senator KYL in submitting a resolution calling for the immediate release of Dr. Yang Jianli. Dr. Yang Jianli. Dr. Yang is a democracy activist who has since been held incommunicado in China for more than a year. Dr. Yang is being held in violation of his human rights and international law. He should be freed now.

Dr. Yang Jianli is a scholar and important democracy activist in his home State of Massachusetts where he is founder and president of the Foundation for China in the 21st Century. Jianli is a permanent United States resident who continues to work for democracy in his native China.

Dr. Yang was taken into custody when he returned to China on April 26, 2002. He has been held incommunicado since then. His family in Massachusetts and Maryland are understandably concerned about his welfare.

The U.S. Department of State has called for China to release Dr. Yang. So has the United Nations Working Group on Arbitrary Detention. The Chinese government refuses to admit to detaining this man illegally. However, the U.N. Working Group on Arbitrary Detention says, ''The non-observance of Dr. Yang's right to a fair trial is of such gravity as to give his deprivation of liberty an arbitrary character. Therefore, his arrest and detention is arbitrary being in contravention of Article 9 of the Universal Declaration of Human rights and Article 9 of the International Covenant of Civil and Political Rights.'' In other words, the Chinese government never bothered to charge Yang Jianli with a crime—they just locked him up and threw away the key.

We can assist by increasing the pressure of the Chinese government and support the U.N. petition on Dr. Yang's behalf. Being deprived of his basic human rights of access to legal counsel and contact with his wife and children is wrong. When China wanted most-favored-nation trade status, we heard a lot of lip service to human rights and democracy. Dr. Yang Jianli's case shows the true face of China's government. They locked him up because he wanted to speak out about democracy and human rights.

I strongly urge the Chinese government to respond to the continual requests for Yang's freedom by the United States government and human rights groups around the world. The House is taking up a similar resolution today. I hope that the Senate will act quickly to add our voices in calling for freedom for Yang Jianli.

Mr. BROWNBACK. Mr. President, after more than a year of suffering abuse and incommunicado detention, I urge this body to call for the immediate and unconditional release of Chinese democracy activist, Dr. Yang Jianli.

Dr. Yang, a permanent resident of the United States, a respected scholar, a pro-democracy advocate, president of the Foundation for China in the 21st Century, as well as a loving husband and father, is now a prisoner and victim of shameless abuse by the Chinese government.

Following his participation in the 1989 Tiananmen Square pro-democracy student protests, Dr. Yang was added to an unofficial blacklist of expatriate Chinese dissidents. Upon his return to the country in 2002, Dr. Yang was detained and has been denied access to his family, legal counsel and due process.

The resolution submitted today in the Senate coupled with H. Res. 199, strongly calls for the release of Dr. Yang Jianli and condemns the People's Republic of China for ongoing deplorable human rights abuses. Clearly, it is not in their interest to deny human rights to any United States citizen or U.S. permanent resident alien.

Let this also be an additional chance to voice our regret and deep concern for the continual abuse of the people in China. Dr. Yang Jianli understands this better than most. He has devoted his life to the cause of democracy and freedom for the people for China and has been, once again, silenced.

China must know and the world must know that denial of basic human rights will no longer be tolerated. Dr. Yang is just one of the many, who suffer daily under the harsh rule of those who refuse to embrace democracy. We must let his story and his voice be heard for the millions of others who can not speak out. Let us continue to pressure the People's Republic of China and let us continue to stand for what is right and just around the world.

SENATE RESOLUTION 185—EXPRESSING THE SENSE OF THE SENATE WITH RESPECT TO RAISING AWARENESS AND ENCOURAGING EDUCATION ABOUT SAFETY ON THE INTERNET AND SUPPORTING THE GOALS AND IDEALS OF NATIONAL INTERNET SAFETY MONTH

Ms. MURKOWSKI (for herself, Mr. STEVENS, and Mr. INOUYE) submitted the following resolution; which was considered and agreed to:

S. RES. 185

Whereas, in the United States, 48 million children between the ages of 5 and 17 use computers;

Whereas 5 to 17 year-olds in the United States currently spend 5 billion hours on-line annually;

Whereas 70 million youth under the age of 18 worldwide are on-line;

Whereas the majority of teenagers' on-line use occurs after school, at home, when working parents are not at home;

Whereas 90 percent of those age 15 to 24 use the Internet, with almost half of them using it once a day or more;

Whereas approximately 3 out of 4 young people have access to the Internet at home, and nearly 1 in 3 has access from their own bedroom;

Whereas 9 out of 10 children between ages 8 and 16 have viewed pornography on the Internet, with most being accessed unintentionally when, often in the process of doing homework, a child used a seemingly innocent sounding word in an Internet search for information or pictures;

Whereas 62 percent of parents of teenagers are unaware that their children have accessed objectionable websites;

Whereas 89 percent of sexual solicitations were made in either chat rooms or Instant Messages;

Whereas 30 percent of the girls responding to a Girl Scout research study reported that they had been sexually harassed in a chat room, but only 7 percent told a parent about the harassment, most fearing their parents would overreact and ban computer usage altogether;

Whereas, in 1996, the Federal Bureau of Investigation was involved in 113 cases involving Internet crimes against children, but in 2001, the FBI opened 1,541 cases against suspects of Internet crimes involving child pornography or abuse; and

Whereas June as National Internet Safety Month will provide national awareness of the dangers of the Internet while offering education about how to be safe, responsible, and accountable on the Internet: Now, therefore, be it

Resolved, That it is the sense of the Senate that—

(1) National Internet Safety Month provides an opportunity to educate the people of the United States on the dangers of the Internet and the importance of being safe and responsible on-line;

(2) national and community organizations should be recognized and applauded for their work in promoting awareness of the dangers of the Internet and for providing information on developing the critical thinking and decision-making skills to be safe on-line; and

(3) Internet safety organizations, law enforcement, educators, and volunteers should increase their efforts to raise the awareness of on-line safety.

SENATE RESOLUTION 186—COMMENDING AUGUST HIEBERT FOR HIS SERVICE TO THE ALASKA COMMUNICATIONS INDUSTRY

Mr. STEVENS (for himself and Ms. MURKOWSKI) submitted the following resolution; which was ordered held at the desk:

S. RES. 186

Whereas Augie Hiebert came to Alaska in 1939 and built the first successful commercial radio station;

Whereas on Dec. 7, 1941, Augie Hiebert picked up the first report of the raid on Pearl Harbor from his radio station in Fairbanks, Alaska giving military leaders the first word of the attack that began World War II;

Whereas in 1953, Augie Hiebert founded Alaska's first television station;

Whereas Augie Hiebert established Alaska's first FM radio station and was named president of the Alaska Broadcasting system, overseeing the affiliation of nine stations that serve all major Alaska communities;

Whereas Augie Heibert helped establish Alaska's first satellite earth station activated in 1970;

Whereas Augie Heibert led in the development of the Territory and State of Alaska, working for over a half century to pioneer modern radio and television on behalf of the broadcast industry;

Whereas Augie Hiebert has been a pillar of the Alaska community as president of the Anchorage Chamber of Commerce and the Association of the U.S. Army in Alaska, and as director of the Alaska Educational Broadcasting Committee, the CBS Television Network Affiliates Association, the Civil Air Patrol, and the Pioneers of Alaska: Now, therefore, be it

Resolved, That it is the sense of the Senate that Augie Hiebert is commended for his service to the communications industry in Alaska and the world and for bringing the best that broadcasting has to offer to the people of Alaska.

AMENDMENTS SUBMITTED AND PROPOSED

SA 1044. Mr. BAYH submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table.

SA 1045. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1046. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1047. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1048. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1049. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1050. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1051. Mr. ENZI (for himself, Mrs. LINCOLN, Mr. PRYOR, and Ms. MURKOWSKI) proposed an amendment to the bill S. 1, supra.

SA 1052. Mr. EDWARDS (for himself and Mr. HARKIN) proposed an amendment to the bill S. 1, supra.

SA 1053. Mr. AKAKA submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1054. Mr. FEINGOLD submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1055. Mrs. HUTCHISON (for herself, Mr. KENNEDY, Mr . DURBIN, Mr. KERRY, and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 1004 proposed by Mrs. HUTCHISON to the bill S. 1, supra; which was ordered to lie on the table.

SA 1056. Mr. SHELBY (for himself, Ms. STABENOW, Mr. SESSIONS, Mr. COCHRAN, Mr. LOTT, and Mrs. MURRAY) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1057. Mrs. DOLE (for herself and Mr. EDWARDS) submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1058. Mr. CRAIG submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1059. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1060. Mr. BAUCUS (for Mrs. FEINSTEIN (for himself, Mr. NICKLES, Mr. CHAFEE, and Mr. GRAHAM, of South Carolina)) proposed an amendment to the bill S. 1, supra.

SA 1061. Mr. BAUCUS (for Mr. AKAKA (for himself and Mr . INOUYE)) proposed an amendment to the bill S. 1, supra.

SA 1062. Mr. REID (for Mrs. BOXER) proposed an amendment to amendment SA 974 proposed by Mr. GRASSLEY (for himself, Mr. LEAHY, Ms. CANTWELL, Mr. DURBIN, and Mr. KOHL) to the bill S. 1, supra.

SA 1063. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1064. Ms. SNOWE (for herself, Mr. ROCKEFELLER, and Mr. SMITH) submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1065. Mr. BINGAMAN (for himself, Mr. DOMENICI, Ms. MIKULSKI, and Mrs. LINCOLN) proposed an amendment to the bill S. 1, supra.

SA 1066. Mr. BINGAMAN proposed an amendment to the bill S. 1 , supra.

SA 1067. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1068. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1069. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1070. Mr. SCHUMER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1071. Mr. ROCKEFELLER (for himself and Mr. SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1072. Mr. ROCKEFELLER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1073. Mr. SMITH (for himself, Mr. FEINGOLD, and Ms . CANTWELL) submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1074. Mr. COLEMAN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1075. Ms. STABENOW (for herself and Mr. LEVIN) proposed an amendment to the bill S. 1, supra.

SA 1076. Ms. STABENOW (for herself and Mr. LEVIN) proposed an amendment to the bill S. 1, supra.

SA 1077. Ms. STABENOW (for herself and Mr. LEVIN) proposed an amendment to the bill S. 1, supra.

SA 1078. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1079. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1080. Mr. DEWINE (for himself and Mr. DURBIN) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1081. Ms. LANDRIEU submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1082. Mr. CONRAD submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1083. Mr. COLEMAN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1084. Mr. VOINOVICH submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1085. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1086. Ms. MURKOWSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1087. Mr. GRASSLEY (for Mr. CRAIG) proposed an amendment to the bill S. 1, supra.

SA 1088. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, supra.

SA 1089. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, supra.

SA 1090. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, supra.

SA 1091. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, supra.

SA 1092. Mr. GRASSLEY (for himself and Mr. BAUCUS) proposed an amendment to the bill S. 1, supra.

SA 1093. Mr. KYL proposed an amendment to amendment SA 1092 proposed by Mr. GRASSLEY (for himself and Mr. BAUCUS) to the bill S. 1, supra.

TEXT OF AMENDMENTS

SA 1044. Mr. BAYH submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. URBAN HEALTH PROVIDER ADJUSTMENT.

(a) IN GENERAL.—Beginning with fiscal year 2004, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) and subject to subsection (c), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in subsection (b) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r–4(f)).

(b) HOSPITAL DESCRIBED.—A hospital is described in this subsection if the hospital—

(1) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act), or by an instrumentality or a municipal governmental unit within a State (as so defined) as of January 1, 2003; and

(2) is located in Marion County, Indiana.

(c) LIMITATION.—The payment adjustment described in subsection (a) for fiscal year 2004 and each fiscal year thereafter shall not exceed 175 percent of the costs of furnishing hospital services described in section 1923(g)(1)(A) of the Social Security Act (42 U.S.C. 1396r–4(g)(1)(A)).

SA 1045. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ___. DEMONSTRATION PROJECT FOR EXCLUSION OF BRACHYTHERAPY DEVICES FROM PROSPECTIVE PAYMENT SYSTEM FOR OUTPATIENT HOSPITAL SERVICES.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which brachytherapy devices shall be excluded from the prospective payment system for outpatient hospital services under the medicare program and, notwithstanding section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), the amount of payment for a device of brachytherapy furnished under the demonstration project shall be equal to the hospital's charges for each device furnished, adjusted to cost.

(b) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—The Secretary shall create additional groups of covered OPD services that classify devices of brachytherapy furnished under the demonstration project separately from the other services (or group of services) paid for under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium–103 and iodine–125 devices.

(c) DURATION.—The Secretary shall conduct the demonstration project under this section for the 3-year period beginning on the date that is 90 days after the date of enactment of this Act.

(d) REPORT.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the demonstration project conducted under this section. The report shall include an evaluation of patient outcomes under the demonstration project, as well as an analysis of the cost effectiveness of the demonstration project.

(e) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project under this section.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration project under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration project under this section was not implemented.

SA 1046. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtile B of title IV, add the following:

SEC. ___. DEMONSTRATION PROJECT FOR COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which payment is made for surgical first assisting services furnished by a certified registered nurse first assistant to medicare beneficiaries.

(b) DEFINITIONS.—In this section:

(1) SURGICAL FIRST ASSISTING SERVICES.—The term ''surgical first assisting services'' means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

(2) CERTIFIED REGISTERED NURSE FIRST ASSISTANT.—The term ''certified registered nurse first assistant'' means an individual who—

(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.

(c) PAYMENT RATES.—Payment under the demonstration project for surgical first assisting services furnished by a certified registered nurse first assistant shall be made at the rate of 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)) for the same services if furnished by a physician.

(d) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in 5 States selected by the Secretary.

(e) DURATION.—The Secretary shall conduct the demonstration project for the 3-year period beginning on the date that is 90 days after the date of the enactment of this Act.

(f) REPORT.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient outcomes under the project, as well as an analysis of the cost effectiveness of the project.

(g) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the project under this section.

(2) BUDGET NEUTRALITY.—In conducting the project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the project under this section was not implemented.

(i) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SA 1047. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 78, line 15, insert before the period the following: ''and all succeeding years. Once such a determination is made with respect to an area, the Administrator shall ensure that a contract of the type entered into under the preceding sentence remains in effect for such area for each such succeeding year and beneficiaries receiving the standard prescription drug coverage under such a contract may elect to remain enrolled in such coverage under a such contract regardless of whether the access required under subsection (d)(1) is going to be provided in the area in the year''.

SA 1048. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 79, between line 22 and 23, insert the following:

''(F) PERMANENT FALLBACK IN CERTAIN AREAS.—

''(i) IN GENERAL.—Notwithstanding paragraph (1), in the case of an applicable area, the Administrator shall enter into a contract under paragraph (1)(B) with respect to the area for each year after the year in which the area meets the definition of an applicable area. Eligible beneficiaries residing in such area may elect to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) under such contract in a year regardless of whether the access required under subsection (d)(1) is going to be provided in the area in that year.

''(ii) APPLICABLE AREA.—For purposes of this subparagraph, the term 'applicable area' means an area—

''(I) that was designated under paragraph (1)(B) for a year;

''(II) in which the access required under subsection (d)(1) was met with respect to a year subsequent to the year described in subclause (I); and

''(III) that was designated under paragraph (1)(B) for a year subsequent to the year described in subclause (II).

SA 1049. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 39, strike line 23 through page 40, line 2, and insert the following:

''(E) RESTRICTIONS ON REMOVING DRUGS FROM FORMULARY.—An eligible entity may not remove a drug from the formulary under the plan—

''(i) during the 2-year contract for the plan; and

''(ii) unless the entity has provided appropriate notice to beneficiaries, physicians, and pharmacists that the drug will be removed at the beginning of the subsequent 2-year contract for the plan.

SA 1050. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 79, between line 22 and 23, insert the following:

''(F) PERMANENT FALLBACK FOR CERTAIN BENEFICIARIES.—

''(i) IN GENERAL.—Notwithstanding paragraph (1), the Administrator shall enter into a contract under paragraph (1)(B) for each area for each year. Applicable eligible beneficiaries residing in such area may elect to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) under such contract in a year regardless of whether the access required under subsection (d)(1) is going to be provided in the area in that year. Other eligible beneficiaries residing in such area may elect to receive such coverage under such contract only if the area has been designated under paragraph (1)(B) for the year.

''(ii) APPLICABLE ELIGIBLE BENEFICIARY.—For purposes of this subparagraph, the term 'applicable eligible beneficiary' means an individual who—

''(I) is enrolled under this part;

''(II) was covered under a group health plan; and

''(III) involuntarily lost such coverage such that the beneficiary was eligible for a special open enrollment period under section 1860D–2(b)(3).

SA 1051. Mr. ENZI (for himself, Mrs. LINCOLN, Mr. PRYOR, and Ms. MURKOWSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 37, between lines 20 and 21, insert the following:

''(C) CONVENIENT ACCESS TO PHARMACIES.—In this section, the term 'convenient access' means access that is no less favorable to enrollees than the rules for convenient access to pharmacies of the Secretary of Defense established as of June 1, 2003, for purposes of the TriCare retail pharmacy program. Such rules shall include adequate emergency access for enrolled beneficiaries.

On page 48, between lines 4 and 5, insert the following:

''(4) TYING OF CONTRACTS.—No eligible entity with a contract under this part, or its agent, may require a pharmacy to participate in a medicare prescription drug plan as a condition of participating in nonmedicare programs or networks, or require a pharmacy to participate in a nonmedicare program or network as a condition of participating in a medicare prescription drug plan.

SA 1052. Mr. EDWARDS (for himself and Mr. HARKIN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicar program, and for other purposes; as follows:

At the end, add the following:

TITLE ____—DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. ___01. DIRECT-TO-CONSUMER ADVERTISING.

Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended by inserting at the end the following:

REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) CONTENTS.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to effectiveness of the drug (including, if available, effectiveness in comparison to other drugs for substantially the same condition or conditions); and

(ii) information relating to side effects and contraindications;

(B) any advertisement present a fair balance, comparable in depth, between—

(i) aural and visual presentations relating to effectiveness of the drug; and

(ii) aural and visual presentations relating to side effects and contraindications, *provided that*, nothing in this section shall require explicit images or sounds depicting side effects and contraindications;

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. ___02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

''(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

''(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

''(A) the Secretary provides the person written notice of the violation; and

''(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

''(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

''(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

''(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

''(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).''.

SEC. ___03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. ___04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisements except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

SA 1053. Mr. AKAKA submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements to the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 633, after line 21, add the following:

(3) APPLICATION TO HAWAII.—Section 1923(f) (42 U.S.C. 1396r–4(f)), as amended by paragraph (1), is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

''(7) TREATMENT OF HAWAII AS A LOW-DSH STATE.—The Secretary shall compute a DSH allotment for the State of Hawaii for each of fiscal years 2004 and 2005 in the same manner as DSH allotments are determined with respect to those States to which paragraph (5) applies (but without regard to the requirement under such paragraph that total expenditures under the State plan for disproportionate share hospital adjustments for any fiscal year exceeds 0).''.

SA 1054. Mr. FEINGOLD submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle D of title I, add the following:

SEC. 133. OFFICE OF THE MEDICARE BENEFICIARY ADVOCATE.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall establish within the Department of Health and Human Services, an Office of the Medicare Beneficiary Advocate (in this section referred to as the ''Office'').

(b) DUTIES.—The Office shall carry out the following activities:

(1) Establishing a toll-free telephone number for medicare beneficiaries to use to obtain information on the medicare program, and particularly with respect to the benefits provided under part D of title XVIII of the Social Security Act and the Medicare Prescription Drug plans and MedicareAdvantage plans offering such benefits. The Office shall ensure that the toll-free telephone number accommodates beneficiaries with disabilities and limited-English proficiency.

(2) Establishing an Internet website with easily accessible information regarding Medicare Prescription Drug plans and MedicareAdvantage plans and the benefits offered under such plans. The website shall—

(A) be updated regularly to reflect changes in services and benefits, including with respect to the plans offered in a region and the associated monthly premiums, benefits offered, formularies, and contact information for such plans, and to ensure that there are no broken links or errors;

(B) have printer-friendly, downloadable fact sheets on the medicare coverage options and benefits;

(C) be easy to navigate, with large print and easily recognizable links; and

(D) provide links to the websites of the eligible entities participating in part D of title XVIII.

(3) Providing regional publications to medicare beneficiaries that include regional contacts for information, and that inform the beneficiaries of the prescription drug benefit options under title XVIII of the Social Security Act, including with respect to—

(A) monthly premiums;

(B) formularies; and

(C) the scope of the benefits offered.

(4) Conducting outreach to medicare beneficiaries to inform the beneficiaries of the medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(5) Working with local benefits administrators, ombudsmen, local benefits specialists, and advocacy groups to ensure that medicare beneficiaries are aware of the medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(c) FUNDING.—

(1) ESTABLISHMENT.—Of the amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures, $2,000,000 may be used to establish the Office in accordance with this section.

(2) OPERATION.—With respect to each fiscal year occurring after the fiscal year in which the Office is established under this section, the Secretary may use, out of amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures for such fiscal year, such sums as may be necessary to operate the Office in that fiscal year.

SA 1055. Mrs. HUTCHISON (for herself, Mr. KENNEDY, Mr. DURBIN, Mr. KERRY, and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 1004 proposed by Mrs. HUTCHISON to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

In lieu of the matter proposed to be added, add the following:

SEC. ___. REVISION OF THE INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by striking ''and'' after the semicolon at the end;

(2) in subclause (VII)—

(A) by striking ''on or after October 1, 2002'' and inserting ''during fiscal year 2003''; and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new subclause:

''(VIII) during fiscal year 2004, 'c' is equal to 1.41; and

''(IX) on or after October 1, 2005, 'c' is equal to 1.47.''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking ''1999 or'' and inserting ''1999,''; and

(2) by inserting '', or the Prescription Drug and Medicare Improvement Act of 2003'' after ''2000''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2003.

At the end of subtitle B of title IV, add the following:

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

SA 1056. Mr. SHELBY (for himself, Ms. STABENOW, Mr. SESSIONS, Mr. COCHRAN, Mr. LOTT, and Mrs. MURRAY) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ___. TREATMENT OF GRANDFATHERED LONG-TERM CARE HOSPITALS.

(a) IN GENERAL.—The last sentence of section 1886(d)(1)(B) is amended by inserting '', and the Secretary may not impose any special conditions on the operation, size, number of beds, or location of any hospital so classified for continued participation under this title or title XIX or for continued classification as a hospital described in clause (iv)'' before the period at the end.

(b) TREATMENT OF PROPOSED REVISION.—The Secretary shall not adopt the proposed revision to section 412.22(f) of title 42, Code of Federal Regulations contained in 68 Federal Register 27154 (May 19, 2003) or any revision reaching the same or substantially the same result as such revision.

(c) EFFECTIVE DATE.—The amendment made by, and provisions of, this section shall apply to cost reporting periods ending on or after December 31, 2002.

SA 1057. Mrs. DOLE (for herself and Mr. EDWARDS) submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ___. TREATMENT OF CERTAIN ENTITIES FOR PURPOSES OF PAYMENTS UNDER THE MEDICARE PROGRAM.

(a) PAYMENTS TO HOSPITALS.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of making payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C. 1395(d)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(b) BUDGET NEUTRAL.—The Secretary shall adjust the area wage index referred to in subsection (a) in a manner which assures that the appropriate payments made under section 1886(d) of the Social Security Act (42 U.S.C., 1395(ww)(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than those which would have be made in the year if this section did not apply.

(c) PAYMENTS TO SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.—Notwithstanding any other provision of law, effective beginning October 1, 2003, for purposes of making payments to skilled nursing facilities (SNFs) and home health agencies (as defined in sections 1861(j) and 1861(o) of the Social Security Act (42 U.S.C. 1395(j)(o)) under the medicare program under title XVIII of such Act (42 U.S.C 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(d) APPLICATION.—Effective for fiscal year 2004, the skilled nursing facility PPS and home health PPS rates for Iredell County, North Carolina, and Rowan County, North Carolina, will be updated by the prefloor, prereclassified hospital wage index available for the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area. This provision must be implemented in a budget neutral manner, using a methodology that maintains the current SNF and home health expenditure levels.

SA 1058. Mr. CRAIG submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title VI, insert the following:

SEC. ___. RESTORATION OF FEDERAL HOSPITAL INSURANCE TRUST FUND.

(a) DEFINITIONS.—In this section:

(1) CLERICAL ERROR.—The term ''clerical error'' means the failure that occurred on April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to the Trust Fund.

(2) TRUST FUND.—The term ''Trust Fund'' means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i).

(b) CORRECTION OF TRUST FUND HOLDINGS.—

(1) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, the Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, the holdings that would have been held by the Trust Fund if the clerical error had not occurred.

(2) OBLIGATIONS ISSUED AND REDEEMED.—The Secretary of the Treasury shall—

(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

(i) would have been issued to the Trust Fund if the clerical error had not occurred; or

(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error; and

(B) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error had not occurred.

(c) APPROPRIATION.—Not later than 120 days after the date of enactment of this Act, there is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the

Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error.

SA 1059. Mr. HATCH sumitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title I, add the following:

SEC. ___. REVIEW AND REPORT ON CURRENT STANDARDS OF PRACTICE FOR PHARMACY SERVICES PROVIDED TO PATIENTS IN NURSING FACILITIES.

(a) REVIEW.—

(1) IN GENERAL.—The Secretary shall conduct a thorough review of the current standards of practice for pharmacy services provided to patients in nursing facilities.

(2) SPECIFIC MATTERS REVIEWED.—In conducting the review under paragraph (1), the Secretary shall—

(A) assess the current standards of practice, clinical services, and other service requirements generally used for pharmacy services in long-term care settings; and

(B) evaluate the impact of those standards with respect to patient safety, reduction of medication errors and quality of care.

(b) REPORT.—

(1) IN GENERAL.—Not later than the date that is 18 months after the date of enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under subsection (a)(1), together with any recommendations for legislation that the Administrator determines to be appropriate as a result of such study.

(2) CONTENTS.—The report submitted under paragraph (1) shall contain—

(A) a detailed description of the plans of the Secretary to implement the provisions of this Act in a manner consistent with applicable State and Federal laws designed to protect the safety and quality of care of nursing facility patients; and

(B) recommendations regarding necessary actions and appropriate reimbursement to ensure the provision of prescription drugs to medicare beneficiaries residing in nursing facilities in a manner consistent with existing patient safety and quality of care standards under applicable State and Federal laws.

SA 1060. Mr. BAUCUS (for Mrs. FEINSTEIN (for herself, Mr. NICKLES, Mr. CHAFEE, and Mr. GRAHAM of South Carolina) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of title IV, insert:

Subtitle D—Part B Premium

SEC. ___. INCOME-RELATED INCREASE IN MEDICARE PART B PREMIUM.

(a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following:

''(h) INCREASE IN PREMIUM FOR HIGH-INCOME BENEFICIARIES.—

''(1) AMOUNT OF INCREASE.—

''(A) IN GENERAL.—Except as provided in paragraph (4), if the modified adjusted gross income of an individual for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (2)) exceeds the threshold amount, the amount of the premium under subsection (a) for the individual for the calendar year shall, in lieu of the amount otherwise determined under subsection (a), be equal to the applicable percentage of an amount equal to 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for the calendar year.

''(B) APPLICABLE PERCENTAGE.—The term 'applicable percentage' means the percentage determined in accordance with the following tables:

''(i) INDIVIDUALS NOT FILING JOINT RETURNS.—

"If the modified adjusted gross income exceeds the threshold amount by:	The applicable percentage is:
Not more than $25,000	50 percent
More than $25,000	100 percent.

''(ii) INDIVIDUALS FILING JOINT RETURNS.—

"If the modified adjusted gross income exceeds the threshold amount by:	The applicable percentage is:
Not more than $50,000	50 percent
More than $50,000	100 percent.

''(C) DEFINITION OF THRESHOLD AMOUNT.—For purposes of this subsection, the term 'threshold amount' means—

''(i) except as provided in clause (ii), $75,000; and

''(ii) $150,000 in the case of a taxpayer filing a joint return.

''(D) INFLATION ADJUSTMENT FOR THRESHOLD AMOUNT.—

''(i) IN GENERAL.—In the case of any calendar year beginning after 2006, the dollar amount in clause (i) of subparagraph (C) shall be increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding calendar year exceeds such average for the 12-month period ending with June 2005.

''(ii) JOINT RETURNS.—The dollar amount described in clause (ii) of subparagraph (C) for any calendar year after 2006 shall be increased to an amount equal to twice the amount in effect under clause (i) of subparagraph (C) (after application of this subparagraph).

''(iii) ROUNDING.—If any dollar amount after being increased under clause (i) is not a multiple of $1,000, such dollar amount shall be rounded to the nearest multiple of $1,000.

''(E) DEFINITION OF MODIFIED ADJUSTED GROSS INCOME.—For purposes of this subsection, the term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

''(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

''(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

''(F) JOINT RETURN.—For purposes of this subsection, the term 'joint return' has the meaning given such term by section 7701(a)(38) of the Internal Revenue Code of 1986.

''(2) DETERMINATION OF MODIFIED ADJUSTED GROSS INCOME.—The Secretary shall make an initial determination of the amount of an individual's modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

''(A) NOTICE.—Not later than September 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's modified adjusted gross income for the year. In providing such notice, the Secretary shall use the most recent poverty line available as of the date the notice is sent.

''(B) CALCULATION BASED ON INFORMATION PROVIDED BY BENEFICIARY.—If, during the 60-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with appropriate information (as determined by the Secretary) on the individual's anticipated modified adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

''(C) CALCULATION BASED ON NOTICE AMOUNT IF NO INFORMATION IS PROVIDED BY THE BENEFICIARY OR IF THE SECRETARY DETERMINES THAT THE PROVIDED INFORMATION IN NOT APPROPRIATE.—The amount initially determined by the Secretary under this paragraph with respect to an individual shall be the amount included in the notice provided to the individual under subparagraph (A) if—

''(i) the individual does not provide the Secretary with information under subparagraph (B); or

''(ii) the Secretary determines that the information provided by the individual to the Secretary under such subparagraph in not appropriate.

''(3) ADJUSTMENTS.—

''(A) IN GENERAL.—If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (2), the Secretary shall increase or decrease the amount of the individual's monthly premium under this part (as the case may be) for months during the following calendar year by an amount equal to 1/12 of the difference between—

''(i) the total amount of all monthly premiums paid by the individual under this part during the previous calendar year; and

''(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's modified adjusted gross income initially determined under paragraph (2) were equal to the actual amount of the individual's modified adjusted gross income determined under this paragraph.

''(B) INTEREST.—

''(i) INCREASE.—In the case of an individual for whom the amount initially determined by the Secretary under paragraph (2) is based on information provided by the individual under subparagraph (B) of such paragraph, if the Secretary determines under subparagraph (A) that the amount of the individual's actual modified adjusted gross income for a taxable year is greater than the amount initially determined under paragraph (2), the Secretary shall increase the amount otherwise determined for the year under subparagraph (A) by an amount of interest equal to the sum of the amounts determined under

clause (ii) for each of the months described in such clause.

''(ii) COMPUTATION.—Interest shall be computed for any month in an amount determined by applying the underpayment rate established under section 6621 of the Internal Revenue Code of 1986 (compounded daily) to any portion of the difference between the amount initially determined under paragraph (2) and the amount determined under subparagraph (A) for the period beginning on the first day of the month beginning after the individual provided information to the Secretary under subparagraph (B) of paragraph (2) and ending 30 days before the first month for which the individual's monthly premium is increased under this paragraph.

''(iii) EXCEPTION.—Interest shall not be imposed under this subparagraph if the amount of the individual's modified adjusted gross income provided by the individual under subparagraph (B) of paragraph (2) was not less than the individual's modified adjusted gross income determined on the basis of information shown on the return of tax imposed by chapter 1 of the Internal Revenue Code of 1986 for the taxable year involved.

''(C) STEPS TO RECOVER AMOUNTS DUE FROM PREVIOUSLY ENROLLED BENEFICIARIES.—In the case of an individual who is not enrolled under this part for any calendar year for which the individual's monthly premium under this part for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium under this part for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

''(D) DECEASED BENEFICIARY.—In the case of a deceased individual for whom the amount of the monthly premium under this part for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual's surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual's estate) in an amount equal to the difference between—

''(i) the total amount by which the individual's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

''(ii) the amount (if any) by which the individual's premium was decreased for months during the year pursuant to subparagraph (A).

''(4) WAIVER BY SECRETARY.—The Secretary may waive the imposition of all or part of the increase of the premium or all or part of any interest due under this subsection for any period if the Secretary determines that a gross injustice would otherwise result without such waiver.

''(5) TRANSFER TO PART B TRUST FUND.—

''(A) IN GENERAL.—The Secretary shall transfer amounts received pursuant to this subsection to the Federal Supplementary Medical Insurance Trust Fund.

''(B) DISREGARD.—In applying section 1844(a), amounts attributable to subparagraph (A) shall not be counted in determining the dollar amount of the premium per enrollee under paragraph (1)(A) or (1)(B) thereof.''

(b) CONFORMING AMENDMENTS.—(1) Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by inserting ''or section subsection (h)'' after ''subsections (b) and (e)'';

(B) in subsection (a)(3) of section 1839(a), by inserting ''or subsection (h)'' after ''subsection (e)'';

(C) in subsection (b), inserting ''(and as increased under subsection (h))'' after ''subsection (a) or (e)''; and

(D) in subsection (f), by striking ''if an individual'' and inserting the following: ''if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))''.

(2) Section 1840(c) (42 U.S.C. 1395r(c)) is amended by inserting ''or an individual determines that the estimate of modified adjusted gross income used in determining whether the individual is subject to an increase in the monthly premium under section 1839 pursuant to subsection (h) of such section (or in determining the amount of such increase) is too low and results in a portion of the premium not being deducted,'' before ''he may''.

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end the following new paragraph:

''(19) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME-RELATED REDUCTION IN MEDICARE PART B PREMIUM.—

''(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Centers for Medicare & Medicaid Services return information with respect to a taxpayer who is required to pay a monthly premium under section 1839 of the Social Security Act. Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the adjusted gross income of such taxpayer,

''(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911,

''(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

''(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Centers for Medicare & Medicaid Services only for the purposes of, and to the extent necessary in, establishing the appropriate monthly premium under section 1839 of the Social Security Act.''

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (3)(A) of section 6103(p) of such Code is amended by striking ''or (18)'' each place it appears and inserting ''(18), or (19)''.

(B) Paragraph (4) of section 6103(p) of such Code is amended by striking ''or (16)'' and inserting ''(16), or (19)''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning with January 2006.

(2) INFORMATION FOR PRIOR YEARS.—The Secretary of Health and Human Services may request information under section 6013(l)(19) of the Social Security Act (as added by subsection (c)) for taxable years beginning after December 31, 2002.

SA 1061. Mr. BAUCUS (for Mr. AKAKA (for himself and Mr. INOUYE)) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 633, after line 21, add the following:

(3) APPLICATION TO HAWAII.—Section 1923(f) (42 U.S.C. 1396r–4(f)), as amended by paragraph (1), is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

''(7) TREATMENT OF HAWAII AS A LOW-DSH STATE.—The Secretary shall compute a DSH allotment for the State of Hawaii for each of fiscal years 2004 and 2005 in the same manner as DSH allotments are determined with respect to those States to which paragraph (5) applies (but without regard to the requirement under such paragraph that total expenditures under the State plan for disproportionate share hospital adjustments for any fiscal year exceeds 0).''.

SA 1062. Mr. REID (for Mrs. BOXER) proposed an amendment to amendment SA 974 proposed by Mr. GRASSLEY (for himself, Mr. LEAHY, Ms. CANTWELL, Mr. DURBIN, and Mr. KOHL) the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of the amendment add the following:

''SEC._____. NO COVERAGE GAP FOR ELIGIBLE BENEFICIARIES WITH CANCER.—

''(A) IN GENERAL.—In the case of an eligible beneficiary with cancer, the following rules shall apply:

''(i) Paragraph (2) shall be applied by substituting 'up to the annual out-of-pocket limit under paragraph (4)' for 'up to the initial coverage limit under paragraph (3)'.

''(ii) The Administrator shall not apply paragraph (3), subsection (d)(1)(C), or paragraph (1)(D), (2)(D), or (3)(A)(iv) of section 1860D–19(a).

''(B) PROCEDURES.—The Administrator shall establish procedures to carry out this paragraph. Such procedures shall provide for the adjustment of payments to eligible entities under section 1860D–16 that are necessary because of the rules under subparagraph (A).

SA 1063. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title IV, insert the following:

SEC. ___. MEDICARE PANCREATIC ISLET CELL TRANSPLANT DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—In order to test the appropriateness of pancreatic islet cell transplantation, not later than 120 days after the date of the enactment of this Act, the Secretary shall establish a demonstration project which the Secretary, provides for

payment under the medicare program under title XVIII of the Social Security Act for pancreatic islet cell transplantation and related items and services in the case of medicare beneficiaries who have type I (juvenile) diabetes and have end stage renal disease.

(b) DURATION OF PROJECT.—The authority of the Secretary to conduct the demonstration project under this section shall terminate on the date that is 5 years after the date of the establishment of the project.

(c) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the outcomes of the demonstration project. Not later than 120 days after the date of the termination of the demonstration project under subsection (b), the Secretary shall submit to Congress a report on the project, including recommendations for such legislative and administrative action as the Secretary deems appropriate.

(d) PAYMENT METHODOLOGY.—The Secretary shall establish an appropriate payment methodology for the provision of items and services under the demonstration project, which may include a payment methodology that bundles, to the maximum extent feasible, payment for all such items and services.

SA 1064. Ms. SNOWE (for herself, Mr. ROCKEFELLER, and Mr. SMITH) submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. MEDICARE COVERAGE OF ALL ANTICANCER ORAL DRUGS.

(a) IN GENERAL.—Section 1861(s)(2)(Q) (42 U.S.C. 1395x(s)(2)(Q)) is amended by striking ''chemotherapeutic agent for a given indication,'' and all that follows and inserting ''agent for a medically accepted indication (as defined in subsection (t)(2)(B));''.

(b) CONFORMING AMENDMENT.—Section 1834(j)(5)(F)(iv) (42 U.S.C. 1395m(j)(5)(F)(iv)) is amended by striking ''therapeutic''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to drugs furnished during the period that begins on January 1, 2004 and ends on January 1, 2006. After January 1, 2006, the Social Security Act shall be applied and administered as if the amendments made by this subsection had never been enacted.

SA 1065. Mr. BINGAMAN (for himself, Mr. DOMENICI, Ms. MIKULSKI, and Mrs. LINCOLN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 120, between lines 16 and 17, insert the following:

''(I) UPDATE OF ASSET OR RESOURCE TEST.—With respect to eligibility determinations for premium and cost-sharing subsidies under this section that are made on or after January 1, 2009, such determinations shall be made (to the extent a State, as of such date, has not already eliminated the application of an asset or resource test under section 1905(p)(1)(C)) in accordance with the following:

''(i) SELF-DECLARATION OF VALUE.—

''(I) IN GENERAL.—A State shall permit an individual applying for such subsidies to declare and certify by signature under penalty of perjury on the application form that the value of the individual's assets or resources (or the combined value of the individual's assets or resources and the assets or resources of the individual's spouse), as determined under section 1613 for purposes of the supplemental security income program, does not exceed $10,0000 ($20,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse).

''(II) ANNUAL ADJUSTMENT.—Beginning on January 1, 2010, and for each subsequent year, the dollar amounts specified in subclause (I) for the preceding year shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

''(ii) METHODOLOGY FLEXIBILITY.—Nothing in clause (i) shall be construed as prohibiting a State in making eligibility determinations for premium and cost-sharing subsidies under this section from using asset or resource methodologies that are less restrictive than the methodologies used under 1613 for purposes of the supplemental security income program.

''(J) DEVELOPMENT OF MODEL DECLARATION FORM.—The Secretary shall—

''(i) develop a model, simplified application form for individuals to use in making a self-declaration of assets or resources in accordance with subparagraph (I)(i); and

''(ii) provide such form to States and, for purposes of outreach under section 1144, the Commissioner of Social Security.''.

SA 1066. Mr. BINGAMAN proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 137, line 6, strike ''Notwithstanding'' and insert ''Except as provided in paragraph (4) and notwithstanding''.

On page 138, line 2, strike ''or 'G''' and insert '' 'G', or a policy described in paragraph (4)''.

On page 138, line 17, insert '', who seeks to enroll with the same issuer who was the issuer of the policy described in clause (ii) of such subparagraph in which the individual was enrolled (unless such issuer does not offer at least one of the policies described in paragraph (4)),'' after ''section 1860D–2(b)(2)''.

On page 140, between lines 13 and 14, insert the following:

''(4) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Prescription Drug and Medicare Improvement Act of 2003, with respect to policies issued to individuals who are enrolled in a Medicare Prescription Drug plan under part D or under a contract under section 1860D–3(e), the changes in standards shall only provide for substituting (for the benefit packages described in paragraph (2)(B)(ii) that included coverage for prescription drugs) two benefit packages that shall be consistent with the following:

''(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

''(i) The policy should provide coverage for benefits other than prescription drugs similar to the coverage for benefits other than prescription drugs provided under a medicare supplemental policy which had a benefit package classified as 'H' before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003.

''(ii) The policy should provide coverage for prescription drugs that—

''(I) compliments, but does not duplicate, the benefits available under part D; and

''(II) does not cover 100 percent of the deductible, copayments, coinsurance (including any cost-sharing applicable under the limitation on out-of-pocket expenditures), or any other cost-sharing applicable under part D.

''(B) SECOND NEW POLICY.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except that the reference to the benefit package classified as 'H' in clause (i) of such subparagraph is deemed to be a reference to the benefit package classified as 'J'.

(b) REPORT.—The Secretary shall enter into an arrangement with the National Association of Insurance Commissioners (in this section referred to as the ''NAIC'') under which, not later than 18 months after the date of enactment of this Act, the NAIC shall submit to Congress a report on the medicare supplemental policies described in section 1882(v)(4) of the Social Security Act, as added by subsection (a), that assesses the viability of the policies described in such section and, if viable, the details of those policies.

SA 1067. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 510, after line 18, add the following:

SEC. ___. MEDICARE COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.

(a) COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C.1395x) is amended—

(A) in subsection (s)(2)—

(i) in subparagraph (U), by striking ''and'' at the end;

(ii) in subparagraph (V)(iii), by adding ''and'' at the end; and

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

''(W) kidney disease education services (as defined in subsection (ww));''; and

(B) by adding at the end the following new subsection:

''Kidney Disease Education Services

''(ww)(1) The term 'kidney disease education services' means educational services that are—

''(A) furnished to an individual with kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant;

''(B) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person (as defined in paragraph (2)); and

''(C) designed—

''(i) to provide comprehensive information regarding—

''(I) the management of comorbidities;

''(II) the prevention of uremic complications; and

''(III) each option for renal replacement therapy (including peritoneal dialysis, hemodialysis (including vascular access options), and transplantation); and

''(ii) to ensure that the individual has the opportunity to actively participate in the choice of therapy.

''(2) The term 'qualified person' means—

''(A) a physician (as described in subsection (r)(1));

''(B) an individual who—

''(i) is—

''(I) a registered nurse;

''(II) a registered dietitian or nutrition professional (as defined in subsection (vv)(2));

''(III) a clinical social worker (as defined in subsection (hh)(1));

''(IV) a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)); or

''(V) a transplant coordinator; and

''(ii) meets such requirements related to experience and other qualifications that the Secretary finds necessary and appropriate for furnishing the services described in paragraph (1); or

''(C) a renal dialysis facility subject to the requirements of section 1881(b)(1) with personnel who—

''(i) provide the services described in paragraph (1); and

''(ii) meet the requirements of subparagraph (A) or (B).

''(3) The Secretary shall develop the requirements under paragraph (2)(B)(ii) after consulting with physicians, health educators, professional organizations, accrediting organizations, kidney patient organizations, dialysis facilities, transplant centers, network organizations described in section 1881(c)(2), and other knowledgeable persons.

''(4) In promulgating regulations to carry out this subsection, the Secretary shall ensure that such regulations ensure that each beneficiary who is entitled to kidney disease education services under this title receives such services in a timely manner that ensures that the beneficiary receives the maximum benefit of those services.

''(5) The Secretary shall monitor the implementation of this subsection to ensure that beneficiaries who are eligible for kidney disease education services receive such services in the manner described in paragraph (4).''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting '', (2)(W)'', after ''(2)(S)''.

(3) PAYMENT TO RENAL DIALYSIS FACILITIES.—Section 1881(b) of such Act (42 U.S.C. 1395rr(b)), as amended by section 433(b)(5), is further amended by adding at the end the following new paragraph:

''(13) For purposes of paragraph (7), the single composite weighted formulas determined under such paragraph shall not take into account the amount of payment for kidney disease education services (as defined in section 1861(ww)). Instead, payment for such services shall be made to the renal dialysis facility on an assignment-related basis under section 1848.''.

(4) ANNUAL REPORT TO CONGRESS.—Not later than April 1, 2004, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the number of medicare beneficiaries who are entitled to kidney disease education services (as defined in section 1861(ww) of the Social Security Act, as added by paragraph (1)) under title XVIII of such Act and who receive such services, together with such recommendations for legislative and administrative action as the Secretary determines to be appropriate to fulfill the legislative intent that resulted in the enactment of that subsection.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the date that is 6 months after the date of enactment of this Act.

SA 1068. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 510, after line 18, add the following:

SEC. ___. MEDICARE COVERAGE OF DIABETES LABORATORY DIAGNOSTIC TESTS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V)(iii), by adding ''and'' at the end; and

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

''(W) diabetes screening tests and services (as defined in subsection (ww));''.

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Diabetes Screening Tests and Services

''(ww)(1) The term 'diabetes screening tests' means diagnostic testing furnished to an individual at risk for diabetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—

''(A) a fasting plasma glucose test; and

''(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

''(2) For purposes of paragraph (1), the term 'individual at risk for diabetes' means an individual who has any, a combination of, or all of the following risk factors for diabetes:

''(A) A family history of diabetes.

''(B) Overweight defined as a body mass index greater than or equal to 25 kg/m^2.

''(C) Habitual physical inactivity.

''(D) Belonging to a high-risk ethnic or racial group.

''(E) Previous identification of an elevated impaired fasting glucose.

''(F) Identification of impaired glucose tolerance.

''(G) Hypertension.

''(H) Dyslipidemia.

''(I) History of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

''(J) Polycystic ovary syndrome.

''(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.''.

(c) FREQUENCY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) in subparagraph (H), by striking ''and'' at the end;

(2) in subparagraph (I), by striking the semicolon at the end and inserting '', and''; and

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

''(J) in the case of a diabetes screening test or service (as defined in section 1861(ww)(1)), which is performed more frequently than is covered under section 1861(ww)(3).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after the date that is 90 days after the date of enactment of this Act.

SA 1069. Mrs. LINCOLN sumitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 499, after line 20, insert the following:

SEC. ___. ELIMINATION OF COST-SHARING FOR BONE MASS MEASUREMENTS.

(a) ELIMINATION OF COINSURANCE.—

(1) IN GENERAL.—Section 1833(a)(1)(N) of the Social Security Act (42 U.S.C. 1395*l*(a)(1)(N)) is amended—

(A) by inserting ''other than bone mass measurement described in section 1861(s)(15)'' after ''(as defined in section 1848(j)(3))''; and

(B) by adding after the comma at the end the following: ''and in the case of such services consisting of such a bone mass measurement, the amounts paid shall be 100 percent of such payment basis,''.

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after ''1861(s)(10)(A)'' the following: '', with respect to bone mass measurement (as defined in section 1861(rr)),''.

(b) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395*l*(b)), as amended by section 432(b), is further amended—

(1) by striking ''and'' before ''(5)''; and

(2) by inserting before the period at the end the following: '', and (6) such deductible shall not apply with respect to bone mass measurement (as defined in section 1861(rr))''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2004.

SA 1070. Mr. SCHUMER sumitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 120, strike lines 3 through 16, and insert the following:

''(H) NONAPPLICATION TO DUAL ELIGIBLE INDIVIDUALS.—In the case of an individual who is a dual eligible individual—

''(i) the subsidies provided under this section shall not apply; and

''(ii) such individuals may be provided with medical assistance for covered outpatient drugs (as such term is defined for purposes of section 1927) in accordance with the State medicaid program under title XIX.

On page 122, line 1, strike ''and territorial residents''.

Beginning on page 149, strike line 22 and all that follows through page 152, line 3, and insert the following:

''(e) DEFINITIONS.—For purposes of this section, the''.

On page 152, strike lines 8 through 11, and insert the following:

(2) EXEMPTION FROM FUNDING LIMITATION FOR THE COMMONWEALTH OF PUERTO RICO AND THE TERRITORIES.—

(A) IN GENERAL.—Section 1108(g) (42 U.S.C. 1308(g)) is amended by adding at the end the following new paragraph:

''(3) CERTAIN PAYMENTS DISREGARDED.—The limitations under subsection (f) and the previous provisions of this subsection shall be

applied without regard to any payments made for medical assistance for covered drugs (as defined in section 1860D(a)(2)) under title XIX for dual eligible individuals (as defined in section 1860D–19(a)(4)(E) or for any payments made in carrying out section 1935.''.

(B) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting ''and section 1935(e)(1)(B)'' after ''Subject to subsection (g)''.

SA 1071. Mr. ROCKEFELLER (for himself and Mr. SMITH) sumitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. MEDICARE COVERAGE OF ALL ANTINEOPLASTIC AND CERTAIN OTHER DRUGS.

(a) IN GENERAL.—Section 1861(s)(2)(Q) (42 U.S.C. 1395x(s)(2)(Q)) is amended by striking ''prescribed for use as an anticancer chemotherapeutic agent'' and all that follows and inserting ''prescribed for use as—

''(i) an antineoplastic agent for a medically accepted anticancer indication (as defined in subsection (t)(2)(B)), excluding (except as provided in subparagraph (T)) drugs for chemotherapy-induced nausea; or

''(ii) an oral alternative to IV-administered medications, but only if the Secretary determines such coverage does not result, as estimated by the Secretary, in expenditures made under this title during any 5-year period that are greater than the expenditures that would have been made under this title during such period if such coverage was not provided.''.

(b) CONFORMING AMENDMENT.—Section 1834(j)(5)(F)(iv) (42 U.S.C. 1395m(j)(5)(F)(iv)) is amended to read as follows:

''(iv) oral drugs described in section 1861(s)(2)(Q); and''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply only with respect to drugs furnished during the period that begins on or after the date that is 90 days after the date of the enactment of this Act and ends on January 1, 2006. After January 1, 2006, the Social Security Act shall be applied and administered as if the amendments made by this section had never been enacted.

SA 1072. Mr. ROCKEFELLER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. MEDICARE COVERAGE OF ALL ANTINEOPLASTIC AND CERTAIN OTHER DRUGS; PUBLIC DISCLOSURE OF MARKET-BASED DRUG PRICING INFORMATION.

(a) MEDICARE COVERAGE OF ALL ANTINEOPLASTIC AND CERTAIN OTHER DRUGS.—

(1) IN GENERAL.—Section 1861(s)(2)(Q) (42 U.S.C. 1395x(s)(2)(Q)) is amended by striking ''prescribed for use as an anticancer chemotherapeutic agent'' and all that follows and inserting ''prescribed for use as—

''(i) an antineoplastic agent for a medically accepted anticancer indication (as defined in subsection (t)(2)(B)), excluding (except as provided in subparagraph (T)) drugs for chemotherapy-induced nausea; or

''(ii) an oral alternative to IV-administered medications, but only if the Secretary determines such coverage does not result, as estimated by the Secretary, in expenditures made under this title during any 5-year period that are greater than the expenditures that would have been made under this title during such period if such coverage was not provided.''.

(2) CONFORMING AMENDMENT.—Section 1834(j)(5)(F)(iv) (42 U.S.C. 1395m(j)(5)(F)(iv)) is amended to read as follows:

''(iv) oral drugs described in section 1861(s)(2)(Q); and''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply only with respect to drugs furnished during the period that begins on or after the date that is 90 days after the date of the enactment of this Act and ends on January 1, 2006. After January 1, 2006, the Social Security Act shall be applied and administered as if the amendments made by this subsection had never been enacted.

(b) PUBLIC DISCLOSURE OF MARKET-BASED DRUG PRICING INFORMATION.—

(1) IN GENERAL.—Section 1927(b)(3)(D) (42 U.S.C. 1396r–8(b)(3)(D)) is amended to read as follows:

''(D) PUBLIC AVAILABILITY OF INFORMATION.—

''(i) TIMELY AVAILABILITY OF INFORMATION.—Notwithstanding any other provision of law, with respect to a manufacturer with an agreement in effect under this section, not later than 30 days after the date the Secretary receives from such manufacturer the information required to be reported under this paragraph (or verifies such information with a wholesaler), the Secretary shall make the information described in clause (ii), including the identity of the manufacturer to which the information applies, publicly available through the Internet or other means of communication.

''(ii) INFORMATION DESCRIBED.—The information described in this clause is the following:

''(I) AVERAGE MANUFACTURER'S PRICE.—The average manufacturer price (as defined in subsection (k)(1)) for each of the manufacturer's covered outpatient drugs.

''(II) BEST PRICE.—With respect to single source drugs and innovator multiple source drugs, the manufacturer's best price (as defined in subsection (c)(1)(C)) for each of the manufacturer's covered outpatient drugs.

''(III) BASE AVERAGE MANUFACTURER PRICE AND INITIAL AVERAGE MANUFACTURER PRICE FOR NEWLY MARKETED DRUGS USED TO DETERMINE AN ADDITIONAL REBATE FOR SINGLE SOURCE AND INNOVATOR MULTIPLE SOURCE DRUGS.—The average manufacturer price described in subparagraphs (A)(ii)(II) (without regard to the percentage increase determined under that subparagraph) and (B) of subsection (c)(2) for each dosage form and strength of a single source drug or an innovator multiple source drug used to determine, with respect to a rebate period, an additional rebate for such dosage form and strength for such a drug.

''(iii) NONDISCLOSURE OF CERTAIN INFORMATION.—Notwithstanding any other provision of law, information disclosed by manufacturers (or verified with wholesalers) under an agreement with the Secretary of Veterans Affairs described in subsection (a)(6)(A) may not be disclosed except—

''(I) as the Secretary determines to be necessary to carry out this section;

''(II) to permit the Comptroller General to review the information provided; or

''(III) to permit the Director of the Congressional Budget Office to review the information provided.

''(iv) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed as affecting any requirement applicable to the Secretary of Veterans Affairs regarding the confidentiality of information required to be disclosed to the Secretary of Veterans Affairs by a manufacturer under section 8126 of title 38, United States Code.''.

(2) EFFECTIVE DATE; IMPLEMENTATION.—

(A) EFFECTIVE DATE.—The amendments made by paragraph (1) take effect upon the date of enactment of this Act and apply to the most recent reported price information under section 1927(b)(3) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)) as of such date, and all such information reported under such section after such date.

(B) ADDITIONAL PERIOD FOR IMPLEMENTATION.—Notwithstanding the 30-day requirement for the public availability of market-based drug pricing information under section 1927(b)(3)(D)(i) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(D)(i)), with respect to the initial public availability of such information, the Secretary of Health and Human Services shall have up to 90 days from the date of the enactment of this Act in which to make such information so available.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out section 1927(b)(3)(D) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(D)), as amended by this subsection, such sums as may be necessary to carry out such section. Amounts appropriated pursuant to this subsection shall be in addition to amounts otherwise appropriated to carry out title XIX of such Act (42 U.S.C. 1396 et seq.).

SA 1073. Mr. SMITH (for himself, Mr. FEINGOLD, and Ms. CANTWELL) sumitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 379, strike lines 9 through 13, and insert:

''(A) IN GENERAL.—The term 'specialized Medicare+Choice plans for special needs beneficiaries' means a Medicare+Choice plan that—

''(i) exclusively serves special needs beneficiaries (as defined in subparagraph (B)), or

''(ii) to the extent provided in regulations prescribed by the Secretary, disproportionately serves such special needs beneficiaries, frail elderly medicare beneficiaries, or both.

SA 1074. Mr. COLEMAN sumitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title IV, add the following:

SEC. ___. IMPROVEMENTS IN NATIONAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the third sentence of subsection (a) by inserting ''consistent with subsection (j)'' after ''the Secretary shall ensure''; and

(B) by adding at the end the following new subsection:

''(j) NATIONAL COVERAGE DETERMINATION PROCESS.—

''(1) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

''(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

''(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

''(2) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—At the end of the 6-month period (with respect to a request under paragraph (1)(A)) or 9-month period (with respect to a request under paragraph (1)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall—

''(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

''(B) provide a 30-day period for public comment on such draft;

''(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to under subparagraph (B);

''(D) include in such final decision summaries of the public comments received and responses thereto;

''(E) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

''(F) in the case of a decision to grant the coverage determination, assign a temporary or permanent code and implement the coverage decision at the end of the 60-day period referred to in subparagraph (C).

''(3) NATIONAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection, the term 'national coverage determination' has the meaning given such term in section 1869(f)(1)(B).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to national coverage determinations as of January 1, 2004.

SA 1075. Ms. STABENOW (for herself and Mr. LEVIN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 676, after line 22, add the following:

SEC. ___. EXTENSION OF MORATORIUM.

(a) IN GENERAL.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 and section 4758 of the Balanced Budget Act of 1997, is amended—

(1) by striking ''until December 31, 2002'', and

(2) by striking ''Kent Community Hospital Complex in Michigan or.''

(b) EFFECTIVE DATES.—

(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

SA 1076. Ms. STABENOW (for herself and Mr. LEVIN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 438, between lines 10 and 11, insert the following:

SEC. ___. COMPREHENSIVE CANCER CENTERS.

(a) IN GENERAL.—Section 1886(d)(1) of the Social Security Act (42 U.S.C. 1395ww(d)(1)) is amended—

(1) in subparagraph (B)(v)—

(A) by striking ''or'' at the end of subclause (III);

(B) by striking the semicolon at the end of subclause (IV) and inserting '', or''; and

(C) by inserting after subclause (IV) the following:

''(IV) a hospital that is a nonprofit corporation, the sole member of which was recognized as a comprehensive cancer center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that specifies in its articles of incorporation that at least 50 percent of its total discharges must have a principal finding of neoplastic disease, as defined in subparagraph (E), and that is a freestanding facility licensed for less than 131 acute care beds;''; and

(2) in subparagraph (E), by striking ''(II) and (III)'' and inserting ''(II), (III), and (IV)''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning after the date of enactment of this Act.

SA 1077. Ms. STABENOW (for herself and Mr. LEVIN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 438, between lines 10 and 11, insert the following:

SEC. ___. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in subparagraph (F)(i), by inserting ''subject to subparagraph (I),'' after ''October 1, 1997,'';

(2) in subparagraph (H)(i), by inserting ''and subject to subparagraph (I),'' after ''subparagraphs (F) and (G),''; and

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

''(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

''(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

''(I) IN GENERAL.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2003, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

''(II) REFERENCE PERIODS DEFINED.—In this clause, the term 'reference periods' means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2001.

''(III) REFERENCE RESIDENT LEVEL.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

''(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2002.

''(ii) REDISTRIBUTION.—

''(I) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

''(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2003, or before the date of the hospital's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2004.

''(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

''(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

''(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

''(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

''(iii) RESIDENT LEVEL AND LIMIT DEFINED.—In this subparagraph:

''(I) RESIDENT LEVEL.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

''(II) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital,

the limit otherwise applicable under subparagraphs (F)(i) and (H) on the resident level for the hospital determined without regard to this subparagraph.''.

(b) NO APPLICATION OF INCREASE TO IME.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: ''The provisions of subsection (h)(4)(I) (determined without regard to clause (ii) thereof) shall apply with respect to the first sentence of this clause in the same manner as such provisions apply with respect to subparagraph (F) of such subsection.''.

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, the Secretary of Health and Human Services shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(i)(II) of the Social Security Act (as added by subsection (a)).

SA 1076. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ___. REVISION OF ALTERNATIVE GUIDELINES FOR GEOGRAPHIC RECLASSIFICATION OF CERTAIN DISPROPORTIONATELY LARGE HOSPITALS.

Section 4409(b) of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) is amended—

(1) in paragraph (1)—

(A) by inserting ''(A)'' after ''(1)'';

(B) by adding ''or'' after the semicolon at the end; and

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

''(B) beginning with fiscal year 2003, the hospital is the only hospital located in such an Area'';

(2) in paragraph (2), by inserting ''in the case of a hospital described in paragraph (1)(A),'' before ''not less than 40 percent''; and

(3) in paragraph (3), by inserting ''for fiscal years before 2003,'' before ''the hospital submitted an application''.

SA 1079. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ___. RECLASSIFICATION OF CERTAIN RURAL COUNTIES FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal years 2003, 2004, and 2005, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), a hospital located in a rural county in a State that is adjacent to 1 or more urban areas is deemed to be located in the urban metropolitan statistical area from which the greatest number of hospital employees commute, if—

(1) the rural county is surrounded by urban metropolitan statistical areas; and

(2) the hospital would be reclassified as being located in an adjacent urban metropolitan statistical area for purposes of determining the wage index and the standardized amount applicable to the hospital but for a requirement that the hospital have a wage index that is 106 percent of its applicable rural wage index.

(b) TREATMENT AS DECISION OF MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD.—For purposes of section 1886(d) of the Social Security Act (42 U.S.C 1395ww(d)), any reclassification under subsection (a) shall be treated as a decision of the Medicare Geographic Classification Review Board under paragraph (10) of that section.

(c) PROCESS FOR APPLICATIONS TO ENSURE THAT PROVISIONS APPLY BEGINNING OCTOBER 1, 2003.—The Secretary of Health and Human Services shall establish a process for the Medicare Geographic Classification Review Board to accept, and make determinations with respect to, applications that are filed by applicable hospitals within 90 days of the date of enactment of this section to reclassify based on the provisions of this section in order to ensure that such provisions shall apply to payments under such section 1886(d) for discharges occurring on or after October 1, 2003.

(d) ADJUSTMENTS TO ENSURE BUDGET NEUTRALITY.—If 1 or more applicable hospital's applications are approved pursuant to the process under subsection (c), the Secretary of Health and Human Services shall make a proportional adjustment in the standardized amounts determined under paragraph (3) of such section 1886(d) for payments for discharges occurring in fiscal year 2004 to ensure that approval of such applications does not result in aggregate payments under such section 1886(d) that are greater or less than those that would otherwise be made if this section had not been enacted.

SA 1080. Mr. DEWINE (for himself and Mr. DURBIN) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements to the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. COMPREHENSIVE IMMUNOSUPPRESSIVE DRUG COVERAGE FOR TRANSPLANT PATIENTS.

(a) COMPREHENSIVE COVERAGE OF IMMUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PROGRAM.—

(1) IN GENERAL.—Section 1861(s)(2)(J) (42 U.S.C. 1395x(s)(2)(J)) is amended by striking '', to an individual who receives'' and all that follows before the semicolon at the end and inserting ''to an individual who has received an organ transplant''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to drugs furnished on or after the date of enactment of this Act.

(b) PROVISION OF APPROPRIATE COVERAGE OF IMMUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PROGRAM FOR ORGAN TRANSPLANT RECIPIENTS.—

(1) CONTINUED ENTITLEMENT TO IMMUNOSUPPRESSIVE DRUGS.—

(A) KIDNEY TRANSPLANT RECIPIENTS.—Section 226A(b)(2) (42 U.S.C. 426–1(b)(2)) is amended by inserting ''(except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))'' after ''shall end''.

(B) OTHER TRANSPLANT RECIPIENTS.—The flush matter following paragraph (2)(C)(ii)(II) of section 226(b) (42 U.S.C. 426(b)) is amended by striking ''of this subsection)'' and inserting ''of this subsection and except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))''.

(C) APPLICATION.—Section 1836 (42 U.S.C. 1395o) is amended—

(i) by striking ''Every individual who'' and inserting ''(a) IN GENERAL.—Every individual who''; and

(ii) by adding at the end the following new subsection:

''(b) SPECIAL RULES APPLICABLE TO INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

''(1) IN GENERAL.—In the case of an individual whose eligibility for benefits under this title has ended except for the coverage of immunosuppressive drugs by reason of section 226(b) or 226A(b)(2), the following rules shall apply:

''(A) The individual shall be deemed to be enrolled under this part for purposes of receiving coverage of such drugs.

''(B) The individual shall be responsible for the full amount of the premium under section 1839 in order to receive such coverage.

''(C) The provision of such drugs shall be subject to the application of—

''(i) the deductible under section 1833(b); and

''(ii) the coinsurance amount applicable for such drugs (as determined under this part).

''(D) If the individual is an inpatient of a hospital or other entity, the individual is entitled to receive coverage of such drugs under this part.

''(2) ESTABLISHMENT OF PROCEDURES IN ORDER TO IMPLEMENT COVERAGE.—The Secretary shall establish procedures for—

''(A) identifying beneficiaries that are entitled to coverage of immunosuppressive drugs by reason of section 226(b) or 226A(b)(2); and

''(B) distinguishing such beneficiaries from beneficiaries that are enrolled under this part for the complete package of benefits under this part.''.

(D) TECHNICAL AMENDMENT.—Subsection (c) of section 226A (42 U.S.C. 426–1), as added by section 201(a)(3)(D)(ii) of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1497), is redesignated as subsection (d).

(2) EXTENSION OF SECONDARY PAYER REQUIREMENTS FOR ESRD BENEFICIARIES.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following new sentence: ''With regard to immunosuppressive drugs furnished on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, this subparagraph shall be applied without regard to any time limitation.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to drugs furnished on or after the date of enactment of this Act.

(c) PLANS REQUIRED TO MAINTAIN COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

(1) APPLICATION TO CERTAIN HEALTH INSURANCE COVERAGE.—

(A) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following:

''SEC. 2707. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

''A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide coverage of immunosuppressive drugs that is at least as comprehensive as the coverage provided by such plan or issuer on the day before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, and such

requirement shall be deemed to be incorporated into this section.''.

(B) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2707)'' after ''requirements of such subparts''.

(2) APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(A) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following new section:

''SEC. 714. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

''A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide coverage of immunosuppressive drugs that is at least as comprehensive as the coverage provided by such plan or issuer on the day before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, and such requirement shall be deemed to be incorporated into this section.''.

(B) CONFORMING AMENDMENTS.—

(i) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(ii) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Coverage of immunosuppressive drugs.''.

(3) APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(A) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Coverage of immunosuppressive drugs.'';

and

(B) by inserting after section 9812 the following:

''SEC. 9813. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

''A group health plan shall provide coverage of immunosuppressive drugs that is at least as comprehensive as the coverage provided by such plan on the day before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, and such requirement shall be deemed to be incorporated into this section.''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2004.

SA 1081. Ms. LANDRIEU submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 476, between lines 5 and 6, insert the following:

(10) EXEMPTION FOR CERTAIN INHALATION DRUGS AND BIOLOGICALS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6) (7) and (9), is amended by adding at the end the following new paragraph:

''(10)(A) Notwithstanding the preceding provisions of this subsection, in the case of existing inhalation drugs and biologicals furnished on or after January 1, 2004, and before January 1, 2011, the payment rate for such drugs and biologicals shall be 95 percent of the average wholesale price (as in effect on June 30, 2003).

''(B) During the period described in subparagraph (A), the Secretary may not make any increased or separate payments under paragraph (8) with respect to existing inhalation drugs and biologicals.

''(C) For purposes of this paragraph, the term 'existing inhalation drugs and biologicals' means inhalation drugs and biologicals furnished through durable medical equipment covered under section 1861(n) that are first available for payment under this part on or before June 30, 2003.''.

SA 1082. Mr. CONRAD submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ___. ACCELERATING THE RATE OF REDUCTION OF BENEFICIARY COPAYMENT LIABILITY UNDER THE MEDICARE HOSPITAL OUTPATIENT DEPARTMENT PROSPECTIVE PAYMENT SYSTEM.

Section 1833(t)(8)(C)(ii) (42 U.S.C. 1395l(t)(8)(C)(ii)) is amended—

(1) in subclause (V), by striking ''and thereafter'' and inserting ''through 2008''; and

(2) by adding at the end the following new subclauses:

''(VI) For procedures performed in 2009, 36 percent.

''(VII) For procedures performed in 2010 and 2011, 34 percent.

''(VIII) For procedures performed in 2012, 32 percent.

''(IX) For procedures performed in 2013 and thereafter, 30 percent.''.

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

SA 1083. Mr. COLEMAN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ___. TREATMENT OF CERTAIN ENTITIES FOR PURPOSES OF PAYMENTS UNDER THE MEDICARE PROGRAM.

(a) PAYMENTS TO HOSPITALS.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of making payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C.

1395(d)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Stearns County, Minnesota, such county is deemed to be located in the Minneapolis-St. Paul, Minnesota-Wisconsin, Metropolitan Statistical Area.

(b) BUDGET NEUTRALITY.—The Secretary shall adjust the area wage index referred to in subsection (a) in a manner which assures that the appropriate payments made under section 1886(d) of the Social Security Act (42 U.S.C., 1395(ww)(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than those which would have be made in the year if this section did not apply.

SA 1084. Mr. VOINOVICH submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 152, between lines 7 and 8, and insert the following:

''(g) STATE OPTION TO PAY MEDICARE PART D PRICE FOR COVERED OUTPATIENT DRUGS FOR DUAL ELIGIBLE INDIVIDUALS.—Notwithstanding any provision of title XVIII, or section 1927(c)(1)(C)(i), with respect to a State that provides medical assistance for a covered drug (as such term is defined in section 1860D(a)(2)) for a dual eligible individual enrolled under the State plan under this title (or under a waiver of such plan) that is also a covered outpatient drug (as defined for purposes of in section 1927) included on the State formulary established under section 1927, if the price the State would pay for the drug under this title exceeds the price that an eligible entity offering a Medicare Prescription Drug plan or a MedicareAdvantage organization offering a MedicareAdvantage plan would pay for the drug under title XVIII, the State may elect to pay the price that applies under title XVIII. An election by a State under the preceding sentence shall have no effect on the terms of a rebate agreement entered into under section 1927 which would otherwise apply to the provision of medical assistance for the covered outpatient drug.''.

SA 1085. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. SENSE OF THE SENATE ON PAYMENT REDUCTIONS UNDER MEDICARE PHYSICIAN FEE SCHEDULE.

(a) FINDINGS.—Congress finds that—

(1) the fees Medicare pays physicians were reduced by 5.4 percent across-the-board in 2002;

(2) recent action by Congress narrowly averted another across-the-board reduction of 4.4 percent for 2003;

(3) based on current projections, the Centers for Medicare & Medicaid Services (CMS) estimates that, absent legislative or administrative action, fees will be reduced across-the-board once again in 2004 by 4.2 percent;

(4) the prospect of continued payment reductions under the Medicare physician fee schedule for the foreseeable future threatens to destabilize an important element of the program, namely physician participation and willingness to accept Medicare patients;

(5) the primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services under Medicare;

(6) the SGR system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between growth in Medicare beneficiary health care costs and our Nation's GDP, and a requirement for immediate recoupment of the difference;

(7) both administrative and legislative action are needed to return stability to the physician payment system;

(8) using the discretion given to it by Medicare law, CMS has included expenditures for prescription drugs and biologicals administered incident to physicians' services under the annual spending targets without making appropriate adjustments to the targets to reflect price increases in these drugs and biologicals or the growing reliance on such therapies in the treatment of Medicare patients;

(9) between 1996 and 2002, annual Medicare spending on these drugs grew from $1,800,000,000 to $6,200,000,000, or from $55 per beneficiary to an estimated $187 per beneficiary;

(10) although physicians are responsible for prescribing these drugs and biologicals, neither the price of the drugs and biologicals, nor the standards of care that encourage their use, are within the control of physicians; and

(11) SGR target adjustments have not been made for cost increases due to new coverage decisions and new rules and regulations.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Center for Medicare & Medicaid Services (CMS) should use its discretion to exclude drugs and biologicals administered incident to physician services from the sustainable growth rate (SGR) system;

(2) CMS should use its discretion to make SGR target adjustments for new coverage decisions and new rules and regulations; and

(3) in order to provide ample time for Congress to consider more fundamental changes to the SGR system, the conferees on the Prescription Drug and Medicare Improvement Act of 2003 should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the variance and creating ''tolerance'' corridors for variations around the update target trend.

SA 1086. Ms. MURKOWSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 37, strike lines 4 and 5 and insert ''reasonable distances to pharmacy services in urban and rural areas and access to pharmacy services of the Indian Health Service and Indian tribes and tribal organizations.''.

On page 165, strike lines 4 and 5 and insert ''into account reasonable distances to pharmacy services in urban and rural areas and access to pharmacy services of the Indian Health Service and Indian tribes and tribal organizations.''.

SA 1087. Mr. GRASSLEY (for Mr. CRAIG) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title II, add the following:

SEC. ___. ESTABLISHMENT OF MEDICAREADVANTAGE CONSUMER-DRIVEN HEALTH PLAN OPTION.

(a) PROGRAM SPECIFICATIONS.—Part C of title XVIII (42 U.S.C. 1395w–21 et seq.), amended by section 205, is amended by inserting after section 1858A the following new section:

''CONSUMER-DRIVEN HEALTH PLAN OPTION

''SEC. 1858B. (a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—Beginning on January 1, 2006, there is established a consumer-driven health plan program under which consumer-driven health plans offered by consumer-driven health plan sponsors are offered to MedicareAdvantage eligible individuals in preferred provider regions.

''(2) DEFINITIONS.—

''(A) CONSUMER-DRIVEN HEALTH PLAN SPONSOR.—The term 'consumer-driven health plan sponsor' means an entity with a contract under section 1857 that meets the requirements of this section applicable with respect to consumer-driven health plan sponsors.

''(B) CONSUMER-DRIVEN HEALTH PLAN.—The term 'consumer-driven health plan' means a MedicareAdvantage plan that—

''(i) provides 100 percent coverage for preventive benefits (as defined by the Secretary);

''(ii) includes a personal care account from which enrollees must pay out-of-pocket costs until the deductible is met; and

''(iii) has a high deductible (as determined by the Secretary).

''(C) PREFERRED PROVIDER REGION.—The term 'preferred provider region' has the meaning given that term under section 1858(a)(2)(C).

''(b) ELIGIBILITY, ELECTION, AND ENROLLMENT; BENEFITS AND BENEFICIARY PROTECTIONS.—

''(1) IN GENERAL.—Except as provided in the succeeding provisions of this subsection, the provisions of sections 1851 and 1852 that apply with respect to coordinated care plans shall apply to consumer-driven health plans offered by a consumer-driven health plan sponsor.

''(2) SERVICE AREA.—The service area of a consumer-driven health plan shall be a preferred provider region.

''(3) AVAILABILITY.—Each preferred provider organization plan must be offered to each MedicareAdvantage eligible individual who resides in the service area of the plan.

''(4) AUTHORITY TO PROHIBIT RISK SELECTION.—The provisions of section 1852(a)(6) shall apply to preferred provider organization plans.

''(5) ASSURING ACCESS TO SERVICES IN CONSUMER-DRIVEN HEALTH PLANS.—The requirements of section 1858(a)(5) shall apply to consumer-driven health plans.

''(6) PERSONAL CARE ACCOUNTS.—

''(A) ESTABLISHMENT.—Each consumer-driven health plan shall establish a personal care account on behalf of each enrollee from which such enrollee shall be required to pay out-of-pockets costs until the deductible described in subsection (a)(2)(B)(iii) is met.

''(B) ROLLOVER.—Subject to subparagraph (C), any amounts remaining in a personal care account at the end of a year shall be credited to such an account for the subsequent year.

''(C) CHANGES OF ELECTION.—If, after electing a consumer-driven health plan, a beneficiary elects a plan under this part that is not a consumer-driven health plan during a subsequent year or elects to receive benefits under the original medicare fee-for-service program option (whether or not as a result of circumstances described in section 1851(e)(4)), any amounts remaining in the account as of the date of such election shall be credited to the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 in such proportion as the Secretary determines is appropriate.

''(c) PAYMENTS TO CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—

''(1) PAYMENTS TO ORGANIZATIONS.—

''(A) MONTHLY PAYMENTS.—

''(i) IN GENERAL.—Under a contract under section 1857 and subject to paragraph (5), subsections (e) and (i), and section 1859(e)(4), the Secretary shall make, to each consumer-driven health plan sponsor, with respect to coverage of an individual for a month under this part in a preferred provider region, separate monthly payments with respect to—

''(I) benefits under the original medicare fee-for-service program under parts A and B in accordance with paragraph (4); and

''(II) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

''(ii) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment applicable with respect to classes of individuals determined to have end-stage renal disease and enrolled in a consumer-driven health plan under this clause that are similar to the separate rates of payment described in section 1853(a)(1)(B).

''(B) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—The Secretary may retroactively adjust the amount of payment under this paragraph in a manner that is similar to the manner in which payment amounts may be retroactively adjusted under section 1853(a)(2).

''(C) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in section 1853(a)(3)(B) to 100 percent of the amount of payments to plans under paragraph (4)(D)(ii).

''(D) ADJUSTMENT FOR SPENDING VARIATIONS WITHIN A REGION.—The Secretary shall establish a methodology for adjusting the amount of payments to plans under paragraph (4)(D)(ii) that achieves the same objective as the adjustment described in paragraph 1853(a)(2)(C).

''(2) APPLICATION OF PREFERRED PROVIDER BENCHMARKS.—The benchmark amounts calculated under section 1858(c)(2) shall apply with respect to consumer-driven health plans.

''(3) APPLICATION OF PREFERRED PROVIDER PAYMENT FACTORS.—The provisions of section 1858(c)(3) shall apply with respect to consumer driven health plans.

''(4) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—The Secretary shall determine the payment amount for plans as follows:

''(A) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under subsection (d)(1) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part and are based on the assumptions described in section 1854(a)(2)(A)(iii).

''(B) DETERMINATION OF PREFERRED PROVIDER REGIONAL BENCHMARK AMOUNTS.—The preferred provider regional benchmark calculated under section 1858(c)(4)(B) shall apply with respect to consumer-drive health plans amount for that plan for the benefits under the original medicare fee-for-service program option for each plan equal to the regional benchmark adjusted by using the assumptions described in section 1854(a)(2)(A)(iii).

''(C) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under subparagraph (A)) and the preferred provider regional benchmark amount (as determined under subparagraph (B)) for purposes of determining—

''(i) the payment amount under subparagraph (D); and

''(ii) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

''(D) DETERMINATION OF PAYMENT AMOUNT.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall determine the payment amount to a consumer-driven health plan sponsor for a consumer-driven health plan as follows:

''(I) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount.

''(II) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

''(ii) APPLICATION OF ADJUSTMENT METHODOLOGIES.—The Secretary shall adjust the amounts determined under subparagraph (A) using the factors described in section 1858(c)(3)(A)(ii).

''(E) FACTORS USED IN ADJUSTING BIDS AND BENCHMARKS FOR CONSUMER-DRIVEN HEALTH PLAN SPONSORS AND IN DETERMINING ENROLLEE PREMIUMS.—Subject to subparagraph (F), in addition to the factors used to adjust payments to plans described in section 1853(d)(6), the Secretary shall use the adjustment for geographic variation within the region established under paragraph (1)(D).

''(F) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—The Secretary shall provide for adjustments for national coverage determinations and legislative changes in benefits applicable with respect to consumer-driven health plan sponsors in the same manner as the Secretary provides for adjustments under section 1853(d)(7).

''(5) PAYMENTS FROM TRUST FUND.—The payment to a consumer-driven health plan sponsor under this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in a manner similar to the manner described in section 1853(g).

''(6) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—Rules similar to the rules applicable under section 1853(h) shall apply with respect consumer-driven health plan sponsors.

''(7) SPECIAL RULE FOR HOSPICE CARE.—Rules similar to the rules applicable under section 1853(i) shall apply with respect to consumer-driven health plan sponsors.

''(d) SUBMISSION OF BIDS BY CONSUMER-DRIVEN HEALTH PLANS; PREMIUMS.—

''(1) SUBMISSION OF BIDS BY CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—

''(A) IN GENERAL.—For the requirements on submissions by consumer-driven health plans, see section 1854(a)(1).

''(B) UNIFORM PREMIUMS.—Each bid amount submitted under subparagraph (A) for a consumer-driven health plan in a preferred provider region may not vary among MedicareAdvantage eligible individuals residing in such preferred provider region.

''(C) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under subparagraph (A) for a consumer-driven health plan must reasonably and equitably reflect the cost of benefits provided under that plan.

''(D) REVIEW.—The Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this paragraph and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the consumer-driven health plan sponsor with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

''(E) NO LIMIT ON NUMBER OF PLANS IN A REGION.—The Secretary may not limit the number of consumer-driven health plans offered in a preferred provider region.

''(2) MONTHLY PREMIUMS CHARGED.—The amount of the monthly premium charged to an individual enrolled in a consumer-driven health plan offered by a consumer-driven health plan sponsor shall be equal to the sum of the following:

''(A) The MedicareAdvantage monthly basic beneficiary premium, as defined in section 1854(b)(2)(A) (if any).

''(B) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, as defined in section 1854(b)(2)(C) (if any).

''(C) The MedicareAdvantage monthly obligation for qualified prescription drug coverage, as defined in section 1854(b)(2)(B) (if any).

''(3) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—The rules for determining premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums under section 1854(d) shall apply with respect to consumer-driven health plan sponsors.

''(4) PROHIBITION OF SEGMENTING PREFERRED PROVIDER REGIONS.—The Secretary may not permit a consumer-driven health plan sponsor to elect to apply the provisions of this section uniformly to separate segments of a preferred provider region (rather than uniformly to an entire preferred provider region).

''(e) PORTION OF TOTAL PAYMENTS TO AN ORGANIZATION SUBJECT TO RISK FOR 2 YEARS.—

''(1) NOTIFICATION OF SPENDING UNDER THE PLAN.—

''(A) IN GENERAL.—For 2007 and 2008, the consumer-driven health plan sponsor offering a consumer-driven health plan shall notify the Secretary of the total amount of costs that the organization incurred in providing benefits covered under parts A and B of the original medicare fee-for-service program for all enrollees under the plan in the previous year.

''(B) CERTAIN EXPENSES NOT INCLUDED.—The total amount of costs specified in subparagraph (A) may not include—

''(i) subject to subparagraph (C), administrative expenses incurred in providing the benefits described in such subparagraph; or

''(ii) amounts expended on providing enhanced medical benefits under section 1852(a)(3)(D).

''(C) ESTABLISHMENT OF ALLOWABLE ADMINISTRATIVE EXPENSES.—For purposes of applying subparagraph (B)(i), the administrative expenses incurred in providing benefits described in subparagraph (A) under a consumer-driven health plan may not exceed an amount determined appropriate by the Administrator.

''(2) ADJUSTMENT OF PAYMENT.—

''(A) NO ADJUSTMENT IF COSTS WITHIN RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)) for the plan for the year, then no additional payments shall be made by the Secretary and no reduced payments shall be made to the consumer-driven health plan sponsor offering the plan.

''(B) INCREASE IN PAYMENT IF COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

''(i) IN GENERAL.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Secretary shall increase the total of the monthly payments made to the consumer-driven health plan sponsor offering the plan for the year under subsection (c)(1)(A) by an amount equal to the sum of—

''(I) 50 percent of the amount of such total costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(iv)); and

''(II) 10 percent of the amount of such total costs which are more than such second threshold upper limit of the risk corridor.

''(C) REDUCTION IN PAYMENT IF COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the Secretary shall reduce the total of the monthly payments made to the consumer-driven health plan sponsor offering the plan for the year under subsection (c)(1)(A) by an amount (or otherwise recover from the plan an amount) equal to—

''(i) 50 percent of the amount of such total costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(ii)); and

''(ii) 10 percent of the amount of such total costs which are less than such second threshold lower limit of the risk corridor.

''(3) ESTABLISHMENT OF RISK CORRIDORS.—

''(A) IN GENERAL.—For 2006 and 2007, the Secretary shall establish a risk corridor for each consumer-driven health plan. The risk corridor for a plan for a year shall be equal to a range as follows:

''(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to 5 percent of such target amount.

''(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to 10 percent of such target amount.

''(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

''(I) such target amount; and

''(II) the amount described in clause (i)(II).

''(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

''(I) such target amount; and

''(II) the amount described in clause (ii)(II).

''(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a consumer-driven health plan offered by a consumer-driven health plan sponsor in a year, an amount equal to the sum of—

''(i) the total monthly payments made to the organization for enrollees in the plan for the year under subsection (c)(1)(A); and

''(ii) the total MedicareAdvantage basic beneficiary premiums collected for such enrollees for the year under subsection (d)(2)(A).

''(4) PLANS AT RISK FOR ENTIRE AMOUNT OF ENHANCED MEDICAL BENEFITS.—A consumer-driven health plan sponsor that offers a consumer-driven health plan that provides enhanced medial benefits under section 1852(a)(3)(D) shall be at full financial risk for the provision of such benefits.

''(5) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the amount of the MedicareAdvantage basic beneficiary premium that a beneficiary is otherwise required to pay under the plan for the year under subsection (d)(2)(A).

''(6) DISCLOSURE OF INFORMATION.—The provisions of section 1860D–16(b)(7), including subparagraph (B) of such section, shall apply to a consumer-driven health plan sponsor and a consumer-driven health plan in the same manner as such provisions apply to an eligible entity and a Medicare Prescription Drug plan under part D.

''(f) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—A consumer-driven health plan sponsor shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State within the preferred provider region in which it offers a consumer-driven health plan.

''(g) INAPPLICABILITY OF PROVIDER-SPONSORED ORGANIZATION SOLVENCY STANDARDS.—The requirements of section 1856 shall not apply with respect to consumer-driven health plan sponsors.

''(h) CONTRACTS WITH CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—The provisions of section 1857 shall apply to a consumer-driven health plan offered by a consumer-driven health plan sponsor under this section.

''(i) BUDGET NEUTRALITY.—Notwithstanding any other provision of this section, in conducting the program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under this title do not exceed the amount the Secretary would have paid if this section had not been enacted.''.

(b) CONSUMER-DRIVEN HEALTH PLAN TERMINOLOGY DEFINED.—Section 1859(a) (42 U.S.C. 1395w–29(a)), as amended by section 211(b), is amended by adding at the end the following new paragraph:

''(4) CONSUMER-DRIVEN HEALTH PLAN SPONSOR; CONSUMER-DRIVEN HEALTH PLAN.—The terms 'consumer-driven health plan sponsor' and 'consumer-driven health plan' have the meaning given such terms in section 1858B(a)(2).''.

SA 1088. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ___. EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

''(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

''(I) CANCER HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(v), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

''(II) CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii), for covered OPD services furnished before October 1, 2003, and for which the PPS amount is less than the pre-BBA amount the amount of payment under this subsection shall be increased by the amount of such difference. In the case of such a hospital, for such services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions incurred in furnishing such services, the amount of payment under this subsection shall be increased by the amount of such difference.''.

SA 1089. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ___. EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

''(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

''(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

''(II) SPECIAL RULE FOR CERTAIN CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii) that is located in a State with a reimbursement system under section 1814(b)(3), but that is not reimbursed under such system, for covered OPD services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions of the hospital in providing such services, the amount of payment under this subsection shall be increased by the amount of such difference.''.

SA 1090. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ___. PERMITTING DIRECT PAYMENT UNDER THE MEDICARE PROGRAM FOR CLINICAL SOCIAL WORKER SERVICES PROVIDED TO RESIDENTS OF SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting ''clinical social worker services,'' after ''qualified psychologist services,''.

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) (42 U.S.C. 1395x(hh)(2)) is amended by striking ''and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2003.

SA 1091. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of title VI, add the following:

SEC. ___. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking ''December 31, 2004, but only with respect to'' and all that follows and inserting ''December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996.''.

SA 1092. Mr. GRASSLEY (for himself and Mr. BAUCUS) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle C of title II, add the following:

Subtitle D—Evaluation of Alternative Payment and Delivery Systems

SEC. 231. ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.

(a) ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.—Section 1858 (as added by section 211(b)) is amended by adding at the end the following new subsection:

''(i) ALTERNATIVE PAYMENT METHODOLOGY FOR HIGHLY COMPETITIVE REGIONS.—

''(1) ANNUAL DETERMINATION AND DESIGNATION.—

''(A) IN 2008.—In 2008, prior to the date on which the Secretary expects to publish the risk adjusters under section 1860D–11, the Secretary shall designate a limited number (but in no case fewer than 1) of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions.

''(B) SUBSEQUENT YEARS.—For each year (beginning with 2009) the Secretary may designate a limited number of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions in addition to any region designated as a highly competitive region under subparagraph (A).

''(C) CONSIDERATIONS.—In determining which preferred provider regions to designate as highly competitive regions under subparagraph (A) or (B), the Secretary shall consider the following:

''(i) Whether the application of this subsection to the preferred provider region would enhance the participation of preferred provider organization plans in that region.

''(ii) Whether the Secretary anticipates that there is likely to be at least 3 bids submitted under subsection (d)(1) with respect to the preferred provider region if the Secretary designates such region as a highly competitive region under subparagraph (A) or (B).

''(iii) Whether the Secretary expects that MedicareAdvantage eligible individuals will elect preferred provider organization plans in the preferred provider region if the region is designated as a highly competitive region under subparagraph (A) or (B).

''(iv) Whether the designation of the preferred provider region as a highly competitive region will permit compliance with the limitation described in paragraph (5).

In considering the matters described in clauses (i) through (iv), the Secretary shall give special consideration to preferred provider regions where no bids were submitted under subsection (d)(1) for the previous year.

''(2) EFFECT OF DESIGNATION.—If a preferred provider region is designated as a highly competitive region under subparagraph (A) or (B) of paragraph (1)—

''(A) the provisions of this subsection shall apply to such region and shall supersede the provisions of this part relating to benchmarks for preferred provider regions; and

''(B) such region shall continue to be a highly competitive region until such designation is rescinded pursuant to paragraph (5)(B)(ii).

''(3) SUBMISSION OF BIDS.—

''(A) IN GENERAL.—Notwithstanding subsection (d)(1), for purposes of applying section 1854(a)(2)(A)(i), the plan bid for a highly competitive region shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of only the benefits described in section 1852(a)(1)(A) to an individual enrolled in the plan that resides in the service area of the plan for a month.

''(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as permitting a preferred provider organization plan not to provide coverage for the benefits described in section 1852(a)(1)(C).

''(4) PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE AREAS.—With respect to highly competitive regions, the following rules shall apply:

''(A) IN GENERAL.—Notwithstanding subsection (c), of the plans described in subsection (d)(1)(E), the Secretary shall substitute the second lowest bid for the benchmark applicable under subsection (c)(4).

''(B) IF THERE ARE FEWER THAN THREE BIDS.—Notwithstanding subsection (c), if there are fewer than 3 bids in a highly competitive region for a year, the Secretary shall substitute the lowest bid for the benchmark applicable under subsection (c)(4).

''(5) FUNDING LIMITATION.—

''(A) IN GENERAL.—

''(i) IN GENERAL.—The total amount expended as a result of the application of this subsection during the period or year, as applicable, may not exceed the applicable amount (as defined in clause (ii)).

''(ii) APPLICABLE AMOUNT DEFINED.—In this paragraph, the term 'applicable amount' means—

''(I) for the period beginning on January 1, 2009, and ending on September 30, 2013, the total amount that would have been expended under this title during the period if this subsection had not been enacted plus $6,000,000,000; and

''(II) for fiscal year 2014 and any subsequent fiscal year, the total amount that would have been expended under this title during the year if this subsection had not been enacted.

''(B) APPLICATION OF LIMITATION.—If the Secretary determines that the application of this subsection will cause expenditures to exceed the applicable amount, the Secretary shall—

''(i) take appropriate steps to stay within the applicable amount, including through providing limitations on enrollment; or

''(ii) rescind the designation under subparagraph (A) or (B) of paragraph (1) of 1 or more preferred provider regions as highly competitive regions.

''(C) TRANSITION.—If the Secretary rescinds a designation under subparagraph (A) or (B) of paragraph (1) pursuant to subparagraph (B)(ii) with respect to a preferred provider region, the Secretary shall provide for an appropriate transition from the payment system applicable under this subsection to the payment system described in the other provisions of this section in that region. Any amount expended by reason of the preceding sentence shall be considered to be part of the total amount expended as a result of the application of this subsection for purposes of applying the limitation under subparagraph (A).

''(D) APPLICATION.—Notwithstanding paragraph (1)(B), on or after January 1 of the year in which the fiscal year described in subparagraph (A)(ii)(II) begins, the Secretary may designate appropriate regions under such paragraph.

''(6) LIMITATION OF JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of designations made under subparagraph (A) or (B) of paragraph (1).

''(7) SECRETARY REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

''(A) a detailed description of—

''(i) the total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

''(ii) the projections of the total amount that will be expended as a result of the application of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

''(iii) amounts remaining within the funding limitation specified in paragraph (5); and

''(iv) the steps that the Secretary will take under clauses (i) and (ii) of paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed the applicable amount described in paragraph (5)(A); and

''(B) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under clauses (i), (ii), (iii), and (iv) of subparagraph (A) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

''(8) BIENNIAL GAO REPORTS.—Not later than January 1, 2011, and biennially thereafter, the Comptroller General of the United States shall submit to the Secretary and Congress a report on the designation of highly competitive regions under this subsection and the application of the payment system under this subsection within such regions. Each report shall include—

''(A) an evaluation of—

''(i) the quality of care provided to beneficiaries enrolled in a MedicareAdvantage preferred provider plan in a highly competitive region;

''(ii) the satisfaction of beneficiaries with benefits under such a plan;

''(iii) the costs to the medicare program for payments made to such plans; and

''(iv) any improvements in the delivery of health care services under such a plan;

''(B) a comparative analysis of the benchmark system applicable under the other provisions of this section and the payment system applicable in highly competitive regions under this subsection; and

''(C) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.''.

(b) CONFORMING AMENDMENT.—Section 1858(c)(3)(A)(i) (as added by section 211(b)) is amended to read as follows:

''(i) Whether each preferred provider region has been designated as a highly competitive region under subparagraph (A) or (B) of subsection (i)(1) and the benchmark amount for any preferred provider region (as calculated under paragraph (2)(A)) for the year that has not been designated as a highly competitive region.''.

SEC. 232. FEE-FOR-SERVICE MODERNIZATION PROJECTS.

(a) ESTABLISHMENT.—

(1) REVIEW AND REPORT ON RESULTS OF EXISTING DEMONSTRATIONS.—

(A) REVIEW.—The Secretary shall conduct an empirical review of the results of the demonstrations under sections 442, 443, and 444.

(B) REPORT.—Not later than January 1, 2008, the Secretary shall submit a report to Congress on the empirical review conducted under subparagraph (A) which shall include estimates of the total costs of the demonstrations, including expenditures as a result of the provision of services provided to beneficiaries under the demonstrations that are incidental to the services provided under the demonstrations, and all other expenditures under title XVIII of the Social Security Act. The report shall also include a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such estimates are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(2) PROJECTS.—Beginning in 2009, the Secretary, based on the empirical review conducted under paragraph (1), shall establish projects under which medicare beneficiaries receiving benefits under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act are provided with coverage of enhanced benefits or services under such program. The purpose of such projects is to evaluate whether the provision of such enhanced benefits or services to such beneficiaries—

(A) improves the quality of care provided to such beneficiaries under the medicare program;

(B) improves the health care delivery system under the medicare program; and

(C) results in reduced expenditures under the medicare program.

(2) ENHANCED BENEFITS OR SERVICES.—For purposes of this section, enhanced benefits or services shall include—

(A) preventive services not otherwise covered under title XVIII of the Social Security Act;

(B) chronic care coordination services;

(C) disease management services; or

(D) other benefits or services that the Secretary determines will improve preventive health care for medicare beneficiaries, result in improved chronic disease management, and management of complex, life-threatening, or high-cost conditions and are consistent with the goals described in subparagraphs (A), (B), and (C) of paragraph (1).

(b) PROJECT SITES AND DURATION.—

(1) IN GENERAL.—Subject to subsection (e)(2), the projects under this section shall be conducted—

(A) in a region or regions that are comparable (as determined by the Secretary) to the region or regions that are designated as a highly competitive region under subparagraph (A) or (B) of section 1858(i)(1) of the Social Security Act, as added by section 231 of this Act; and

(B) during the years that the region or regions are designated as such a highly competitive region.

(2) RULE OF CONSTRUCTION.—For purposes of paragraph (1), a comparable region does not necessarily mean the identical region.

(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) only to the extent and for such period as the Secretary determines is necessary to provide for enhanced benefits or services consistent with the projects under this section.

(d) BIENNIAL GAO REPORTS.—Not later than January 1, 2011, and biennially thereafter for as long as the projects under this section are being conducted, the Comptroller General of the United States shall submit to the Secretary and Congress a report that evaluates the projects. Each report shall include—

(1) an evaluation of—

(A) the quality of care provided to beneficiaries receiving benefits or services under the projects;

(B) the satisfaction of beneficiaries receiving benefits or services under the projects;

(C) the costs to the medicare program under the projects; and

(D) any improvements in the delivery of health care services under the projects; and

(2) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

(e) FUNDING.—

(1) IN GENERAL.—Payments for the costs of carrying out the projects under this section shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), as determined appropriate by the Secretary.

(2) LIMITATION.—The total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the period or year, as applicable, may not exceed—

(A) for the period beginning on January 1, 2009, and ending on September 30, 2013, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act during the period if the projects had not been conducted plus $6,000,000,000; and

(B) for fiscal year 2014 and any subsequent fiscal year, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of such title during the year if the projects had not been conducted.

(3) MONITORING AND REPORTS.—

(A) ONGOING MONITORING BY THE SECRETARY TO ENSURE FUNDING LIMITATION IS NOT VIOLATED.—The Secretary shall continually monitor expenditures made under title XVIII of the Social Security Act by reason of the projects under this section to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

(B) REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(i) a detailed description of—

(I) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the previous year compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(II) the projections of the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the year in which the report is submitted compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(III) amounts remaining within the funding limitation specified in paragraph (2); and

(IV) how the Secretary will change the scope, site, and duration of the projects in subsequent years in order to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated; and

(ii) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under subclauses (I), (II), (III), and (IV) of clause (i) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(4) APPLICATION OF LIMITATION.—If the Secretary determines that the projects under this section will cause the limitations described in subparagraphs (A) and (B) of paragraph (2) to be violated, the Secretary shall take appropriate steps to reduce spending under the projects, including through reducing the scope, site, and duration of the projects.

(5) AUTHORITY.—Beginning in 2014, the Secretary shall make necessary spending adjustments (including pro rata reductions in payments to health care providers under the medicare program) to recoup amounts so that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

SA 1093. Mr. KYL proposed an amendment to amendment SA 1092 proposed by Mr. GRASSLEY (for himself and Mr. BAUCUS) to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

In lieu of the matter proposed to be inserted, insert the following:

Subtitle D—Evaluation of Alternative Payment and Delivery Systems

SEC. 231. ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.

(a) ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.—Section 1858 (as added by section 211(b)) is amended by adding at the end the following new subsection:

''(i) ALTERNATIVE PAYMENT METHODOLOGY FOR HIGHLY COMPETITIVE REGIONS.—

''(1) ANNUAL DETERMINATION AND DESIGNATION.—

''(A) IN 2008.—In 2008, prior to the date on which the Secretary expects to publish the risk adjusters under section 1860D–11, the Secretary shall designate a limited number (but in no case fewer than 1) of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions.

''(B) SUBSEQUENT YEARS.—For each year (beginning with 2009) the Secretary may designate a limited number of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions in addition to any region designated as a highly competitive region under subparagraph (A).

''(C) CONSIDERATIONS.—In determining which preferred provider regions to designate as highly competitive regions under subparagraph (A) or (B), the Secretary shall consider the following:

''(i) Whether the application of this subsection to the preferred provider region would enhance the participation of preferred provider organization plans in that region.

''(ii) Whether the Secretary anticipates that there is likely to be at least 3 bids submitted under subsection (d)(1) with respect to the preferred provider region if the Secretary designates such region as a highly competitive region under subparagraph (A) or (B).

''(iii) Whether the Secretary expects that MedicareAdvantage eligible individuals will elect preferred provider organization plans in the preferred provider region if the region is designated as a highly competitive region under subparagraph (A) or (B).

''(iv) Whether the designation of the preferred provider region as a highly competitive region will permit compliance with the limitation described in paragraph (5).

In considering the matters described in clauses (i) through (iv), the Secretary shall give special consideration to preferred provider regions where no bids were submitted under subsection (d)(1) for the previous year.

''(2) EFFECT OF DESIGNATION.—If a preferred provider region is designated as a highly competitive region under subparagraph (A) or (B) of paragraph (1)—

''(A) the provisions of this subsection shall apply to such region and shall supersede the provisions of this part relating to benchmarks for preferred provider regions; and

''(B) such region shall continue to be a highly competitive region until such designation is rescinded pursuant to paragraph (5)(B)(ii).

''(3) SUBMISSION OF BIDS.—

''(A) IN GENERAL.—Notwithstanding subsection (d)(1), for purposes of applying section 1854(a)(2)(A)(i), the plan bid for a highly competitive region shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of only the benefits described in section 1852(a)(1)(A) to an individual enrolled in the plan that resides in the service area of the plan for a month.

''(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as permitting a preferred provider organization plan not to provide coverage for the benefits described in section 1852(a)(1)(C).

''(4) PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE AREAS.—With respect to highly competitive regions, the following rules shall apply:

''(A) IN GENERAL.—Notwithstanding subsection (c), of the plans described in subsection (d)(1)(E), the Secretary shall substitute the second lowest bid for the benchmark applicable under subsection (c)(4).

''(B) IF THERE ARE FEWER THAN THREE BIDS.—Notwithstanding subsection (c), if there are fewer than 3 bids in a highly competitive region for a year, the Secretary shall substitute the lowest bid for the benchmark applicable under subsection (c)(4).

''(5) FUNDING LIMITATION.—

''(A) IN GENERAL.—

''(i) IN GENERAL.—The total amount expended as a result of the application of this subsection during the period beginning on January 1, 2009, and ending on September 30, 2013, may not exceed the applicable amount (as defined in clause (ii)).

''(ii) APPLICABLE AMOUNT DEFINED.—In this paragraph, the term 'applicable amount' means the total amount that would have been expended under this title during the period described in clause (i) if this subsection had not been enacted plus $6,000,000,000.

''(B) APPLICATION OF LIMITATION.—If the Secretary determines that the application of this subsection will cause expenditures to exceed the applicable amount, the Secretary shall—

''(i) take appropriate steps to stay within the applicable amount, including through providing limitations on enrollment; or

''(ii) rescind the designation under subparagraph (A) or (B) of paragraph (1) of 1 or more preferred provider regions as highly competitive regions.

''(C) TRANSITION.—If the Secretary rescinds a designation under subparagraph (A) or (B) of paragraph (1) pursuant to subparagraph (B)(ii) with respect to a preferred provider region, the Secretary shall provide for an appropriate transition from the payment system applicable under this subsection to the payment system described in the other provisions of this section in that region. Any amount expended by reason of the preceding sentence shall be considered to be part of the total amount expended as a result of the application of this subsection for purposes of applying the limitation under subparagraph (A).

''(D) APPLICATION.—Notwithstanding paragraph (1)(B), on or after January 1 of the year in which the fiscal year described in subparagraph (A)(ii)(II) begins, the Secretary may designate appropriate regions under such paragraph.

''(6) LIMITATION OF JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of designations made under subparagraph (A) or (B) of paragraph (1).

''(7) SECRETARY REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

''(A) a detailed description of—

''(i) the total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

''(ii) the projections of the total amount that will be expended as a result of the application of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

''(iii) amounts remaining within the funding limitation specified in paragraph (5); and

''(iv) the steps that the Secretary will take under clauses (i) and (ii) of paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed the applicable amount described in paragraph (5)(A); and

''(B) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under clauses (i), (ii), (iii), and (iv) of subparagraph (A) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

''(8) BIENNIAL GAO REPORTS.—Not later than January 1, 2011, and biennially thereafter, the Comptroller General of the United States shall submit to the Secretary and Congress a report on the designation of highly competitive regions under this subsection and the application of the payment system under this subsection within such regions. Each report shall include—

''(A) an evaluation of—

''(i) the quality of care provided to beneficiaries enrolled in a MedicareAdvantage preferred provider plan in a highly competitive region;

''(ii) the satisfaction of beneficiaries with benefits under such a plan;

''(iii) the costs to the medicare program for payments made to such plans; and

''(iv) any improvements in the delivery of health care services under such a plan;

''(B) a comparative analysis of the benchmark system applicable under the other provisions of this section and the payment system applicable in highly competitive regions under this subsection; and

''(C) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.''.

(b) CONFORMING AMENDMENT.—Section 1858(c)(3)(A)(i) (as added by section 211(b)) is amended to read as follows:

''(i) Whether each preferred provider region has been designated as a highly competitive region under subparagraph (A) or (B) of subsection (i)(1) and the benchmark amount for any preferred provider region (as calculated under paragraph (2)(A)) for the year that has not been designated as a highly competitive region.''.

SEC. 232. FEE-FOR-SERVICE MODERNIZATION PROJECTS.

(a) ESTABLISHMENT.—

(1) REVIEW AND REPORT ON RESULTS OF EXISTING DEMONSTRATIONS.—

(A) REVIEW.—The Secretary shall conduct an empirical review of the results of the demonstrations under sections 442, 443, and 444.

(B) REPORT.—Not later than January 1, 2008, the Secretary shall submit a report to Congress on the empirical review conducted under subparagraph (A) which shall include estimates of the total costs of the demonstrations, including expenditures as a result of the provision of services provided to beneficiaries under the demonstrations that are incidental to the services provided under the demonstrations, and all other expenditures under title XVIII of the Social Security Act. The report shall also include a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such estimates are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(2) PROJECTS.—Beginning in 2009, the Secretary, based on the empirical review conducted under paragraph (1), shall establish

projects under which medicare beneficiaries receiving benefits under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act are provided with coverage of enhanced benefits or services under such program. The purpose of such projects is to evaluate whether the provision of such enhanced benefits or services to such beneficiaries—

(A) improves the quality of care provided to such beneficiaries under the medicare program;

(B) improves the health care delivery system under the medicare program; and

(C) results in reduced expenditures under the medicare program.

(2) ENHANCED BENEFITS OR SERVICES.—For purposes of this section, enhanced benefits or services shall include—

(A) preventive services not otherwise covered under title XVIII of the Social Security Act;

(B) chronic care coordination services;

(C) disease management services; or

(D) other benefits or services that the Secretary determines will improve preventive health care for medicare beneficiaries, result in improved chronic disease management, and management of complex, life-threatening, or high-cost conditions and are consistent with the goals described in subparagraphs (A), (B), and (C) of paragraph (1).

(b) PROJECT SITES AND DURATION.—

(1) IN GENERAL.—Subject to subsection (e)(2), the projects under this section shall be conducted—

(A) in a region or regions that are comparable (as determined by the Secretary) to the region or regions that are designated as a highly competitive region under subparagraph (A) or (B) of section 1858(i)(1) of the Social Security Act, as added by section 231 of this Act; and

(B) during the years that the region or regions are designated as such a highly competitive region.

(2) RULE OF CONSTRUCTION.—For purposes of paragraph (1), a comparable region does not necessarily mean the identical region.

(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) only to the extent and for such period as the Secretary determines is necessary to provide for enhanced benefits or services consistent with the projects under this section.

(d) BIENNIAL GAO REPORTS.—Not later than January 1, 2011, and biennially thereafter for as long as the projects under this section are being conducted, the Comptroller General of the United States shall submit to the Secretary and Congress a report that evaluates the projects. Each report shall include—

(1) an evaluation of—

(A) the quality of care provided to beneficiaries receiving benefits or services under the projects;

(B) the satisfaction of beneficiaries receiving benefits or services under the projects;

(C) the costs to the medicare program under the projects; and

(D) any improvements in the delivery of health care services under the projects; and

(2) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

(e) FUNDING.—

(1) IN GENERAL.—Payments for the costs of carrying out the projects under this section shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), as determined appropriate by the Secretary.

(2) LIMITATION.—The total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the period or year, as applicable, may not exceed—

(A) for the period beginning on January 1, 2009, and ending on September 30, 2013, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act during the period if the projects had not been conducted plus $6,000,000,000; and

(B) for fiscal year 2014 and any subsequent fiscal year, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of such title during the year if the projects had not been conducted.

(3) MONITORING AND REPORTS.—

(A) ONGOING MONITORING BY THE SECRETARY TO ENSURE FUNDING LIMITATION IS NOT VIOLATED.—The Secretary shall continually monitor expenditures made under title XVIII of the Social Security Act by reason of the projects under this section to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

(B) REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(i) a detailed description of—

(I) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the previous year compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(II) the projections of the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the year in which the report is submitted compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(III) amounts remaining within the funding limitation specified in paragraph (2); and

(IV) how the Secretary will change the scope, site, and duration of the projects in subsequent years in order to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated; and

(ii) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under subclauses (I), (II), (III), and (IV) of clause (i) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(4) APPLICATION OF LIMITATION.—If the Secretary determines that the projects under this section will cause the limitations described in subparagraphs (A) and (B) of paragraph (2) to be violated, the Secretary shall take appropriate steps to reduce spending under the projects, including through reducing the scope, site, and duration of the projects.

(5) AUTHORITY.—Beginning in 2014, the Secretary shall make necessary spending adjustments (including pro rata reductions in payments to health care providers under the medicare program) to recoup amounts so that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

NOTICES OF HEARINGS/MEETINGS

COMMITTEE ON INDIAN AFFAIRS

Mr. CAMPBELL. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on Thursday, June 26, 2003, at 11:00 a.m. in Room 485 of the Russell Senate Office Building to conduct a BUSINESS MEETING on pending Committee matters.

Those wishing additional information may contact the Indian Affairs Committee at 224–2251.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Wednesday, June 25, 2003, at 9:30 a.m., in open session to consider the nomination of Lieutenant General John P. Abizaid, USA, for appointment to the grade of General and to be commander, United States Central Command.

The PRESIDING OFFICER. Without objection, is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate, on Wednesday, June 25 at 10:00 a.m. to consider pending calendar business.

On Wednesday, June 25, at 10:00 a.m., the Committee will hold a Business Meeting in Room SD–366 to consider the following items on the Agenda:

Agenda Item #3: S. 470—A bill to extend the authority for the construction of a memorial to Martin Luther King, Jr.

Agenda Item #4: S. 490—A bill to direct the Secretary of Agriculture to convey certain land in the Lake Tahoe Basin Management Unit, Nevada, to the Secretary of the Interior, in trust for the Washoe Indian Tribe of Nevada and California.

Agenda Item #6: S. 546—A bill to provide for the protection of paleontological resources on Federal lands, and for other purposes.

Agenda Item #7: S. 643—A bill to authorize the Secretary of the Interior, in cooperation with the University of New Mexico, to construct and occupy a portion of the Hibben Center for Archaeological Research at the University of New Mexico.

Agenda Item #8: S. 651—A bill to amend the National Trails System Act to clarify Federal authority relating to land acquisition from willing sellers for the majority of the trails in the System, and for other purposes.

Agenda Item #9: S. 677—A bill to revise the boundary of the Black Canyon of the Gunnison National Park and Gunnison Gorge National Conservation Area in the State of Colorado, and for other purposes.

Agenda Item #10: S. 924—A bill to authorize the exchange of lands between an Alaska Native Village Corporation and the Department of the Interior, and for other purposes.

Agenda Item #13: S. 1076—A bill to authorize construction of an education center at or near the Vietnam Veterans Memorial.

Agenda Item #14: H.R. 255—To authorize the Secretary of the Interior to grant an easement to facilitate access to the Lewis and Clark Interpretative Center in Nebraska City, Nebraska.

Agenda Item #15: H.R. 1577—To designate the visitor center in Organ Pipe National Monument in Arizona as the ''Kris Eggle Visitor Center'', and for other purposes.

In addition, the Committee may turn to any other measures that are ready for consideration.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 25, 2003 at 9:30 a.m. to hold a hearing on The African Growth and Opportunity Act.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 25, 2003 at 2:00 p.m. to hold a hearing on Constitutionalism, Human Rights and the Rule of Law in the Nation of Iraq.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 25, 2003, at 2:30 p.m. to hold a hearing on The Successor States to Pre-1991 Yugoslavia: Progress & Challenges.

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

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet on Wednesday, June 25, 2003, at 9:30 a.m. to consider the nomination of the Joshua B. Bolton to be Director of the Office of Management and Budget.

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

COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions be authorized to meet in Executive Session during the session of the Senate on Wednesday, June 25, 2003. The following agenda will be considered:

Agenda

S. 1248, Individuals with Disabilities Education Improvement Act of 2003.

Any nominees that have been cleared for action.

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

COMMITTEE ON THE JUDICIARY

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a hearing on ''Oversight Hearing: Lessons Learned—The Inspector General's Report on the 9/11 Detainees'' on Wednesday, June 25, 2003, at 10:00 a.m. in the Dirksen Senate Office Building Room 226.

Tentative Witness List

Panel I: The Honorable Glenn A. Fine, Inspector General, Department of Justice, Washington, DC.

Panel II: Harley G. Lappin, Director, Federal Bureau of Prisons, Department of Justice, Washington, DC; Michael E. Rolince, Assistant Director in Charge, Washington Field Office, Federal Bureau of Investigation, Washington, DC; and David Nahmias, Counsel to the Assistant Attorney General, Criminal Division, Department of Justice, Washington, DC.

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

COMMITTEE ON THE JUDICIARY

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a hearing on ''Department of Justice and Judicial Nominations'' on Wednesday, June 25, 2003, at 2:00 p.m. in the Dirksen Senate Office Building Room 215 [Finance Committee Hearing Room].

Revised Tentative Agenda

Panel I: Senators.

Panel II: Allyson K. Duncan to be United States Circuit Judge for the Fourth Circuit.

Panel III: Robert C. Brack to be United States District Judge for the District of New Mexico; Samuel Der-Yeghiayan to be United States District Judge for the Northern District of Illinois; Louise W. Flanagan to be United States District Judge for the Eastern District of North Carolina; Lonny R. Suko to be United States District Judge for the Eastern District of Washington; and Earl Leroy Yeakel III to be United States District Judge for the Western District of Texas.

Panel IV: Karen P. Tandy to be Administrator of the Drug Enforcement Administration, United States Department of Justice; and Christopher A. Wray to be Assistant Attorney General for the Criminal Division, United States Department of Justice.

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

SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS, AND PROPERTY RIGHTS

SUBCOMMITTEE ON NEAR EASTERN AND SOUTH ASIAN AFFAIRS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on the Judiciary Subcommittee on the Constitution, Civil Rights and Property Rights and the Senate Foreign Relations Subcommittee on Near Eastern and South Asian Affairs be authorized to meet to conduct a joint hearing on ''Constitutionalism, Human Rights and the Rule of Law in Iraq,'' on Wednesday, June 25, 2003, at 2:00 p.m. in SD226.

Tentative Witness List

Panel I: Mr. Sermid Al-Sarraf, Iraqi Jurists Association, Los Angeles, CA; Dr. Khaled Abou El Fadl, Professor of Law, The Omar and Azmeralda Alfi Distinguished Fellow in Islamic Law, UCLA School of Law, Los Angeles, CA; Mr. Bernard Haykel, Assistant Professor of Middle Eastern Studies and History, New York University, New York, NY; Dr. Kenneth M. Pollack, Director of Research, Saban Center for Middle East Policy, Brookings Institution, Washington, DC; and Ms. Zainab Salbi, President and Founder, Women for Women International, Washington, DC.

Panel II: Mr. Naoyuki Agawa, Former Professor of Constitutional Law, Keio University, Minister and Director of the Japan Information and Culture Center, Embassy of Japan, Washington, DC; Mr. A. E. Dick Howard, White Burkett Miller Professor of Law and Public Affairs, Roy L. and Rosamond Woodruff Morgan Research Professor, University of Virginia School of Law, Charlottesville, VA; Dr. Donald P. Kommers, Joseph and Elizabeth Robbie Professor of Government and International Studies, University of Notre Dame, Professor of Law, Notre Dame Law School, Notre Dame, IN; Mr. Neil J. Kritz, Director, Rule of Law Program, U.S. Institute of Peace, Washington, DC; and Mr. John C. Yoo, Professor of Law, Boalt Hall School of Law, University of California at Berkeley, Visiting Fellow, American Enterprise Institute, Washington, DC.

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

SUBCOMMITTEE ON ECONOMIC POLICY

Mr. SANTORUM. Mr. President, I ask unanimous consent that the subcommittee on economic policy of the committee on banking, housing, and urban affairs be authorized to meet during the session of the Senate on June 25, 2003, at 2:00 p.m. to conduct a hearing on ''Jumpstarting the Economy: Rural America.''

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

SUBCOMMITTEE ON FISHERIES, WILDLIFE AND WATER

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Subcommittee on Fisheries, Wildlife, and Water be authorized to meet on Wednesday, June 25th at 9:30 am to examine the consulting process required by Section 7 of the Endangered Species Act.

The hearing will take place in SD 406 (Hearing Room).

SUBCOMMITTEE ON PUBLIC LANDS AND FORESTS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the subcommittee on public lands and forests of the committee on energy and natural resources be authorized to meet during the session of the Senate on Wednesday, June 25, at 2:30 p.m. in room SD–366. The purpose of this oversight hearing is to gain an understanding of the grazing programs of the Bureau of Land Management and the United States Forest Service. The subcommittee will receive testimony on grazing permit renewal, BLM's potential changes to grazing regulations, range monitoring, drought and other grazing issues.

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

PRIVILEGES OF THE FLOOR

Mr. THOMAS. Mr. President, I ask unanimous consent that an intern, Samantha Muirhead, be granted privilege of the floor.

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

Mr. REED. Mr. President, I ask unanimous consent that Dr. Susan Dimock, a fellow in my office, be granted floor privileges for the duration of the debate on S. 1.

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

Mr. REID. Mr. President, I ask unanimous consent that Jennifer Crow, an American Political Science Association fellow in the office of Senator CANTWELL, be given floor privileges during consideration of S. 1.

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

MEASURE PLACED ON THE CALENDAR—S. 1323

Mr. TALENT. Mr. President, I understand S. 1323 is at the desk and is due for its second reading.

The PRESIDING OFFICER. The Senator is correct.

The clerk will read the bill by title for the second time.

The legislative clerk read as follows:

A bill (S. 1323) to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months.

Mr. TALENT. I object to further proceedings on the measure at this time.

The PRESIDING OFFICER. Objection is heard. The bill will be placed on the calendar.

THE CALENDAR

Mr. TALENT. Mr. President, I ask unanimous consent that the Senate proceed en bloc to the immediate consideration of the following post office naming bills: Calendar No. 150, S. 867; Calendar No. 152, S. 1207; Calendar No. 153, H.R. 825; Calendar No. 154, H.R. 917; Calendar No. 155, H.R. 925; Calendar No. 156, H.R. 981; Calendar No. 157, H.R. 985; Calendar No. 158, H.R. 1055; Calendar No. 159, H.R. 1368; Calendar No. 160, H.R. 1465; Calendar No. 161, H.R. 1596; Calendar No. 162, H.R. 1609; Calendar No. 163, H.R. 1740; and Calendar No. 164, H.R. 2030.

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

Mr. TALENT. Mr. President, I further ask unanimous consent that the bills be read a third time and passed, the motions to reconsider be laid upon the table, and that any statements relating to the bills be printed in the RECORD, with the above occurring en bloc.

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

RONALD REAGAN POST OFFICE BUILDING

The bill (S. 867) to designate the facility of the United States Postal Service located at 710 Wicks Lane in Billings, Montana, as the ''Ronald Reagan Post Office Building,'' was considered, ordered to be engrossed for a third reading, read the third time, and passed, as follows:

S. 867

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

SECTION 1. DESIGNATION OF RONALD REAGAN POST OFFICE BUILDING.

(a) IN GENERAL.—The facility of the United States Postal Service located at 710 Wicks Lane in Billings, Montana, shall be known and designated as the ''Ronald Reagan Post Office Building''.

(b) REFERENCES.—Any reference in a law, map, regulation, document, paper, or other record of the United States to the facility referred to in subsection (a) shall be deemed to be a reference to the Ronald Reagan Post Office Building.

WALT DISNEY POST OFFICE BUILDING

The bill (S. 1207) to redesignate the facility of the United States Postal Service located at 120 East Ritchie Avenue in Marceline, Missouri, as the ''Walt Disney Post Office Building,'' was considered, ordered to be engrossed for a third reading, read the third time, and passed, as follows:

S. 1207

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

SECTION 1. WALT DISNEY POST OFFICE BUILDING.

(a) REDESIGNATION.—The facility of the United States Postal Service located at 120 East Ritchie Avenue in Marceline, Missouri, and known as the Marceline Main Office, shall be known and designated as the ''Walt Disney Post Office Building''.

(b) REFERENCES.—Any reference in a law, map, regulation, document, paper, or other record of the United States to the facility referred to in subsection (a) shall be deemed to be a reference to the Walt Disney Post Office Building.

MICHAEL J. HEALY POST OFFICE BUILDING

The bill (H.R. 825) to redesignate the facility of the United States Postal Service located at 7401 West 100th Place in Bridgeview, Illinois, as the ''Michael J. Healy Post Office Building'' was considered, ordered to a third reading, read the third time, and passed.

FLOYD SPENCE POST OFFICE BUILDING

This bill (H.R. 917) to designate the facility of the United States Postal Service located at 1830 South Lake Drive in Lexington, South Carolina, as the ''Floyd Spence Post Office Building,'' was considered, ordered to a third reading, read the third time, and passed.

CESAR CHAVEZ POST OFFICE

This bill (H.R. 925) to redesignate the facility of the United States Postal Service located at 1859 South Ashland Avenue in Chicago, Illinois, as the ''Cesar Chavez Post Office,'' was considered, ordered to a third reading, read the third time, and passed.

JAMES R. MERRY POST OFFICE

This bill (H.R. 981) to designate the facility of the United States Postal Service located at 141 Erie Street in Linesville, Pennsylvania, as the ''James R. Merry Post Office'' was considered, ordered to a third reading, read the third time, and passed.

DELBERT L. LATTA POST OFFICE BUILDING

This bill (H.R. 985) to designate the facility of the United States Postal Service located at 111 West Washington Street in Bowling Green, Ohio, as the ''Delbert L. Latta Post Office Building,'' was considered, ordered to a third reading, read the third time, and passed.

DR. ROSWELL N. BECK POST OFFICE BUILDING

This bill (H.R. 1055) to designate the facility of the United States Postal Service located at 1901 West Evans Street in Florence, South Carolina, as the ''Dr. Roswell N. Beck Post Office Building,'' was considered, ordered to a third reading, read the third time, and passed.

NORMAN D. SHUMWAY POST OFFICE BUILDING

The bill (H.R. 1368) to designate the facility of the United States Postal Service located at 7554 Pacific Avenue in Stockton, California, as the ''Norman D. Shumway Post Office Building'' was considered, ordered to a third reading, read the third time, and passed.

GENERAL CHARLES GABRIEL POST OFFICE

The bill (H.R. 1465) to designate the facility of the United States Postal

Service located at 4832 East Highway 27 in Iron Station, North Carolina, as the ''General Charles Gabriel Post Office'' was considered, ordered to a third reading, read the third time, and passed.

TIMOTHY MICHAEL GAFFNEY POST OFFICE BUILDING

The bill (H.R. 1596) to designate the facility of the United States Postal Service located at 2318 Woodson Road in St. Louis, Missouri, as the ''Timothy Michael Gaffney Postal Office Building'' was considered, ordered to a third reading, read the third time, and passed.

ADMIRAL DONALD DAVIS POST OFFICE BUILDING

The bill (H.R. 1609) to redesignate the facility of the United States Postal Service located at 201 West Boston Street in Brookfield, Missouri, as the ''Admiral Donald Davis Post Office Building'' was considered, ordered to a third reading, read the third time, and passed.

DR. CAESAR A. W. CLARK, SR. POST OFFICE BUILDING

The bill (H.R. 1740) to designate the facility of the United States Postal Service located at 1502 East Kiest Boulevard in Dallas, Texas, as the ''Dr. Caesar A. W. Clark, Sr. Post Office Building'' was considered, ordered to a third reading, read the third time, and passed.

PATSY TAKEMOTO MINK POST OFFICE BUILDING

The bill (H.R. 2030) to designate the facility of the United States Postal Service located at 120 Baldwin Avenue in Paia, Maui, Hawaii, as the ''Patsy Takemoto Mink Post Office Building'' was considered, ordered to a third reading, read the third time, and passed.

SAFETY ON THE INTERNET

Mr. TALENT. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 185 which was submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 185) expressing the sense of the Senate with respect to raising awareness and encouraging education about safety on the Internet.

There being no objection, the Senate proceeded to consider the resolution.

Ms. MURKOWSKI. Mr. President, I rise in support of this resolution expressing the sense of the Senate with respect to raising awareness and encouraging education about safety on the Internet and supporting the goals and ideals of National Internet Safety Month.

The Internet has become one of the most significant advances in the twentieth century and, as a result, it affects people's lives in a positive manner each day. However, this technology is fraught with dangers that need to be brought to the attention of all Americans.

Never before has the problem of online predatory behavior been more of a concern. Consider the pervasiveness of Internet access by children and the rapid increase in Internet crime and predatory behavior. Never before have powerful educational solutions—like Internet safety curricula for grades kindergarten through 12, youth empowerment Internet safety campaigns and community-based Internet safety awareness presentations with the formation of community action teams, such as what I-Safe America, a nonprofit Internet safety foundation, does—been more critical and readily at hand. It is imperative that every community in every state be apprised of the increase in Internet-based criminal activity so that all Americans may learn about the Internet safety strategies which will enable them to keep their children safe from victimization. Consider the facts: Worldwide, 70 million youth under the age of 18 are online. This is considered to be a conservative estimate since it is projected that there are two million new Internet users per month in America alone. The Family/PC Survey in 2000 reported that 1 in 4 kids participate in real-time online chats. The Pew Study reported in the Journal of the American Medical Association in June 2001 that 13 million youth use Instant Messaging and that 89 percent of sexual solicitations were made in either chat rooms or Instant Messages. One in five teenagers who are online note that they have received unwanted sexual solicitations, according to the Crimes Against Children Research Center in a study completed in 2000.

It's important to note that while it's reported that 90 percent of teens and young adults ages 15 to 24 go online and half of them go online once a day or more, three out of four young people have access at home and nearly one in three has access from their own bedroom, according to the Kaiser Family Foundation. According to a 1999 Arbitron New Media study, the majority of teenagers' online use occurs at home, right after school, when working parents are not at home. Thirty percent of the girls responding to a 2002 Girl Scout Research Institute study, ''The Net Effect: Girls and New Media,'' said they had been sexually harassed in a chat room, but only seven percent told a parent about the harassment, most fearing their parents would overreact and ban computer usage altogether.

From a parental perspective, 75 percent of parents say that they know where their children spend time online. The truth about kids' Internet habits, according to WebSense, USA Today, and the National Foster Parent Association show that 58 percent of teens say they have accessed an objectionable website. A 2000 Time/CNN poll indicated that 43 percent of children say they do not have rules about Internet use in their homes. Also, 62 percent of parents of teenagers are unaware that their children have accessed objectionable websites, according to a Yankelovich Partners Study. According to the London School of Economics, 9 out of 10 children between the ages of 8 and 16 have viewed pornography on the Internet. In most cases, sex websites were accessed unintentionally when a child, often in the process of doing homework, used a seemingly innocent sounding word to search for information or pictures.

Most disturbing, however, are the patterns of Internet crimes against children. In 1996, the Federal Bureau of Investigation was involved in 113 cases involving Internet crimes against children. In 2001, the FBI opened 1,541 cases against people suspected of using the Internet to commit crimes involving child pornography or abuse. The U.S. Customs Service now places the number of websites offering child pornography at more than 100,000. Moreover, there was a 345 percent increase in the production of these sites just between February 2001 and July 2001, according to a recent study. The FBI notes that child pornography and the sexual exploitation of children through online means is the most significant crime problem it confronts.

Now is the time for America to focus its attention on supporting Internet safety, especially now that children are now on summer vacation and will subsequently spend more time online. Recent Internet crime trends indicate a call to action as it pertains to national Internet safety awareness at all levels.

Mr. TALENT. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table, and any statements relating to this matter be printed in the RECORD.

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

The resolution (S. Res. 185) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 185

Whereas, in the United States, 48 million children between the ages of 5 and 17 use computers;

Whereas 5 to 17 year-olds in the United States currently spend 5 billion hours on-line annually;

Whereas 70 million youth under the age of 18 worldwide are on-line;

Whereas the majority of teenagers' on-line use occurs after school, at home, when working parents are not at home;

Whereas 90 percent of those age 15 to 24 use the Internet, with almost half of them using it once a day or more;

Whereas approximately 3 out of 4 young people have access to the Internet at home,

and nearly 1 in 3 has access from their own bedroom;

Whereas 9 out of 10 children between ages 8 and 16 have viewed pornography on the Internet, with most being accessed unintentionally when, often in the process of doing homework, a child used a seemingly innocent sounding word in an Internet search for information or pictures;

Whereas 62 percent of parents of teenagers are unaware that their children have accessed objectionable websites;

Whereas 89 percent of sexual solicitations were made in either chat rooms or Instant Messages;

Whereas 30 percent of the girls responding to a Girl Scout research study reported that they had been sexually harassed in a chat room, but only 7 percent told a parent about the harassment, most fearing their parents would overreact and ban computer usage altogether;

Whereas, in 1996, the Federal Bureau of Investigation was involved in 113 cases involving Internet crimes against children, but in 2001, the FBI opened 1,541 cases against suspects of Internet crimes involving child pornography or abuse; and

Whereas June as National Internet Safety Month will provide national awareness of the dangers of the Internet while offering education about how to be safe, responsible, and accountable on the Internet: Now, therefore, be it

Resolved, That it is the sense of the Senate that—

(1) National Internet Safety Month provides an opportunity to educate the people of the United States on the dangers of the Internet and the importance of being safe and responsible on-line;

(2) national and community organizations should be recognized and applauded for their work in promoting awareness of the dangers of the Internet and for providing information on developing the critical thinking and decision-making skills to be safe on-line; and

(3) Internet safety organizations, law enforcement, educators, and volunteers should increase their efforts to raise the awareness of on-line safety.

ENVIRONMENTAL POLICY AND CONFLICT RESOLUTION ADVANCEMENT ACT OF 2003

Mr. TALENT. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 64, S. 163.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 163) to reauthorize the United States Institute for Environmental Conflict Resolution, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. TALENT. Mr. President, I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and any statements relating to the bill be printed in the RECORD.

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

The bill (S. 163) was read the third time and passed, as follows:

S. 163

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 ''Environmental Policy and Conflict Resolution Advancement Act of 2003''.

SEC. 2. ENVIRONMENTAL DISPUTE RESOLUTION FUND.

Section 13 of the Morris K. Udall Scholarship and Excellence in National Environmental and Native American Public Policy Act of 1992 (20 U.S.C. 5609) is amended by striking subsection (b) and inserting the following:

''(b) ENVIRONMENTAL DISPUTE RESOLUTION FUND.—There is authorized to be appropriated to the Environmental Dispute Resolution Fund established by section 10 $4,000,000 for each of fiscal years 2004 through 2008, of which—

''(1) $3,000,000 shall be used to pay operations costs (including not more than $1,000 for official reception and representation expenses); and

''(2) $1,000,000 shall be used for grants or other appropriate arrangements to pay the costs of services provided in a neutral manner relating to, and to support the participation of non-Federal entities (such as State and local governments, tribal governments, nongovernmental organizations, and individuals) in, environmental conflict resolution proceedings involving Federal agencies.''.

RECOGNITION OF JOSEPH A. DE LAINE

Mr. TALENT. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 167, S. 498.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 498) to authorize the President to posthumously award a gold medal on behalf of Congress to Joseph A. De Laine in recognition of his contributions to the Nation.

There being no objection, the Senate proceeded to consider the bill.

Mr. TALENT. Mr. President, I ask unanimous consent that the committee amendment be agreed to, the bill, as amended, be read three times, passed, the motion to reconsider be laid upon the table, and any statements relating thereto be printed in the RECORD with no intervening action or debate.

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

The committee amendment was agreed to.

The bill (S. 498), as amended, was read the third time and passed, as follows:

S. 498

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

SECTION 1. FINDINGS.

Congress finds that—

(1) the Reverend Joseph Armstrong De Laine, one of the true heroes of the civil rights struggle, led a crusade to break down barriers in education in South Carolina;

(2) the efforts of Reverend De Laine led to the desegregation of public schools in the United States, but forever scarred his own life;

(3) in 1949, Joseph De Laine, a minister and principal, organized African-American parents in Summerton, South Carolina, to petition the school board for a bus for black students, who had to walk up to 10 miles through corn and cotton fields to attend a segregated school, while the white children in the school district rode to and from school in nice, clean buses;

(4) in 1950, these same parents sued to end public school segregation in Briggs v. Elliott, 1 of 5 cases that collectively led to the landmark 1954 Supreme Court decision of Brown v. Board of Education;

(5) because of his participation in the desegregation movement, Reverend De Laine was subjected to repeated acts of domestic terror, in which—

(A) he, along with 2 sisters and a niece, lost their jobs;

(B) he fought off an angry mob;

(C) he received frequent death threats; and

(D) his church and his home were burned to the ground;

(6) in October 1955, after Reverend De Laine relocated to Florence County in South Carolina, shots were fired at the De Laine home, and because Reverend De Laine fired back to mark the car, he was charged with assault and battery with intent to kill;

(7) the shooting incident drove him from South Carolina to Buffalo, New York, where he organized an African Methodist Episcopal Church;

(8) believing that he would not be treated fairly by the South Carolina judicial system if he returned to South Carolina, Reverend De Laine told the Federal Bureau of Investigation, ''I am not running from justice but injustice'', and it was not until 2000 (26 years after his death and 45 years after the incident) that Reverend De Laine was cleared of all charges relating to the October 1955 incident;

(9) Reverend De Laine was a humble and fearless man who showed the Nation that all people, regardless of the color of their skin, deserve a first-rate education, a lesson from which the Nation has benefited immeasurably; and

(10) Reverend De Laine deserves rightful recognition for the suffering that he and his family endured to teach the Nation one of the great civil rights lessons of the last century.

SEC. 2. CONGRESSIONAL GOLD MEDAL.

(a) PRESENTATION AUTHORIZED.—The President is authorized, on behalf of Congress, to award a gold medal of appropriate design to Joseph De Laine, Jr. to honor his father, Reverend Joseph Armstrong De Laine (posthumously), for his contributions to the Nation.

(b) DESIGN AND STRIKING.—For the purposes of the award referred to in subsection (a), the Secretary of the Treasury (hereafter in this Act referred to as the ''Secretary'') shall strike a gold medal with suitable emblems, devices, and inscriptions, to be determined by the Secretary.

SEC. 3. DUPLICATE MEDALS.

The Secretary may strike and sell duplicates in bronze of the gold medal struck pursuant to section 2, under such regulations as the Secretary may prescribe, and at a price sufficient to cover the costs thereof, including labor, materials, dies, use of machinery, and overhead expenses, and the cost of the gold medal.

SEC. 4. STATUS AS NATIONAL MEDALS.

The medals struck pursuant to this Act are national medals for purposes of chapter 51 of title 31, United States Code.

SEC. 5. FUNDING.

(a) AUTHORITY TO USE FUND AMOUNTS.—There is authorized to be charged against the United States Mint Public Enterprise Fund an amount not to exceed $30,000 to pay for the cost of the medals authorized by this Act.

(b) PROCEEDS OF SALE.—Amounts received from the sale of duplicate bronze medals under section 3 shall be deposited in the United States Mint Public Enterprise Fund.

ORDERS FOR TOMORROW

Mr. TALENT. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 9:15 a.m, Thursday, June 26. I further ask that following the prayer and the pledge, the morning hour be deemed to have expired, the Journal of the proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then resume consideration of S. 1, the prescription drug benefit bill, as provided under the previous order.

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

PROGRAM

Mr. TALENT. Mr. President, tomorrow the Senate will resume consideration of S. 1, the prescription drug benefit bill. Under the previous agreement, the Senate will begin with two back-to-back rollcall votes upon returning to the bill. The voting sequence will be as follows:

The first vote will be in relation to the Harkin amendment No. 991. The second vote will be in relation to the Edwards amendment No. 1052.

Again, the first vote of tomorrow's session will occur at 9:15 a.m. For the remainder of the day, we will continue to process amendments to S. 1. Members can expect rollcall votes throughout the day and late into the evening tomorrow as the Senate progresses toward completion of this landmark legislation.

ADJOURNMENT UNTIL 9:15 A.M. TOMORROW

Mr. TALENT. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 10:50 p.m., adjourned until Thursday, June 26, 2003, at 9:15 a.m.

NOMINATIONS

Executive nominations received by the Senate June 25, 2003:

CHEMICAL SAFETY AND HAZARD INVESTIGATION BOARD

RIXIO ENRIQUE MEDINA, OF OKLAHOMA, TO BE A MEMBER OF THE CHEMICAL SAFETY AND HAZARD INVESTIGATION BOARD FOR A TERM OF FIVE YEARS, VICE ANDREA KIDD TAYLOR, TERM EXPIRING.

DEPARTMENT OF COMMERCE

JULIE L. MYERS, OF KANSAS, TO BE AN ASSISTANT SECRETARY OF COMMERCE, VICE MICHAEL J. GARCIA.

DEPARTMENT OF STATE

JEFFREY A. MARCUS, OF TEXAS, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO BELGIUM.

DEPARTMENT OF JUSTICE

DEBORAH ANN SPAGNOLI, OF CALIFORNIA, TO BE A COMMISSIONER OF THE UNITED STATES PAROLE COMMISSION FOR A TERM OF SIX YEARS, VICE JOHN R. SIMPSON, TERM EXPIRED.

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be vice admiral

REAR ADM. (SELECT) ERIC T. OLSON, 0000

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. VICTOR E. RENUART JR., 0000

IN THE NAVY

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

CHAD F ACEY, 0000
MICKEY S BATSON, 0000
WILLIAM R BERTRAM, 0000
JOSEPH D BOOGREN, 0000
DAVID B CARSON, 0000
DARYL S DAVIS, 0000
ERIC S DIETZ, 0000
DAVID L FLAKE, 0000
SHELLIE FOUNTAIN JR., 0000
ROBERT J GIBSON JR., 0000
DONNA A HULSE, 0000
ALBERT C KINNEY III, 0000
DEBRA A LANKHORST, 0000
GARY A RICHARDS, 0000
TIMOTHY G ROHRER, 0000
STEPHEN K SAULS, 0000
VINCENT H SCOTT, 0000
FRANK A SHAUL, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

CONRADO K ALEJO, 0000
GEORGE M BAIN, 0000
JEFFREY S BAKER, 0000
JAMES C BEENE, 0000
MICHAEL P BETTS, 0000
DONALD A BUZARD, 0000
ANTONIO J CARDOSO, 0000
ALLEN CRISP, 0000
KNARVELL DAILEY, 0000
JAMES V DANIELS, 0000
EDWARD A FLINT, 0000
LEONARD M FRIDDLE, 0000
ALAN D FULLERTON, 0000
ANGELITO R GALICINAO, 0000
SHELDON GERINGER, 0000
DONALD GRIFFIN, 0000
RHONDA K HARDERS, 0000
JEFFREY K HAYHURST, 0000
DOUGLAS J HOLDERMAN, 0000
CHRISTOPHER L HULL, 0000
EDWARD J JOHNSON, 0000
RICHARD D JONES, 0000
DONALD H KELLER JR., 0000
LINDSAY C LECUYER, 0000
PATRICIA R LOONAM, 0000
MARK C LOOSE, 0000
JON B LUNDQUIST, 0000
RICHARD D MCCLELLAN, 0000
JIMMY R MCLAUGHLIN, 0000
DWAINE D MEAGHER, 0000
SYLVESTER MOORE, 0000
WILLIAM K NESMITH, 0000
ROBERT S NEVILLE, 0000
ROBERT E NOVOTNY, 0000
GARY E PERKINS, 0000
SEAN R PRASSER, 0000
THOMAS L PRICE, 0000
TERRY W PULLIAM, 0000
DALE C RAMSEY, 0000
JEFFREY S RANDALL, 0000
STEPHEN R SKAW, 0000
DANIEL SPAGONE, 0000
RUSTIN E STOBER, 0000
JOHN D THOMAS, 0000
PETER H THOMAS, 0000
JAMES H TRAVERS, 0000
RICHARD C VALENTINE, 0000
CARL B WEICKSEL, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

BARBARA M BURGETT, 0000
ROBERT A DEWS JR., 0000
ELLEN H EMERSON, 0000
ROBERT J FINK, 0000
KIM D HILL, 0000
ELIZABETH S HOSTETLER, 0000
DONNA M KASPAR, 0000
KATHLEEN A KEELY, 0000
CATHY M KIMMEL, 0000
LESA J KIRSCH, 0000
CARL K KLOTZSCHE, 0000
WILLIAM R KRONZER, 0000
JOHN D NELL, 0000
CAROLYN R OWENS, 0000
MARY E SMITH, 0000
KRISTIN B STRONG, 0000
CRAIG D UNION, 0000
MARGARET M WARD, 0000
ROBERT C WEITZMAN, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

ROBERT J ALLEN, 0000
RICKY D BALCOM, 0000
KYLE B BECKMAN, 0000
JOSEPH F BEVERLY, 0000
JAMES S BIGGS, 0000
THOMAS R CROWELL, 0000
BRIAN F EGGLESTON, 0000
MARK R H ELLIOTT, 0000
JAMES M ELLIS, 0000
MICHAEL A ELSBERG, 0000
ALLEN W HAMMERQUIST, 0000
HOWARD D HART, 0000
JUAN J HOGAN, 0000
DAVID R HUNT, 0000
MARK M JAREK, 0000
JAMES A KNORTZ, 0000
MICHAEL T LENTS, 0000
MICHAEL L MARAVILLA, 0000
FRANCIS M MOLINARI, 0000
LAURAN W RYE, 0000
MICHAEL W STUDEMAN, 0000
BLAKE D WARD, 0000
HAROLD E WILLIAMS, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

ERIC J BUCH, 0000
RAYMOND E CHARTIER JR., 0000
TIMOTHY C GALLAUDET, 0000
JOHN V GURLEY, 0000
JAMES R JARVIS, 0000
GREG M JIMENEZ, 0000
PETER M KLEIN, 0000
PAUL E MATTHEWS, 0000
BRUCE J MORRIS, 0000
WILLIAM H NISLEY II, 0000
PAUL S OOSTERLING, 0000
DEAN A SADANAGA, 0000
EUGENE P TRAMM, 0000
ERIC J TREHUBENKO, 0000
ROBIN D TYNER, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

LEE K ALLRED, 0000
TRACY A BARKHIMER, 0000
MARTIN R BEAULIEU, 0000
JOSEPH G DACQUISTO, 0000
DANA S DEWEY, 0000
SHAWN P HENDRICKS, 0000
ERIC D HOLMBERG, 0000
JOHN M HOOD, 0000
RICHARD W KAMMANN JR., 0000
STEVEN J LABOWS, 0000
RALPH D LEE, 0000
JOHN S LEMMON, 0000
MATTHEW A LETOURNEAU, 0000
THOMAS C POPP, 0000
SCOTT D PORTER, 0000
JAMES K REINING, 0000
PATRICK W SMITH, 0000
DAVID M SWENSON, 0000
JACK H WATERS, 0000
PETER M WATERS, 0000
DONALD L ZWICK, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

ALLAN D ANDREW, 0000
MICHAEL A BALLOU, 0000
JOHN H BITTING III, 0000
LAWRENCE J BRACHFELD, 0000
WILLIAM J BROUGHAM, 0000
ALVARO F CUELLAR, 0000
JOHN D DANNECKER, 0000
PHILLIP E DAWSON III, 0000
STEVEN M DEBUS, 0000
JAY F DILL, 0000
DILIP B GHATE, 0000
PATRICIA A GILL, 0000
DAVID A GOGGINS, 0000
WILLIAM C GREENE, 0000
DONALD R HARDER, 0000
THOMAS W HEATTER, 0000
SCOTT D HELLER, 0000
PAUL A HERBERT, 0000
TODD A HOOKS, 0000
MICHAEL C LADNER, 0000
DOUGLAS M LEMON, 0000
JOSEPH D MAUSER, 0000
JAMES E MELVIN, 0000
MARSHALL G MILLETT, 0000

BRIAN P MURPHY, 0000
F S NESSLER, 0000
SEAN P OMALLEY, 0000
WILLIAM G PLOTT, 0000
MARTIN RODRIGUEZ, 0000
ELTON G SAYWARD JR., 0000
ZACHARY M SCRUTON, 0000
DOUGLAS W SMALL, 0000
FRANCIS E SPENCER III, 0000
HENRY W STEVENS III, 0000
BRIAN S TAIT, 0000
VINH X TRAN, 0000
RONALD R VANCOURT, 0000
MARK R VANDROFF, 0000
RANDOLPH R WEEKLY, 0000
STEPHEN F WILLIAMSON, 0000
JOHNNY R WOLFE JR., 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

ANGELA D ALBERGOTTIE, 0000
JOYCE M BERNARD, 0000
AMY D BURIN, 0000
KATHLEEN M CREIGHTON, 0000
BRUCE R DEMELLO, 0000
PETER R FALK, 0000
CARRIE A HASBROUCK, 0000
WINNIE L HUSKEY, 0000
SANDRA M JAMSHIDI, 0000
DOREEN M JONES, 0000
MICHAEL G LARIOS, 0000
SCOTT A MARGULIS, 0000
BRANDEE L MURPHY, 0000
LAWRENCE A PEMBERTON, 0000
SUZANNE PROSE, 0000
KATHLEEN M SAYLOR, 0000
JOSEPH B SPEGELE, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

CHARLES J CHAN, 0000
BART L GROSSMAN, 0000
KENNETH W JALALI, 0000
JOHN L LARSON, 0000
GREGORY A MUNNING, 0000
KENNETH W PARNELL, 0000
KURT B REINHOLT, 0000
GEORGE S ROBINSON, 0000
ROBERT J STAILEY, 0000
RICK T TAYLOR, 0000
DANIEL VANORDEN, 0000
MARK S WASSIL, 0000
MATTHEW A WEBBER, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

CHRISTOPHER A ADAMS, 0000
CHARLES N ALBRECHT, 0000
WILLIAM T ALEX, 0000
TOMAS A ALKSNINIS, 0000
DAVID W ALLDRIDGE, 0000
GLENN R ALLEN, 0000
THOMAS R AMBLAD, 0000
CRAIG A ANDERSON, 0000
MARK A ANDERSON, 0000
BRUCE A APGAR, 0000
DANIEL D ARENSMEYER, 0000
RAYMOND A ART, 0000
SCOTT W ASKINS, 0000
RUSSELL B AUSLEY, 0000
STUART P BAKER, 0000
BARRY BAKOS, 0000
JAY C BALLARD, 0000
JOHN S BANIGAN, 0000
MICHAEL P BARATTA, 0000
TIMOTHY S BARBIER, 0000
ERIC T BARKDULL, 0000
USHER L BARNUM JR., 0000
BENJAMIN K BARRETT, 0000
GREGORY L BARRINGER, 0000
JEFFREY B BARTA, 0000
KENNETH G BECK, 0000
MARK W BEDDOES, 0000
ALAN E BELL, 0000
TODD A BELTZ, 0000
MARK B BENJAMIN, 0000
AUGUSTUS P BENNETT, 0000
MICHAEL L BENO, 0000
JAMES H BENTON, 0000
PAUL R BERNADO, 0000
WILLIE D BILLINGSLEA, 0000
RANDY B BLACKMON, 0000
DAVID I BLAIR, 0000
ANTHONY R BLANKENSHIP, 0000
BRETT F BONIFAY, 0000
DAVID C BORAH, 0000
BRIAN K BORING, 0000
DAVID L BOSSERT, 0000
DAVID W BOUVE, 0000
MORDAUNT P BRABNER, 0000
ALBERT A BRADY, 0000
RANDY L BRATCHER, 0000
WILLIAM J BREITFELDER, 0000
KEVIN S BRENNAN, 0000
MICHAEL J BRESLAUER, 0000
BARRY D BROCKWAY, 0000
JOHN S BRUCE, 0000
DAN W BRUNE, 0000
CHRISTOPHER W BRUNETT, 0000
MARK R BRUNNER, 0000
ROBERT B BURGIO, 0000
ERIK A BURIAN, 0000
CHRISTOPHER T BURKETT, 0000
MICHAEL P BURNS, 0000
RONALD S BUSH, 0000
CHRISTOPHER J BUSHNELL, 0000
SHAN M BYRNE, 0000
ROBERT A H CADY, 0000
JAMES S CAMPBELL, 0000
GEORGE S CAPEN, 0000
LESLIE T CARDENAS, 0000
STEVEN M CARLISLE, 0000
JOHN A CARTER, 0000
DANIEL L CHEEVER, 0000
JOHN W CHEWNING, 0000
CHRISTOPHER W CHOPE, 0000
CHRISTIAN E CHRISTENSON, 0000
BRIAN K CHRISTIANSON, 0000
ARTHUR E CIMILUCA JR., 0000
STEVEN J CINCOTTA, 0000
KEVIN M CLAFFY, 0000
ANTHONY J CLAPP, 0000
BRYAN L CLARK, 0000
ROBERT E CLARK, 0000
JOHN S COFFEY, 0000
MATTHEW J COLBURN, 0000
MICHAEL J COLMAN, 0000
CLAYTON L CONLEY, 0000
BLAKE L CONVERSE, 0000
CHARLES B COOPER II, 0000
MATTHEW F COUGHLIN, 0000
STEPHEN J COUGHLIN, 0000
JOHN R CRAIG, 0000
MICHAEL L CROCKETT, 0000
MICHAEL S CRUDEN, 0000
THOMAS CURRAN, 0000
REX L CURTIN, 0000
RANDY C DARROW, 0000
REEVES A DAVES, 0000
YVETTE M DAVIDS, 0000
ANDREW N DAVIS, 0000
DUANE T DAVIS, 0000
JACK E DAVIS, 0000
JAMES P DAVIS, 0000
GARY L DEAL, 0000
STEVEN E DEAL, 0000
THOMAS L DEARBORN, 0000
JEFFREY E DEBOLT, 0000
BRUCE A DEFIBAUGH, 0000
ALBERT E DEMPSEY III, 0000
RONALD M DENNIS, 0000
DON E DIZON, 0000
RICHARD E DODSON JR., 0000
MICHAEL P DONNELLY, 0000
MICHAEL P DORAN, 0000
CHAD O DORR, 0000
FRANK J DOWD, 0000
PAUL T DRUGGAN, 0000
SHAWN P DUFFY, 0000
SCOTT E DUGAN, 0000
ROBERT B DUMONT III, 0000
JOHN T DYE JR., 0000
RANDELL W DYKES, 0000
JOHN P ECKARDT, 0000
BRIAN P ECKERLE, 0000
HENRY B EDWARDS III, 0000
JASON C EHRET, 0000
GERALD L ELLIOTT II, 0000
JAMES A EMMERT, 0000
DARREL W ENGWELL JR., 0000
ROMMEL M ESTEVES, 0000
NEWMAN J EVANS III, 0000
BRIAN G FALKE, 0000
ANDREW L FEINBERG, 0000
MICHAEL S FEYEDELEM, 0000
WILLIAM C FILAN, 0000
STEPHEN M FIMPLE, 0000
STEVEN C FINCO, 0000
CHRISTOPHER M FITZGERALD, 0000
EDWARD M FLANAGAN, 0000
TODD J FLANNERY, 0000
ANDREW FLEMING, 0000
CHRISTOPHER J FLETCHER, 0000
DAVID K FLICK, 0000
ROBERT L FLOYD, 0000
THOMAS D FOHR, 0000
DURANTE A FOOTMAN, 0000
BRETT C FOSTER, 0000
JOSEPH P FRANSON JR., 0000
TYLER L FRAUTSCHI, 0000
BRIAN W FRAZIER, 0000
MICHAEL S FULGHAM, 0000
FREDERICK E GAGHAN JR., 0000
THOMAS D GAJEWSKI, 0000
SCOTT R GALLAGHER, 0000
ROBERT D GAMBERG, 0000
HARRY L GANTEAUME, 0000
EDWARD G GANUN, 0000
DANIEL L GARCIA, 0000
MICHAEL C GARD, 0000
PETER A GARVIN, 0000
JOSEPH E GELARDI, 0000
GREGORY J GIBSON, 0000
JASON A GILBERT, 0000
CHARLES W GILL, 0000
JEFFREY W GILLETTE, 0000
CRAIG S GIVENS, 0000
DONALD J GLATT, 0000
THOMAS C GOMEZ, 0000
MARK R GONZALES, 0000
JUAN C GONZALEZ, 0000
CURTIS J GOODNIGHT, 0000
BENJAMIN B GOODWIN, 0000
ANDREW M GORZELA, 0000
FREDERICK J GOSEBRINK II, 0000
MICHAEL V GOSHGARIAN, 0000
SCOTT C GOVER, 0000
JEFFREY C GRAF, 0000
CHRISTOPHER E GRAY, 0000
CHRISTOPHER S GRAY, 0000
BRIAN C GRIMM, 0000
PAUL F GRONEMEYER, 0000
TIMOTHY J GROUT, 0000
WESLEY R GUINN, 0000
JOHN E GUMBLETON, 0000
STEVEN J HADDAD, 0000
PAUL C HAEBLER, 0000
MARK L HAGENLOCHER, 0000
ROBERT A HALL JR., 0000
PATRICK M HALLER, 0000
WILLIAM K HALVERSON, 0000
TIMOTHY W HANSEN, 0000
MICHAEL S HARBER, 0000
MICHAEL V HARBER, 0000
ROGER D HARDY, 0000
DANIEL P HARMON, 0000
MICHAEL S HARRINGTON, 0000
GREGORY M HARRIS, 0000
MITCHELL R HAYES, 0000
JURGEN HEITMANN, 0000
EDWIN M HENDERSON, 0000
GARY M HERBERT, 0000
JOHN W HERMAN, 0000
EDMUND B HERNANDEZ, 0000
PATRICK D HERRING, 0000
EDWARD L HERRINGTON, 0000
ALAN L HERRMANN, 0000
CHRISTOPHER E HICKS, 0000
GRANT R HIGHLAND, 0000
MATTHEW B HOGAN, 0000
ALVIN HOLSEY, 0000
WILLIAM D HOPPER, 0000
KENNETH M HOUCK, 0000
REGINALD M HOWARD, 0000
PATRICK N HUETE, 0000
GREGORY C HUFFMAN, 0000
EDWARD C HUTT, 0000
JAMES A IMANIAN, 0000
WILLIAM T IPOCK II, 0000
ROGER G ISOM, 0000
RHETT R JAEHN, 0000
ANDREW D JAMES, 0000
BRIAN S JAMES, 0000
JEFFREY W JAMES, 0000
ROBERT W JANSSEN, 0000
ANDREW C JARRETT, 0000
JOKER L JENKINS, 0000
BRADLEY T JENSEN, 0000
JON J JERGE, 0000
MARK A JOHNSON, 0000
ERNEST R JONES JR., 0000
JAMES T JONES, 0000
SARA A JOYNER, 0000
MARK A JOYNT, 0000
JOEL D JUNGEMANN, 0000
KURT A KASTNER, 0000
SUSANNE G KECK, 0000
GREGORY J KEITHLEY, 0000
SCOTT K KELLY, 0000
JOHN E KENNINGTON, 0000
ANDREW M KENNY JR., 0000
DABNEY R KERN, 0000
WILLIAM E KERN, 0000
IAN J KERR, 0000
JARED A KEYS, 0000
BRADLEY J KIDWELL, 0000
DOUGLAS P KIEM, 0000
KEVIN G KING, 0000
KEVIN E KINSLOW, 0000
GREGORY S KIRKWOOD, 0000
DAVID R KLAIN, 0000
JOHN J KLEIN, 0000
JOSEPH G KLEIN II, 0000
JAMES F KOELTZOW, 0000
WILLIAM S KOYAMA, 0000
NEAL D KRAFT, 0000
CARY J H KRAUSE, 0000
SCOTT C KRAVERATH, 0000
KEVIN F KROPP, 0000
THOMAS A KUBISTA, 0000
TIMOTHY C KUEHHAS, 0000
GLENN P KUFFEL JR., 0000
ERIC G KUKANICH, 0000
CARL A LAHTI, 0000
DENNIS A LAZAR JR., 0000
RICKY A LEE, 0000
DAVID T LEMLY, 0000
TODD L LENNON, 0000
ZIGMOND V LESZCZYNSKI, 0000
MICHAEL W LEUPOLD, 0000
RANDALL K LEWIS, 0000
STUART W LEWIS, 0000
MARK F LIGHT, 0000
STEVEN W LIGLER, 0000
PAUL J LING III, 0000
JAMES M LINS, 0000
DAVID J LOBDELL, 0000
PAUL J LOMMEL, 0000
JAMES P LOPER, 0000
STEPHEN E LORENTZEN, 0000
MARK LOTZE, 0000
WALLACE G LOVELY, 0000
JON E LUX, 0000
PAUL J LYONS, 0000
JOHN L MACMICHAEL JR., 0000
MARK P MAGLIN, 0000
GREGORY M MAGUIRE, 0000
JAMES A MANN, 0000
JEFFREY S MANNING, 0000
TIMOTHY J MARICLE, 0000
JEFFREY P MARSHALL, 0000
GREGG W MARTIN, 0000

MATTHEW J MARTIN II, 0000
MICHAEL W MARTIN, 0000
RANDALL H MARTIN, 0000
VINCENT R MARTINEZ, 0000
PETER W MATISOO, 0000
STEVEN P MCALEARNEY, 0000
MICHAEL W MCCALLUM, 0000
ANDREW C MCCUE, 0000
LARRY A MCELVAIN JR., 0000
TIM MCGARVEY, 0000
JAMES L MCREYNOLDS, 0000
PETER A MEHL, 0000
DARRYL C MELTON, 0000
JEFFREY P MENNE, 0000
MARK V METZGER, 0000
GEORGE D MICHAELS, 0000
MARIO MIFSUD, 0000
JOHN L MIHELICH III, 0000
ANDREW W MILES, 0000
JEFFERY S MILLER, 0000
MATTHEW C MILLER, 0000
RANDALL B MILLER, 0000
RICHARD M MILLER JR., 0000
ERIC J MITCHELL, 0000
GREGORY H MOLINARI, 0000
MASON K MOLPUS, 0000
BRIAN T MOORE, 0000
CHARLES C MOORE II, 0000
II C D MORAN, 0000
MICHAEL S MORENO, 0000
BRIAN L MORGAN, 0000
SEAN T MORIARTY, 0000
KURUSH F MORRIS, 0000
TERRY S MORRIS, 0000
GERALD M MOST, 0000
RICHARD P MOUNTAIN, 0000
SCOTT E MULVANIA, 0000
CHRISTOPHER P MURDOCH, 0000
MARK E MUZII, 0000
JEFFREY S MYERS, 0000
RICHARD D NELSON, 0000
JOHN R NETTLETON, 0000
ROBERT A NEWSON, 0000
TROY M NICHOLS, 0000
THAD E NISBETT, 0000
NORBERTO M D NOBREGA, 0000
RONALD J NOVAK, 0000
MARK T NOWICKI, 0000
HEIDI C OCHS, 0000
RICHARD M ODOM II, 0000
WILLIAM A OEFELEIN, 0000
STEVEN B OKUN, 0000
MICHAEL F OTT JR., 0000
GREGORY B OWENS, 0000
MARCELL S PADILLA, 0000
EUGENE F PALUSO II, 0000
SCOTT W PAPPANO, 0000
WILLIAM J PARKER III, 0000
VERNON J PARKS JR., 0000
PETER J PASQUALE, 0000
BENJAMIN J I PEARSON, 0000
GREGORY S PEKARI JR., 0000
ROBERT A PEREBOOM, 0000
DOUGLAS G PERRY, 0000
ERIC S PFISTER, 0000
CATHERINE K PHILLIPS, 0000
DUANE A PHILLIPS, 0000
PATRICK M PICKARD, 0000
WILLIAM S PIESESKI, 0000
IAN R POLLITT, 0000
PATRICK J PORTER, 0000
GANDOLFO A PRISINZANO, 0000
ERIC W PURDY, 0000
VINCENT J QUIDACHAY, 0000
FRANK N QUILES, 0000
KEVIN J QUINN, 0000
JOHN L RADKA, 0000
CHARLES E RADOSTA, 0000
CHRISTOPHER M RANKIN, 0000
KEVIN H RASCH, 0000
KENDALL M RASMUSSEN, 0000
STEVEN R RASMUSSEN, 0000
JOHN J REESE, 0000
JAMES C RENTFROW, 0000
KENNETH J REYNARD, 0000
JOHN E RIES, 0000
ROBERT M RIGGS, 0000
JR W J RILEY, 0000
DANIEL J RIVERA, 0000
JAMES L ROBBINS, 0000
DAVID A ROBERTS, 0000
WILBUR L J ROBERTS, 0000
CHRISTOPHER ROBINSON, 0000
CHRISTOPHER A RODEMAN, 0000
JAMES R ROGERS II, 0000
GREGORY R ROMERO, 0000
AARON L RONDEAU, 0000
MARC A RZEPCZYNSKI, 0000
BENJAMIN D SALERNO, 0000
MARK E SANDERS, 0000
LEONARD D SANTIAGO, 0000
MICHAEL T SCARRY, 0000
PAUL J SCHLISE, 0000
TIMOTHY L SCHORR, 0000
JAMES C SEALS JR., 0000
TODD J SENIFF, 0000
CURTIS A SETH, 0000
PATRICK J SHAFFER, 0000
JOHN E SHASSBERGER, 0000
DANIEL P SHAW, 0000
MICHAEL D SHEAHAN, 0000
JOHN M SHEEHAN, 0000
JOE C SHIPLEY, 0000
ERIC S SHIREY, 0000
KARIN A SHUEY, 0000
DANIEL A SHULTZ, 0000
PHILLIP T SICARD, 0000
OTTO F SIEBER, 0000
JAMES W SIGLER, 0000
RICHARD A SKIFF JR., 0000
KATHY L SLOAN, 0000
BRENT E SMITH, 0000
FRED W SMITH JR., 0000
JED C SMITH, 0000
THOMAS B SMITH II, 0000
TIMOTHY J SMITH, 0000
VICTOR S SMITH, 0000
JAMES B SNELL, 0000
MICHAEL C SPARKS, 0000
WESLEY W SPENCE, 0000
JAMES L SPENCER IV, 0000
MARK F SPRINGER, 0000
RAY A STAPF, 0000
STEPHEN P STARBOARD, 0000
MARC A STERN, 0000
MARK L STEVENS, 0000
JONATHAN R STEVENSON, 0000
WILLIAM R STEVENSON, 0000
JOHN L STOFAN, 0000
JERRY K STOKES, 0000
RICK J STONER, 0000
DAVID A STRACENER, 0000
SHRI J STROUD, 0000
ORLANDO A SUAREZ, 0000
KEVIN W SUTTON, 0000
PAUL TANKS JR., 0000
RANDALL D TASHJIAN, 0000
JAMES L TAYLOR JR., 0000
MICHAEL J TESAR, 0000
FREDERICK N TEUSCHER JR., 0000
CHRISTOPHER P THOMAS, 0000
MARK A THOMAS, 0000
JOHN J THOMPSON, 0000
JOSEPH M THOMPSON, 0000
THOMAS L THOMPSON, 0000
DAVID L TIDWELL, 0000
RYAN C TILLOTSON, 0000
JOHN V TOLLIVER, 0000
JOHN D TOUGAS, 0000
KARL W TRAHAN JR., 0000
TIMOTHY R TRAMPENAU, 0000
MARC G TRANCHEMONTAGNE, 0000
BRADDOCK W TREADWAY, 0000
JOHN C TREUTLER, 0000
WILLIAM M TRIPLETT, 0000
WADE D TURVOLD, 0000
RONALD B TUTTLE JR., 0000
KIERAN S TWOMEY, 0000
PATRICK J TWOMEY, 0000
MURRAY J TYNCH III, 0000
MATTHEW S TYSLER, 0000
ROY C UNDERSANDER, 0000
MAURICE R VARGAS, 0000
DAVID J VARNES, 0000
LAWRENCE R VASQUEZ, 0000
HENRY L VELARDE, 0000
ERIC H VENEMA, 0000
DEAN M VESELY, 0000
THOMAS K VINSON, 0000
DANIEL E VOTH, 0000
MARK D WADDELL, 0000
GREGORY J WALLS, 0000
COLIN S WALSH, 0000
DENNIS J WALSH JR., 0000
HOWARD C WARNER III, 0000
JAMES P WATERS III, 0000
ROBERT WEBBER JR., 0000
JAMES R WICKMAN, 0000
STEVEN J WIEMAN, 0000
DOUGLAS E WILCOX, 0000
JEFFREY B WILLIAMS, 0000
MARK T WILLIAMS, 0000
RICHARD C WILLIAMS JR., 0000
STEVEN M WILLIAMS, 0000
CRAIG L WILSON, 0000
JAMES A WINSHIP, 0000
JEFFREY S WINTER, 0000
PETER J WINTER, 0000
NEIL W WOODWARD III, 0000
RAYMOND B WORTHINGTON, 0000
ERIC K WRIGHT, 0000
BRIAN F WYSOCKI, 0000
ELIZABETH A YEOMANS, 0000
EUGENE S YOUNG, 0000
ROBERT E YOUNG, 0000
RICHARD J ZINS, 0000

FOREIGN SERVICE

THE FOLLOWING-NAMED PERSONS OF THE AGENCIES INDICATED FOR APPOINTMENT AS FOREIGN SERVICE OFFICERS OF THE CLASS STATED, AND ALSO FOR THE OTHER APPOINTMENTS INDICATED HEREWITH:

FOR APPOINTMENT AS FOREIGN SERVICE OFFICERS OF CLASS TWO, CONSULAR OFFICER AND SECRETARY IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA:

DEPARTMENT OF COMMERCE

JAMES M. CUNNINGHAM, OF CALIFORNIA
RICK A. DELAMBERT, OF CALIFORNIA
JAMES C. RIGASSIO, OF NEW JERSEY
JOHN E. SIMMONS, OF CALIFORNIA

FOR APPOINTMENT AS FOREIGN SERVICE OFFICERS OF CLASS THREE, CONSULAR OFFICER AND SECRETARY IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA:

DEPARTMENT OF COMMERCE

MITCHEL I. AUERBACH, OF FLORIDA
REBECCA M. BALOGH, OF VIRGINIA
ISABELLA G. CASCARANO, OF THE DISTRICT OF COLUMBIA
WILLIAM B. CZAJKOWSKI, OF ILLINOIS
ANGELA R. DAWKINS, OF VIRGINIA
ROBERT J. DONOVAN, OF THE DISTRICT OF COLUMBIA
STEPHEN R. JACQUES, OF VIRGINIA
WILLIAM S. LAWTON, OF WASHINGTON
GREGORY J. O'CONNOR, OF VIRGINIA
ALYCE CAMILLE RICHARDSON, OF FLORIDA
PAMELA R. WARD, OF OREGON
JENNIFER ANNE WOODS, OF VIRGINIA

THE FOLLOWING-NAMED MEMBERS OF THE FOREIGN SERVICE OF THE DEPARTMENT OF STATE AND COMMERCE TO BE CONSULAR OFFICERS AND/OR SECRETARIES IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA, AS INDICATED:

CONSULAR OFFICERS AND SECRETARIES IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA:

DEPARTMENT OF COMMERCE

DOUGLAS J. WALLACE, OF MARYLAND

DEPARTMENT OF STATE

ORY S. ABRAMOWICZ, OF ILLINOIS
VALERIE T. ADAMCYK, OF NEW YORK
PETER JAMES ANTHES, OF VIRGINIA
JOHN M. BARRETT, OF CALIFORNIA
SALLY P. BEHRHORST, OF CALIFORNIA
MANU BHALLA, OF NEW HAMPSHIRE
THOMAS EDWARD BROWN JR., OF MARYLAND
JOSEPH J. CALLAHAN IV, OF FLORIDA
MICHAEL R. CARPENTER, OF MICHIGAN
MICHAEL CARVER, OF TEXAS
BENJAMIN CHIANG, OF VIRGINIA
JASON JOHN CHIODI, OF VIRGINIA
LEWIS ANDREW CLARK, OF VIRGINIA
MARY GARDNER COPPOLA, OF THE DISTRICT OF COLUMBIA
RODNEY DEVI CUNNINGHAM, OF NEW YORK
FRANK DEPARIS, OF VIRGINIA
SONIA M. DESAI, OF CALIFORNIA
DANIEL SCOTT DUANE, OF NEW YORK
JENNIFER W. EADIE, OF VIRGINIA
MEGAN ALLISON ELLIS, OF CALIFORNIA
SHANNON BELL FARRELL, OF WISCONSIN
TIMOTHY J. FINGARSON, OF NORTH DAKOTA
DONALD LOREN FRERICHS, OF TEXAS
ANGELA LOUISE GEMZA, OF MINNESOTA
SARAH GORDON, OF NEW YORK
C. COLIN GUEST, OF VIRGINIA
JASON KAMATA HACKWORTH, OF WASHINGTON
SCOTT WILLIAM HANSEN, OF COLORADO
RONALD E. HAWKINS JR., OF MARYLAND
RICH HEATON, OF COLORADO
CHRISTINE BINH-AN PHAM HENNING, OF MICHIGAN
DEBORAH ANN HICK, OF FLORIDA
ERIK JONATHAN HOLMGREN, OF ILLINOIS
BRADLEY A. HURST, OF CALIFORNIA
SUZANNE MARY INZERILLO, OF ILLINOIS
KENNETH JONES, OF NEW JERSEY
PAUL A. KIRSCHBAUM, OF VIRGINIA
ELIZABETH J. KONICK, OF NEW YORK
COURTNEY ALLISON KRAMER, OF THE DISTRICT OF COLUMBIA
JAMIE TYLER LA MORE, OF ARIZONA
MICHAEL D. LAMPEL, OF ILLINOIS
MEGAN E. LARSON-KONE, OF MARYLAND
SARA MARGARET LUTHER, OF COLORADO
THOMAS H. LYONS, OF TENNESSEE
PETER K. MALECHA, OF WASHINGTON
JOHN RUSH MARBURG, OF MARYLAND
ELIZABETH KATHLEEN MARTIN, OF ILLINOIS
MARISSA M. MARTIN, OF FLORIDA
ANDREW MCCLEARN, OF COLORADO
JASON MCINERNEY, OF CALIFORNIA
ANTHONY LUIS MIRANDA, OF WASHINGTON
GONS GUTIERREZ NACHMAN, OF FLORIDA
ARI NATHAN, OF CALIFORNIA
JAMES PATRICK NEEL, OF NEVADA
PETER NEISULER, OF THE DISTRICT OF COLUMBIA
TIMOTHY D. NELSON, OF CALIFORNIA
AMY LORENE NICODEMUS, OF NEW JERSEY
JONATHAN R. PECCIA, OF ILLINOIS
CAROLINE L. PRICE, OF GEORGIA
JUDITH RAVIN, OF NEW JERSEY
SIMEON RASAY RAYA JR., OF NEW JERSEY

ANTHONY FERRER RENZULLI, OF THE DISTRICT OF COLUMBIA
FREDERIC JORGE ROCAFORT-PABON, OF FLORIDA
JACQUELYN BURKE ROSHOLT, OF MINNESOTA
KIRK HARRIS SAMSON, OF WISCONSIN
JANET NICOLE SANDERS, OF GEORGIA
SATRAJIT SARDAR, OF TEXAS
GABRIELLE HAYES SARRANO, OF VIRGINIA
ERIN A. SAWYER, OF CALIFORNIA
VERONICA SCARBOROUGH, OF VIRGINIA
ELIZABETH GRACE NICHOLS SCHLACHTER, OF CALIFORNIA
LAURA KATHRYN SCHEIBE, OF SOUTH DAKOTA
JON M. SELLE, OF TEXAS
MICHAEL T. SESTAK, OF NEW YORK
GEOFFREY C. SIEBENGARTNER, OF NEW YORK
JESSICA LEIGH SIMON, OF OREGON
DAVID WALKER SIMPSON, OF TEXAS
CHRISTOPHER MAGNUS SMITH, OF MARYLAND
ALEXANDER W. SOKOLOFF, OF FLORIDA
ROBERT J. TATE, OF WASHINGTON
ADAM RICHARD VOGELZANG, OF MARYLAND
MARGARET C. WHITE, OF VIRGINIA
THOMAS WISE, OF MINNESOTA

THE FOLLOWING-NAMED CAREER MEMBER OF FOREIGN SERVICE OF THE DEPARTMENT OF STATE FOR PROMOTION IN THE SENIOR FOREIGN SERVICE TO THE CLASS INDICATED:

CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF COUNSELOR, IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA:

DEPARTMENT OF STATE

HOWARD M. KRAWITZ, OF PENNSYLVANIA